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"REVIEW OF THE AFFORDABLE CARE ACT HEALTH INSURANCE CO-OP PROGRAM"

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"Review of the Affordable Care Act Health Insurance CO-OP Program"
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Chairman Portman, Ranking Member McCaskill, and members of the Subcommittee, thank you for the invitation to discuss the Consumer Operated and Oriented Plan (CO-OP) program. The Centers for Medicare & Medicaid Services (CMS) is committed to overseeing the CO-OP program and is hard at work providing CO-OP consumers and taxpayers important protections as CO-OPs expand access, choice, and competition, helping Americans access high quality, affordable health insurance coverage.

CMS's priority is to provide Marketplace customers with access to quality, affordable coverage. In the years since the passage of the Affordable Care Act, we have seen increased competition among health plans and more choices for consumers.[1] During the third Marketplace Open Enrollment, nine out of ten returning customers were able to choose from three or more issuers for 2016 coverage, up from seven in ten in 2014.[2] The CO-OPs have played an important role in the Marketplace, particularly in the early years of the Affordable Care Act by providing additional options for access to affordable health coverage from local, non-profit health insurers. Moving forward, CMS is eager to build on the progress in reducing the number of uninsured Americans – an estimated 17.6 million Americans gained coverage since the Affordable Care Act's coverage provisions have taken effect,[3] and the Nation's uninsured rate is at its lowest level since data collection began over five decades ago.[4,5] During the third open enrollment that concluded at the end of January, 12.7 million Americans selected affordable, quality health plans for 2016 coverage through the Marketplaces.[6]

[1] www.hhs.gov/about/news/2015/07/30/competition-and-choice-in-the-health-insurance-marketplace-lowered-premiums-in-2015.html
[2] www.hhs.gov/about/news/2015/07/30/competition-and-choice-in-the-health-insurance-marketplace-lowered-premiums-in-2015.html
[3] http://aspe.hhs.gov/health-insurance-coverage-and-affordable-care-act-aspe-issue-brief-september-2015
[4] http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201602.pdf
[5] http://www.cdc.gov/nchs/data/nhsr/nhsr017.pdf
[6] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-04.html

CMS Implementation of the CO-OP Program

Section 1322 of the Affordable Care Act established the CO-OP Program to foster the creation of non-profit health insurance issuers to give more choices and control to consumers, promote local competition, and improve diversity in the health insurance market. To this end, the law provided funding for loans to eligible entities to help establish and maintain these new plans. The funding initially provided by the law was intended to provide capital sufficient to support start-up costs, such as establishing provider network relationships, claims and financial operations, developing products, and meeting regulatory surplus requirements through the initial phase of operations. In implementing the CO-OP Program as required by statute and with the funds available, CMS evaluated loan applications, monitors financial performance, conducts financial and operational oversight, and supports state departments of insurance (DOIs), which are the primary regulators of insurance issuers in the states.

CMS established the CO-OP Program as outlined in the CO-OP Program Funding Opportunity Announcement[7] and the CO-OP Program Final Rule.[8] The framework for implementing the CO-OP Program was based on a report submitted by a Federal Advisory Committee appointed by the Government Accountability Office (GAO) under section 1322(a)(3) of the Affordable Care Act to advise the Secretary of Health and Human Services (HHS) regarding the award of CO-OP loans. The report included recommendations on governance, finance, infrastructure, criteria, process, and compliance for CO-OPs and a timeline for the CO-OP Program.[9] This report guided the major elements of how CO-OPs were selected, awarded loans, and monitored.

The CO-OP application review process was rigorous, objective, and conducted with input and expertise from an independent party, Deloitte Consulting, LLP. Deloitte used a team of insurance experts, actuaries, former state insurance regulators, and other experts to verify eligibility and evaluate each element of the application, such as the business plan, financial projections, and a feasibility study, using the criteria established in the Funding Opportunity Announcement. The Deloitte findings and recommendations were then sent to the internal CMS review committee,

[7] https://www.cms.gov/CCIIO/Resources/Funding-Opportunities/Downloads/final_premium_review_grant_solicitation_with_disclosure_statement.pdf
[8] https://www.gpo.gov/fdsys/pkg/FR-2011-12-13/pdf/2011-31864.pdf
[9] https://www.cms.gov/CCIIO/Resources/Files/Downloads/coop_faca_finalreport_04152011.pdf

which was led by insurance experts and an actuary who was not on the CO-OP program staff. A July 2013 HHS Office of Inspector General (OIG) Report found that "CMS established a prospective oversight system to safeguard CO-OP funding and ensure timely implementation of the program."[10]

Of 147 applications,[11] 24 were selected to receive loan funds and ultimately entered into CO-OP loan agreements with CMS. Ultimately, CMS awarded $2.5 billion in loan funding to the 24 CO-OPs, over $2.1 billion, or 85 percent, of which was awarded before coverage began on January 1, 2014. The Federal Advisory Group emphasized the importance of awarding the funds "as expeditiously as possible" in order for CO-OPs to be able to compete in the 2014 Open Enrollment period.[12] As the statute required, loans were made in two forms:[13] start-up loans and solvency loans. Start-up loan obligations were specific to each CO-OP in an amount based on estimated costs of particular start-up activities. A disbursement schedule that governed the basis, timing, and amount of sequential disbursements of start-up loan funding was incorporated into each CO-OP borrower's loan agreement.

As set forth in the statute, solvency loan funds assisted loan recipients with meeting regulatory capital and surplus requirements of the state(s) in which they are licensed, as well as additional CMS CO-OP Program requirements. CO-OPs requested disbursements of solvency loan funding to maintain state and CO-OP loan agreement required solvency levels. Solvency loan award levels were made based on the particular business plan included in the loan agreement and state regulatory capital requirements.

After the start of coverage on January 1, 2014, CMS awarded additional solvency funding to several existing CO-OPs. In making subsequent loan decisions, CMS undertook a rigorous review process substantially similar to what was conducted for the initial round of loans. This included both an external and internal review of updated business plans, feasibility studies,

[10] http://oig.hhs.gov/oei/reports/oei-01-12-00290.pdf
[11] Including 34 applications that were not subject to a full review process, but were subsequently denied due to funding rescissions.
[12] https://www.cms.gov/CCIIO/Resources/Files/Downloads/coop_faca_finalreport_04152011.pdf
[13] Sec. 1322(b) the Affordable Care Act

programmatic and regulatory compliance, actuarial soundness, and financial statements. Requests were made for more funding than was available, so the comparative level of need was also an important factor. The applications included actuarially-certified analysis and financial projections, which incorporated data regarding the current and projected level of enrollment. During 2014, CMS provided approximately $352.5 million in additional solvency loan funding.

CMS used information available after the first round of funding about the size of enrollment and operational compliance to evaluate applications for additional loan funding. The enrollment, claims, and financial data available during the review of applications for both the first and second rounds of opportunity for additional solvency loan funding was limited in scope because these CO-OPs were in their initial stages of operation, and a substantial number of CO-OP members enrolled on or after the January 1, 2014 coverage start date. The late enrollment and the length of time it takes to receive, process, and pay claims and for those claims to have actuarial meaning, meant that at that time, CO-OPs had six to nine months of enrollment data and claims experience for Deloitte and CMS to review.

While the Affordable Care Act appropriated $6 billion for the program, the Congress made a number of substantial rescissions to that initial funding level. The Department of Defense and Full Year Continuing Appropriations Act, 2011, rescinded $2.2 billion; the Consolidated Appropriations Act, 2012, rescinded an additional $400 million; and the American Taxpayer Relief Act of 2012 further reduced the remaining $3.4 billion of CO-OP funding by rescinding 90 percent of funds unobligated as of the date of enactment. Finally, an additional $13 million was reduced due to sequester in Fiscal Year 2013. The remaining balance was assigned to a new contingency fund available for oversight and assistance to the existing CO-OP loan recipients.

CO-OP Accomplishments and Challenges

CO-OPs have provided health insurance coverage to more than one million consumers, helping people access needed medical care. This program has increased competition and provided more consumer choices and control in choosing health insurance coverage. For example, Maryland's

CO-OP (Evergreen Health) was the first new issuer to enter the state's market in 25 years,[14] and New Jersey's CO-OP (Health Republic of New Jersey) was the first new issuer to enter the state's market in 19 years.[15] In Maine, the CO-OP (Maine Community Health Options) was one of two issuers on the Exchange in 2014; that year, it enrolled 83 percent of individuals who used the Marketplace to sign up for coverage. The CO-OP began offering coverage to the residents of New Hampshire in 2015.[16] Overall, CO-OPs have added both choice and affordability to health insurance coverage options available to consumers.

CO-OPs are also introducing local innovation. Ohio's CO-OP (InHealth Mutual) offers a disease management program for six different conditions that includes education, case management, and no copays for any visit, prescription, or supplies associated with management of the disease.[17] New Jersey's CO-OP (Health Republic of New Jersey) implemented a harm reduction program to help enrollees quit and reduce smoking.[18] CMS will continue our work to support CO-OPs as they pursue innovative approaches to coverage.

However, new entrants to any market, especially the insurance market, face numerous pressures and must overcome multiple barriers, particularly in their early stages of operations. In its July 2013 report, HHS OIG found that "the extent to which any particular CO-OP can achieve program goals and remain financially viable depends on a number of unpredictable factors. These factors include the CO-OP's State's Exchange operations, the number of people who enroll in the CO-OP and their medical costs, and the way in which competing plans will affect the CO-OP's market share."[19] CO-OPs entered the health insurance market facing a variety of challenges, including building a provider network and customer support, no previous claims experience on which to base pricing, and competition from larger, experienced issuers. The Federal Advisory Group found that many of the challenges the CO-OPs faced were the same as

[14] http://www.nytimes.com/2015/09/16/business/health-cooperatives-find-the-going-tough.html?_r=0
[15] http://docs.house.gov/meetings/IF/IF02/20151105/104146/HHRG-114-IF02-Wstate-MorrisonJ-20151105.pdf
[16] http://www.pressherald.com/2014/09/30/maine-insurance-co-operative-accelerates-plans-to-cover-new-hampshire/
[17] http://www.inhealthohio.org/shop-for-insurance/individuals-and-families/2016-enrollment-material-individual-family-benefits
[18] https://newjersey.healthrepublic.us/smoking-cessation/smoking-cessationtobacco-harm-reduction-faq/
[19] http://oig.hhs.gov/oei/reports/oei-01-12-00290.pdf

any new health insurance entity.[20] The Commonwealth Fund published a report on the factors that contributed to the CO-OPs' challenges, which provided further evidence of the issues faced by new entrants into the market, including having to outsource important functions, in particular network contracting, limited information about existing provider practices and referral habits, and initial enrollment that diverged from expectations.[21]

CMS Oversight

CMS has obligations to operate as a proper steward of the taxpayer dollars issued through the loan program and to administer the CO-OP Program for the benefit of consumers. Since awarding both start-up and solvency loans, CMS has been closely monitoring and evaluating the CO-OPs to assess performance and compliance, and has engaged regularly with state DOIs, which are the primary regulators of insurance issuers in the states. Twelve CO-OPs are no longer selling coverage in the Marketplace and are in various stages of winding down operations. The remaining eleven CO-OPs, serving thirteen states, are being monitored closely.

CMS's oversight approach, informed by the work of both HHS OIG and GAO, consists of four parts. First, all CO-OPs are subject to standardized, ongoing reporting to and interactions with CMS that include weekly, biweekly, or monthly calls to monitor goals and challenges; periodic on-site visits; performance and financial auditing; and monthly, quarterly, semi-annual, and annual reporting obligations. Since March 2015, CMS has conducted site visits of CO-OPs in 15 states. We believe these visits are a benefit to plans, consumers, and taxpayers. These visits provide CMS with an opportunity to verify whether and how a CO-OP meets its obligations. During these visits, CMS reviews management structure and staffing, financial status, business strategy, the policies and procedures of the CO-OP, marketing and sales information, and operations, including vendor management and oversight. CMS also reviews whether a CO-OP is meeting their obligations for medical management and member relations. CMS also collaborates with DOIs concerning each CO-OP loan recipient.

[20] https://www.cms.gov/CCIIO/Resources/Files/Downloads/coop_faca_finalreport_04152011.pdf
[21] http://www.commonwealthfund.org/~/media/files/publications/fund-report/2015/dec/1847_corlette_why_are_many_coops_failing.pdf?la=en

Second, CMS monitors the CO-OPs' overall financial condition using several factors of the Federal Deposit Insurance Corporation's Uniform Financial Institutions Rating System. CO-OPs have monthly, semi-annual, and annual reporting requirements, including financial statements, balance sheets, income statements, statements of cash flow, and enrollment statistics. Last year, CMS increased the data and financial reporting requirements for CO-OPs. Each CO-OP is required to provide a semi-annual statement of its compliance with all relevant State licensure requirements, and, if necessary, an explanation of any deficiencies, warnings, additional oversight, or any other adverse action or determination by DOIs received by the CO-OP. If the CO-OP is experiencing compliance issues with State regulators, the CO-OP is required to describe the steps being taken to resolve those issues. CMS meets monthly with the state insurance regulators regarding each CO-OP. This additional financial data collection has helped CMS to identify underperforming CO-OPs and gives CMS the opportunity to work with the CO-OPs and DOIs to help correct issues that are identified.

Third, CMS regularly uses enhanced oversight plans (EOPs) and corrective action plans (CAPs) as part of our CO-OP monitoring and oversight process, as laid out in the CO-OP loan agreements and recommended by the HHS OIG. CMS places a CO-OP on an EOP or CAP when it identifies an issue that can be resolved through corrective action. A CO-OP can be on an EOP or CAP for a variety of reasons relating to its operations, compliance, management, or finances. A CAP could require a CO-OP to make improvements to its claim payment processes, customer service, premium billing, or other administrative functions. The reasons for an EOP or a CAP are often common issues for any issuer in the difficult, competitive, and complicated health insurance market, and are not unique to the CO-OPs.

Finally, CMS can terminate its loan agreement with a CO-OP if we determine it is no longer viable, sustainable, or serving the interests of the community. CMS works closely with DOIs and shares information to assist in their assessments of CO-OPs. If a loan agreement is terminated, CMS works with the state DOI and the CO-OP board to wind down operations in an orderly way to mitigate impact to the consumer. While it is too early to tell how much money may be recovered, CMS has begun the recovery process, and once the wind down of these CO-OPs is complete, we will use every available tool to recoup Federal funding, based on applicable law

and the loan agreements. During closeout, most CO-OPs exiting the market were placed into a receivership or supervisory status that controls assets, expenses, and contractual rights and obligations including ongoing operating costs and claims payment. These arrangements help protect remaining funds.

In addition to protecting taxpayer dollars, CMS also works to protect consumers. For the CO-OPs that are closing, we are working closely with the CO-OP and state regulators to facilitate a smooth transition for consumers to retain access to coverage and ensure providers are reimbursed for covered services rendered to CO-OP enrollees. Each of the consumers in the CO-OPs that closed at the end of 2015 maintained coverage until the end of the year, and nearly three-quarters[22] of the CO-OP Marketplace consumers have continued their coverage in a new plan in 2016. Affected CO-OP enrollees had access to a special enrollment period, and were able to shop for 2016 coverage on the Marketplace until February 28, 2016. In all cases, CMS is focused on making sure consumers continue to receive medical services.

Moving Forward

Since the enactment of the Affordable Care Act, CMS has worked to increase access to quality, affordable coverage through the Marketplaces and to be responsible stewards of taxpayer dollars. The CO-OP program was designed to give consumers more choices, promote competition, and improve quality in the health insurance market. Though not all CO-OPs have continued to offer coverage, consumers continue to have a variety of affordable health insurance coverage choices that meet the health care needs of their families. While CO-OPs are primarily responsible for their own success, CMS will continue to help them identify and correct issues and make improvements. CMS is committed to continuing its work with the CO-OPs offering coverage this year to facilitate progress and expand into new markets when appropriate. CMS has also clarified our policies on important topics[23] and is exploring what changes could be made to help CO-OPs diversify their boards and grow and raise capital, while still preserving the fundamentally member-run nature of the CO-OP program. Working with state DOIs and the CO-OPs, CMS will continue its rigorous ongoing monitoring and oversight processes in order to

[22] Does not include consumers who enrolled in new plans outside the Marketplace.
[23] https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/CO-OP-Questions-Final-1-27-16.pdf

prevent consumers from experiencing potential disruption in health insurance coverage. Additionally, we will use every tool available to recoup Federal dollars, where appropriate. We appreciate the Committee's interest and are happy to answer your questions.