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Implementing Obamacare: A Review of CMS' Management of the Failed CO-OP Program

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II. Executive Summary

In March 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law. Because the law required individuals to purchase health care insurance, lawmakers and stakeholders anticipated an unprecedented number of new, previously-uninsured individuals signing up for health care insurance. To help achieve the law's objective of increasing choice in health care insurance plans, Section 1322 of the PPACA established the Consumer Operated and Oriented Plan (CO-OP) program. The law authorized the Secretary of Health and Human Services (HHS) to provide loans to help establish CO-OPs, thus increasing choice and creating competition among insurers. The Centers for Medicare and Medicaid Services (CMS) funded 24 CO-OPs in 23 states.

The CO-OPs were established with loan terms, set by CMS, which disadvantaged CO-OPs from the start. Limitations on the CO-OPs ability to seek outside capital, restrictions for board their composition, and a lack of prior claims experience are some of the handicaps that hindered the CO-OPs from the onset. As a result, they faced numerous challenges that set them up for failure.

Instability with premium stabilization programs such as Risk Corridor and Risk Adjustment, in addition to CO-OP enrollment extremes, hindered the CO-OP's financial stability, and it was not long before they began to fail. The Risk Corridor, a temporary three-year program, was created to protect insurers in the event that claims costs exceeded initial projected losses, by providing transfer payments to insurers with significant financial losses. On October 1, 2015, CMS announced that the risk corridor payments would be only 12.6 percent of what was initially calculated and promised, resulting in CMS paying out $2.5 billion less than what they had represented would be paid to the insurers. This extreme shortfall in funds undercut the financial planning and therefore the financial stability of the CO-OPs. Further, despite numerous inquiries from the CO-OPs, CMS failed to notify the CO-OPs that the risk corridor payment was going to fall short of initial projections leaving the CO-OPs blindsided on October 1, 2015.

The Risk Adjustment program was created to protect against adverse risk selection in the marketplace, by requiring insurance companies with healthier individuals to make payments to insurance companies with sicker individuals to offset costs. On June 30, 2016, HHS released the initial Risk Adjustment scores for 2015—the first year that CO-OPs had to make payments into the program—and the data indicated that all but one of the remaining CO-OPs were responsible for making substantial risk adjustment payments. In many cases, these payments exceeded the CO-OP's capital. This announcement triggered a domino effect, in which many CO-OPs announced they would be shutting down their doors.

Closures of the CO-OPs—particularly ones that occurred outside of the open enrollment period—left consumers scrambling to find health care insurance in order to maintain their health insurance coverage. These closures left those consumers with fewer and likely less affordable choices for health insurance. For the CO-OPs that didn't have enough capital to pay outstanding claims, other entities, such as other health insurance companies or Insurance Commissioners, were left to find alternative ways to pay the doctors that were left with outstanding claims.

CMS' mismanagement and ineffective oversight also contributed to the failure of the CO-OPs. CMS's primary oversight mechanism for the CO-OPs is a Corrective Action Plan (CAP). When CMS identifies an issues regarding financial instability, compliance, or operational and management issues within the CO-OP, the CO-OP was placed on a CAP in an attempt to alert the CO-OP of the issue, and further identify why this put the CO-OP at risk, and suggest ways to remedy the situation and ensure that they were in compliance with the terms of the loan agreement. These CAPs often were reactionary to a problem that the CO-OP was already aware of and contained errors and outdated information. The committee's investigation found the CAPs to be unsuccessful and burdensome on the CO-OPs.

Less than three years into the program, only six of the original 23 CO-OPs remain, indicating the future of existing CO-OPs remains uncertain. Several CO-OPs—both ones that are still open and ones that have since closed—have filed lawsuits against the federal government regarded the PPACA's flawed premium stabilization programs which contributed to CO-OP's financial insolvency. Moreover, a recent HHS-OIG report has found that the remaining CO-OPs are becoming financially insolvent, thus, reducing the likelihood that the federal government will be repaid for startup loans. Not only does the failure of CO-OPs waste taxpayer dollars, it also leaves hundreds of thousands of individuals displaced with insurance coverage—the exact opposite objective of the Affordable Care Act. As Congress continues to discover red flags regarding the viability of the program, it is imperative that CMS is held accountable to oversee the administration of the remaining CO-OPs.

III. Findings

- CO-OPs either failed to meet enrollment targets or surpassed enrollment capacity, and both scenarios created financial insolvency.
- CMS paid approximately $2.5 billion less than anticipated in Risk Corridor payments.
- HHS and Congress designed the Risk Corridor program to be budget neutral.
- State regulators notified CO-OPs of violations of state laws, requested enrollment freezes, and weighed in on potential loan conversions.
- CMS issued CAPs in response to oversight conducted not by CMS, but rather by state regulators and the HHS OIG.
- CMS issued CAPs that contained obvious errors and outdated information.
- CMS failed to notify CO-OPs before October 1, 2015, that Risk Corridor payments would be less than CMS' initial calculations.
- CMS failed to provide technical assistance as CO-OPs raised Risk Adjustment concerns.
- CMS has not enforced the rules on Special Enrollment Periods, contributing to unpredictable enrollment figures.
- By delaying rulemaking, CMS gave CO-OPs only four months to secure outside investors.
- Operational CO-OPs are not likely to pay back loans because of potential insolvency.

IV. Background

President Obama signed the Patient Protection and Affordable Care Act into law on March 23, 2010.[1] The law imposed new taxes and regulations for health care insurance on individuals and families, including a mandate requiring individuals to purchase insurance or pay a tax. The PPACA also created an entirely new framework for individuals and small businesses to purchase health care insurance, known as a health care insurance exchange. Exchanges operate in all 50 states and the District of Columbia, with the stated goal of facilitating the purchase of health insurance by individuals and small businesses as required under the law.[2] Because the law required individuals to purchase health care insurance, lawmakers and stakeholders anticipated an unprecedented number of new, previously-uninsured individuals would sign up for coverage at the start of open enrollment.

To help achieve the law's objective of increasing choice in health care insurance plans, Section 1322 of the PPACA established the Consumer Operated and Oriented Plan program. A CO-OP is a non-profit health insurance organization that is directed by its customers, and sells individual and small business health insurance plans through the exchanges established by PPACA.[3] The law authorized the Secretary of Health and Human Services to provide loans to help establish CO-OPs, thus increasing choice and creating competition among insurers. Organizations such as small business coalitions, physician and hospital providers and associations, agricultural organizations and unions have all applied for and received loans to establish a CO-OP through this program.

Although Congress initially allotted $6 billion for the program, subsequent legislation rescinded over half of the initial funding. The Centers for Medicare and Medicaid Service (CMS), the agency within HHS charged with implementing the CO-OP program, ultimately provided loans totaling $2.4 billion to 24 CO-OPs in 23 states.

On January 1, 2014 – the first day plans were available through the PPACA – 23 out of the original 24 CO-OPs offered health insurance coverage through the new health insurance marketplaces in 23 states. At their peak, over one million individuals were enrolled in health insurance plans offered by one of the CO-OPs.

However, of the 23 CO-OPs that sold health insurance plans, 17 have closed to date.[4] Of those, 10 CO-OPs failed within a span of four months between July 2015 and December 2015.

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[1] Patient Protection and Affordable Care Act, Pub. L. No 111-148, 124 Stat. 119 (2010).
[2] *Id*.
[3] Originally, all the members of the Board of Directors were required to enroll in a plan through the CO-OP. HHS recently loosened those rules to require that a majority of the Board must have CO-OP plans. This will be discussed further in Section VII(B)(2).
[4] This total does not include Vermont's CO-OP, which state regulators dissolved before it enrolled a single person. Despite receiving an award approved for over $33 million, Vermont's CO-OP failed to meet the state's insurance standards and was denied a license to sell health insurance. Vermont's former Chief Executive has said it will be unable to repay $4.5 million that had been spent. *See* State of Vt. Dep't of Fin. Regulation, In the Matter of: Application by the Proposed Vermont Health CO-OP for a Certificate of Public Good and Certificate of Authority to Commence Business as a Domestic Mutual Insurance Company, Docket No. 12-041-I (May 22, 2013); Jerry

CMS awarded these 17 failed CO-OPs just over $1.8 billion in taxpayer dollars, and to date, none of those CO-OPs have paid back the taxpayer-funded loans. Currently, only six CO-OPs are in operation.

These failures resulted in significant social costs and individual hardships. The committee examined the reasons behind these failures, and concluded that the failure of the 17 CO-OPs can be attributed to both fundamental flaws in the underlying law that placed CO-OPs at a disadvantage from the beginning, and failures by CMS to manage CO-OPs so that they could succeed and pay back taxpayer-funded loans. These same challenges continue to plague the remaining six operating CO-OPs, and a number of them face uncertain futures.

A. The ACA Authorizes CMS to Establish and Regulate CO-OPs

Section 1322 of the PPACA established the CO-OP program, to provide consumers more choices in their healthcare plans and increase competition among insurers. According to CMS, CO-OPs were designed to be "directed by their customers and designed to offer individuals and small businesses additional affordable, consumer-friendly, and high-quality health insurance options."[5]

CMS awarded $2.4 billion in federally funded loans to the 24 CO-OPs established under the law through two types of loans – start-up loans and solvency loans. Start-up loans were intended to assist CO-OPs with start-up activities and initial operations and must be repaid within five years. Solvency loans were intended to enable CO-OPs to meet the capital reserve requirements of the various states in which the applicants sought a license to sell insurance;[6] CO-OPs are required to repay solvency loans with interest within 15 years. Each CO-OP received both types of loans. Of the $2.4 billion in loans to CO-OPs, $358 million were in the form of start-up loans and $2.08 billion were for solvency loans. Further, under the terms of the program, CO-OPs must pay any outstanding debts or obligations before repaying the loan funds to CMS.

CMS made initial start-up loans to the 24 CO-OPs from February 2012 to December 2012. The following chart details the schedule of loans. The chart also shows the dates the 17 of the 23 failed, including the 10 that failed between July 2015 and December 2015. The data in the chart was published on CMS' website.[7]

Markon, *Health co-ops, created to foster competition and lower insurance costs, are facing danger*, THE WASH. POST Oct. 22, 2013.

[5] The Center for Consumer Information & Insurance Oversight, *New Federal Loan Program Helps Nonprofits Create Customer-Driven Health Insurers, available at*: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/coop_final_rule.html (last visited August 29, 2016).

[6] State regulators require insurance companies to maintain certain levels of capital in order to conduct business. Requirements differ by state.

[7] *See* Center for Consumer Information, *supra* note 5.

Name of CO-OP	Award Amount	Award Date	Date of Closure Announcement
Compass Cooperative Mutual Health Network, Inc. d/b/a Meritus Health Partners (Arizona)	$93,313,233	June 7, 2012	October 30, 2015
Colorado Health Insurance Cooperative, Inc. (CHI) d/b/a Colorado HealthOp	$72,335,129	July 23, 2012	October 16, 2015
HealthyCT, Inc. d/b/a HealthyCT (Connecticut)	$127,980,768	June 7, 2012	July 5, 2016
Land of Lincoln Health Mutual Health Insurance Company (formerly Metropolitan Chicago Healthcare Council CO-OP) d/b/a Land of Lincoln Health (Illinois)	$160,154,812	December 21, 2012	July 12, 2016
CoOportunity Health (formerly Midwest Members Health) (Iowa and Nebraska)	$145,312,100	February 17, 2012	January 23, 2015
Kentucky Health Cooperative, Inc. (Kentucky and West Virginia)	$146,494,772	June 19, 2012	October 9, 2015
Louisiana Health Cooperative, Inc.	$65,790,660	September 27, 2012	July 24, 2015
Maine Community Health Options (MCHO)	$132,316,124	March 23, 2012	N/A
Evergreen Health Cooperative Inc. (Maryland)	$65,450,900	September 27, 2012	N/A
Minuteman Health, Inc. (Massachusetts and New Hampshire)	$156,442,995	August 13, 2012	N/A
Michigan Consumer's Healthcare CO-OP	$71,534,300	May 17, 2012	November 3, 2015
Montana Health Cooperative	$85,019,688	February 17, 2012	N/A
Nevada Health Cooperative (formerly Hospitality Health CO-OP)	$65,925,396	May 17, 2012	August 25, 2015
Freelancers CO-OP of New Jersey d/b/a Health Republic Insurance of New Jersey	$109,074,550	February 17, 2012	September 12, 2016
New Mexico Health Connections	$77,317,782	February 17, 2012	N/A
Freelancers Health Service Corporation d/b/a Health Republic Insurance of New York	$265,133,000	February 17, 2012	September 25, 2015
Coordinated Health Mutual, Inc. (Formerly Coordinated Health Plans of Ohio, Inc.) d/b/a InHealth Mutual (Ohio)	$129,225,604	October 12, 2012	May 26, 2016
Freelancers CO-OP of Oregon d/b/a Health Republic Insurance of Oregon	$60,648,505	February 21, 2012	October 16, 2015
Oregon's Health CO-OP (Formerly Community Care of Oregon)	$56,656,900	March 23, 2012	July 8, 2016
Consumers' Choice Health Insurance Company (CCHIC) (South Carolina)	$87,578,208	March 27, 2012	October 22, 2015
Community Health Alliance Mutual Insurance Company (Tennessee)	$73,306,700	August 29, 2012	October 14, 2015
Arches Mutual Insurance Company (Formerly Arches Community Healthcare) (Utah)	$89,650,303	July 6, 2012	October 27, 2015
Common Ground Healthcare Cooperative (Wisconsin)	$107,739,354	February 17, 2012	N/A

B. Early Concerns about the CO-OP Program Prompts Committee Investigation

Even before CMS awarded the first loan to a CO-OP, there were signals that the program would not be a good investment for the taxpayer. In 2009, Senator John Rockefeller (D-WV) expressed concern about the viability of the CO-OP model for providing health care insurance, calling it a "dying business model for health insurance":

> [T]here has been no significant research into consumer co-ops as a model for health insurance. What we do know, however, is that this model was tried in the early part of the 20th century and largely failed…This is a dying business model for health insurance…I believe it is irresponsible to invest over $6 billion in a concept that has not proven to provide quality, affordable health care.[8]

PPACA imposed restrictions on the use of federal funds, and CO-OPs were unable to use federal funds for marketing purposes or to attempt to influence legislation.[9] Also, regulations issued pursuant to PPACA imposed additional restrictions, such as restricting board membership to CO-OP enrollees.[10] The law also made the CO-OPs – entirely new businesses in a new marketplace – subject to the complexities and volatility of the Risk Corridor and Risk Adjustment programs.

Not surprisingly, even before CMS awarded loans to any of the CO-OPs, both HHS and the Office of Management and Budget (OMB) projected significant losses of taxpayer dollars because of the taxpayer-funded loans made through this program. In its 2011 proposed rule to implement the CO-OP program, HHS estimated that the CO-OPs would fail to repay approximately one-third of the loans, predicting that only "65 percent of the Solvency Loans and 60 percent of the Start-up Loans" would be repaid.

> The capital requirements for CO-OPs would be financed, in part, by member premiums and in part by the $3.8 billion dollars available for loans over the next five years. The net Federal costs of these loans to CO-OPs are "transfers." The net transfer costs resulting from default and loss of interest over the relevant 5 year (Start-up Loan) and 15 year (Solvency Loan) periods are estimated later in this analysis, in Table 1. We estimate that 65 percent of the Solvency Loans and 60 percent of the Start-up Loans will be repaid.[11]

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[8] Letter from John D. Rockefeller, Chairman, S. Comm. on Commerce, Sci., & Transp., to S. Comm. on Fin. Chairman Max Baucus and S. Comm. on Fin. Ranking Member Charles Grassley (Sept. 16, 2009).
[9] PPACA Section 1322
[10] "Patient Protection and Affordable Care Act; Establishment of Consumer Operated and Oriented Plan (CO-OP) Program," 76 FR 77392 (December 13, 2011).
[11] "Patient Protection and Affordable Care Act; Establishment of Consumer Operated and Oriented Plan (CO-OP) Program," 76 Federal Register 139 (July 20, 2011), p. 43247.

HHS' final rule further assessed CO-OP's repayment terms and acknowledged that "[t]he business plan, disbursement schedule, and repayment terms will vary for each loan recipient. As such, these transfers are uncertain, and will vary from loan to loan."[12] One year later, as part of its proposed budget for fiscal year 2013, OMB also projected significant losses.[13] In the following chart, OMB predicted that the federal government would not recover approximately 37 percent of startup loans, and approximately 43 percent of solvency loans. This projected loss is characterized in the chart as a "loan subsidy:"

Table 1. DIRECT LOANS: SUBSIDY RATES, OBLIGATIONS, AND AVERAGE LOAN SIZE—Continued
(Dollars in thousands)

Agency, Bureau, Program and Risk Category	BEA Category	2012			2013		
		Subsidy rate (percent)	Obligations	Average loan size	Subsidy rate (percent)	Obligations	Average loan size
Department of Health and Human Services							
Centers for Medicare and Medicaid Services:							
Consumer Operated and Oriented Plan:							
Startup Loans	Mandatory	37.51	675,000	15,000	37.66	195,000	15,000
Solvency Loans	Mandatory	43.99	4,950,000	110,000	43.78	1,430,000	110,000

Based on these troubling projections, the committee launched an investigation of the CO-OP program. In April of 2012, after OMB projected that CO-OPs would be unable to repay over 40 percent of the loans offered through the program, the committee sent a letter to then CMS Acting Administrator Marilyn Tavenner, requesting information and documents about CMS's implementation of the program, and expressed concern that the CO-OPs would not be financially viable.[14]

In its July 12, 2012, response to the committee, CMS stated that the loan subsidy rate, 43.21 percent, in the President's Budget is a "general budget assumption factor used in all federal loan programs."[15] CMS noted that figure includes "important program features such as discounted loan rates and flexible repayment schedules" which CMS said would help CO-OPs succeed so they could repay loans. Further, the default rate assumed in the 43.21 percent subsidy rate is defined as "scheduled principle and interest not received on time." CMS argued that delayed repayment could in fact be a "sign of growth."

Congress' concerns were not assuaged by these arguments. Initially, the PPACA allotted $6 billion[16] for the CO-OP program, and the administration set a goal to establish a CO-OP in

[12]"Patient Protection and Affordable Care Act; Establishment of Consumer Operated and Oriented Plan (CO-OP) Program," 76 FR 77392 (December 13, 2011), p. 77392 -77415.
[13] Office of Management and Budget, *Budget of the U.S. Government*, Fiscal Year 2013, *available at* https://www.whitehouse.gov/sites/default/files/omb/budget/fy2013/assets/cr_supp.pdf. p. 3
[14] Letter from Hon. Fred Upton, Chairman, H. Comm. on Energy & Commerce, to Marilyn Tavenner, Acting Administrator, Centers for Medicare & Medicaid Serv. (April 24, 2012), *available at* https://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/letters/20120424CMS.pdf
[15] Letter from Marilyn Tavenner, Acting Administrator, Centers for Medicare & Medicaid Services, to Fred Upton, Chairman, H. Comm. on Energy & Commerce. (July 12, 2012), on file with the Committee.
[16] *See* Kaiser Family Foundation, *Summary of the Affordable Care Act*, Kaiser Family Foundation: Health Reform, (April 25, 2013), *available at:* http://kff.org/health-reform/fact-sheet/summary-of-the-affordable-care-act/

each of the 50 states.[17] However, concerns about the solvency of the CO-OPs and their ability to repay taxpayer-funded loans led Congress to rescind partial funding for the program.[18] Ultimately, Congress rescinded funding for the program three times. In April 2011, Congress passed a continuing resolution, signed by President Obama, which cut $2.2 billion from the program.[19] In December 2011, Congress cut an additional $400 million in its Omnibus Appropriations Act.[20] Then, in January 2013, Congress rescinded another $2.3 billion from the program.[21]

By the time Congress made its last rescission in January 2013, CMS had already awarded $1.98 billion in taxpayer-funded loans to 24 CO-OPs. Another 26 potential CO-OPs had applied for funding through the program, but Congress rescinded funding before CMS awarded any additional loans.[22] The funding restrictions, however, did not affect loans to the original 24 CO-OPs. In fact, some of the 24 CO-OPs received $350 million in additional funding from CMS in December 2014. Altogether, funding to the 24 CO-OPs totaled $2.4 billion.

In July 2013, the HHS Office of the Inspector General (HHS OIG) released its first audit of the CO-OP program. In this audit, the HHS OIG identified factors that could adversely affect the CO-OP program, including limited private monetary support and startup expenditures that exceeded available funding, despite large federal loans from CMS. The HHS OIG audit found that "11 of 16 CO-OPs reported estimated startup expenditures in their applications that exceeded the total startup funding provided by CMS."[23]

The HHS OIG released another audit in July 2015 that found most of the 23 CO-OPs reviewed had not met their initial program enrollment and profitability projections. In 13 of the 23 CO-OPs, member enrollment was considerably lower than the CO-OPs' initial annual projections, and 21 of the 23 CO-OPs incurred net losses from January 1, through December 31, 2014.[24] More than half of the 23 CO-OPs had net losses of at least $15 million for this period. The HHS OIG explained that "low enrollments and net losses might limit the ability of some

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[17] Amy Goldstein, *Financial Health Shaky at Many Obamacare Insurance Co-Ops*, WASH. POST, Oct. 10, 2015, *available at* https://www.washingtonpost.com/national/health-science/financial-health-shaky-at-many-obamacare-insurance-co-ops/2015/10/08/2ab8f3ec-6c66-11e5-9bfe-e59f5e244f92_story.html

[18] CO-OP plans are prohibited from using loans for marketing purposes, prohibited from working with insurers already in operation and they have to enroll members and contract with providers. Because of these factors, the solvency of the CO-OPs' was risky. *See e.g.* Avik Roy, *Six Solyndras: Obamacare Blows $3 Billion on Faulty CO-OP Insurance Loans*, FORBES, May 30, 2012, *available at:* http://www.forbes.com/sites/theapothecary/2012/05/30/six-solyndras-obamacare-blows-3-billion-on-faulty-co-op-insurance-loans/#4f246825d013

[19] Pub. L. No. 112−10, 125 Stat. 38 (April 15, 2011).

[20] Pub. L. No. 112-74, 125 Stat. 786 (Dec. 23, 2011)

[21] Pub. L. No. 112-240, 126 Stat. 2313, 2362 (Jan. 2, 2013).

[22] National Alliance of State Health CO-OPs, *Health Insurance CO-OPs Outraged at Cuts to CO-OP Loan Program*, Jan. 3, 2013, *available at*: http://nashco.org/health-insurance-co-ops-outraged-at-cuts-to-co-op-loan-program/.

[23] Office of Inspector Gen., Dep't of Health and Human Servs., *The Centers for Medicare & Medicaid Services Awarded Consumer Operated and Oriented Plan Program Loans in Accordance with Federal Requirements, and Continued Oversight is Needed*, Audit no. A-05-12-00043 (July 2013).

[24] Office of Inspector Gen., Dep't of Health and Human Servs., Actual Enrollment and Profitability Was Lower Than Projections Made By The Consumer Operated and Oriented Plans and Might Affect Their Ability To Repay Loans Provided Under the Affordable Care Act, Audit no. A-05-14-00055 (July 2015).

CO-OPs to repay startup and solvency loans."[25] In the four months following the release of this audit, 10 CO-OPs collapsed. Seven additional CO-OPs failed the following year.

The committee's Oversight and Investigations Subcommittee convened a hearing on November 5, 2015, titled "Examining the Costly Failures of ObamaCare's CO-OP Insurance Loans."[26] The hearing featured testimony from state regulators, CO-OP representatives, the HHS OIG, and CMS Chief of Staff Mandy Cohen. At the hearing, and throughout its investigation, the committee sought to understand the factors that contributed to the collapse of 17 CO-OPs, to date, and CMS' process to recover loans awarded to CO-OPs that failed. The committee has also examined the effectiveness of CMS' oversight mechanisms to monitor CO-OPs, and steps that CMS, CO-OPs and state regulators can take to help CO-OPs repay the loans and minimize loss to taxpayers.

Following the hearing, the committee sent a letter to CMS' Acting Administrator Andrew Slavitt on November 24, 2015, requesting additional information and documents regarding the CO-OP program.[27] CMS has provided all of the oversight plans issued by CMS to the struggling CO-OPs, known as Corrective Action Plans (CAP). In addition, the CAPs for existing CO-OPs were made available to committee staff for review *in camera* at CMS.

To gain a better understanding of the functioning of this program, the committee also requested information and documents from the CO-OPs themselves. On May 16, 2016, the committee requested that each of the 11 CO-OPs then in existence provide information and documents about the CO-OP loan process, the financial viability of the CO-OP, CMS' oversight processes, and policy changes that could help the CO-OP pay back taxpayer funded-loans.[28] A copy of the committee's letter can be found in the Appendix. The committee received substantive responses from the 10 CO-OPs, although three have since failed. One CO-OP, InHealth Mutual of Ohio, did not reply because state regulators closed the CO-OP weeks after the committee sent its request letter.

The documents produced by 10 CO-OPs, hearing testimony, briefings with the National Alliance of State Health CO-OPs, and reports issued by the HHS OIG have allowed the committee to assess the factors contributing to the failure of the CO-OP program, and CMS' oversight relationship with CO-OPs. The committee has found that fundamental flaws in the CO-OP program, along with premium stabilization challenges and CMS' mismanagement and lack of oversight contributed to the failures of the CO-OPs.

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[25] Office of Inspector Gen., Dep't of Health and Human Servs., Actual Enrollment and Profitability Was Lower Than Projections Made By The Consumer Operated and Oriented Plans and Might Affect Their Ability To Repay Loans Provided Under the Affordable Care Act, Audit no. A-05-14-00055 (July 2015).

[26] H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations, *Examining the Costly Failures of Obamacare's CO-OP Insurance Loans*, 114th Cong. (Nov. 5, 2015).

[27] Letter from Hon. Fred Upton, Chairman, H. Comm. on Energy & Commerce, to Andrew Slavitt, Acting Administrator, Centers for Medicare & Medicaid Serv. (November 24, 2015), *available at*: https://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/114/Letters/20151124CMS.pdf.

[28] *See, e.g.*, Letter from Hon. Fred Upton, Chairman, H. Comm. on Energy & Commerce, to Cathy Mahaffey, Chief Executive Office, Common Ground Healthcare Cooperative (May 16, 2016).

V. CO-OPs Face Unpredictable Enrollment and Volatile Risk Programs, Leading to Closures

Ultimately, the root cause of the CO-OPs failure stems from poor policies established through the PPACA and CMS's lack of flexibility or action to help CO-OPs succeed. HHS, OMB, and HHS OIG all acknowledged that the CO-OPs faced fundamental obstacles. The committee's investigation found that CO-OPs were poorly situated to succeed from the very beginning largely due to the inflexibilities of the underlying law, CO-OPs faced extremes in enrollment numbers and were more vulnerable than other insurance providers to the volatility of the Risk Adjustment and Risk Corridor programs. From January 1, 2014 – the first day CO-OPs offered plans through the PPACA – to the issuance of this report, 17 CO-OPs have shut down, causing approximately 885,600 members to lose insurance coverage.[29] The fast and massive failure rate for the CO-OP program has not only squandered millions of taxpayer funds, but also caused hundreds of thousands of individuals to have displaced insurance coverage.

A. Enrollment Extremes Led to Financial Insolvency

FINDING:	**CO-OPs either failed to meet enrollment targets or surpassed enrollment capacity, and both scenarios created financial insolvency.**

Shortly after CO-OPs began selling health care insurance plans through exchanges established by PPACA, problems became evident with both higher-than-expected enrollment and lower-than-expected enrollment. In 2014, *over half* of the CO-OPs fell short of meeting their enrollment targets, and overall, member enrollment was considerably lower than initial projections.[30] However, nine of the 23 CO-OPs *surpassed* enrollment projections. Large enrollment margins stemming from both failing to enroll enough individuals, and enrolling too many individuals crippled the financial solvency of CO-OPs. The following chart reflects the actual enrollment versus projected enrollment for the CO-OPs as of December 31, 2014, and also provides a percentage of projected enrollments for each CO-OP:[31]

[29] U.S. Health Policy Gateway, *Nonprofit Consumer Operated and Oriented Plan Organizations*, U.S. Health Policy Gateway.Com, *available at*: http://ushealthpolicygateway.com/vii-key-policy-issues-regulation-and-reform/patient-protection-and-affordable-care-act-ppaca/ppaca-repeal/components-of-aca-not-working-well/components-of-aca-not-working-well-health-exchanges/nonprofit-consumer-operated-and-oriented-plan-organizations-co-ops/
[30] Office of Inspector Gen., Dep't of Health and Human Servs., *Actual Enrollment and Profitability Was Lower Than Projections Made By The Consumer Operated and Oriented Plans and Might Affect Their Ability To Repay Loans Provided Under the Affordable Care Act*, Audit no. A-05-14-00055 (July 2015).
[31] *Id.*

Table 1: Consumer Operated and Oriented Plans' 2014 Enrollment

CO-OP[18]	Actual Enrollment as of 6/30/2014[19]	Actual Enrollment as of 12/31/2014[20]	Projected Enrollment at 12/31/2014[21]	Percentage of Projected Enrollment
AZ	353	869	23,998	4%
IL	3,221	3,461	94,249	4%
MA	1,907	1,700	38,853	4%
OR (OHC)[22]	1,055	1,582	34,466	5%
TN[23]	1,588	2,287	25,082	9%
OH	3,816	6,677	60,352	11%
CT	3,197	7,966	40,589	20%
NJ	3,111	4,254	17,984	24%
MI	1,510	11,122	37,874	29%
LA	13,022	9,980	28,106	36%
MD	1,589	11,694	32,556	36%
NV	15,551	16,523	33,748	49%
OR (HRI)[24]	5,230	8,813	14,579	60%
NM	9,412	14,297	14,185	101%
UT	18,865	22,397	20,524	109%
MT	12,052	13,160	11,250	117%
CO	13,466	14,657	12,067	121%
KY	55,852	56,680	30,929	183%
SC	49,554	45,668	19,204	238%
ME	38,226	39,742	15,486	257%
WI	27,475	26,034	10,000	260%
NY	126,738	155,402	30,864	504%
IA/NE[25]	79,762	N/A	11,142	N/A

1. The Impact of Low Enrollment

In 2014, a majority of the CO-OPs enrolled fewer individuals than projected.[32] Notably CO-OPs in Arizona, Illinois, Massachusetts, Oregon, and Tennessee failed to enroll 10 percent of their initial projections.[33] In a 2015 report, HHS OIG determined a number of CO-OPs failed to achieve projected enrollment targets for the following reasons:

- Marketplace technical difficulties (i.e. website crashes, long wait times, inability for site to capture all customer information);

- Delays in obtaining licenses to sell insurance on the exchange;

[32] *Id.*

[33] Community Health Alliance (CHA), Tennessee's CO-OP enrolled fewer than 1,000 individuals in five of eight rating areas, against its goal of 25,000 in 2014. In 2015, CHA's enrollment grew exponentially, and the CO-OP faced problems from exceeding enrollment capacity, which is further discussed in Section V of this report. Also see, Jeff Byers, *Tennessee Health Co-OP to Stop Offering Coverage in 2016,* Healthcare Dive, Oct. 14, 2015, *available at*: http://www.healthcaredive.com/news/tennessee-health-co-op-to-stop-offering-coverage-in-2016/407340/

- CO-OP management changes affecting ability to market and sell health plans;

- CO-OPs pricing plans higher than other health insurers with more name-brand recognition.[34]

As a result of low enrollment, CO-OPs were not able to cover medical claims expenses that exceeded the income from premiums collected, ultimately contributing to losses.[35]

This negative outcome should not have come as a surprise to CMS. For example, in a 2013 audit, HHS OIG advised CMS that unpredictable circumstances, such as limited enrollment, would impede CO-OPs from becoming operational.[36] HHS OIG explicitly mentioned that such circumstances would increase the risk of CO-OPs exhausting all startup funding before establishing sufficient operating income to become self-supporting.[37] This very scenario came to fruition for several CO-OPs. In 2015, Louisiana, Nevada, and one of the two Oregon CO-OPs announced plans to wind down operations after two unsuccessful enrollment periods led to insolvency.[38]

2. The Impact of High Enrollment

Higher enrollment proved to be an even greater challenge than low enrollment for the CO-OPs. If the CO-OP did not set premiums adequately, the CO-OP is not able to remain financially solvent. This too, negatively affects the viability of CO-OPs because the greater the enrollment, the greater the costs to run an insurance company and cover claims.

In contrast, too many enrollees can also present a threat to the viability of CO-OP. Table 1 on the preceding page shows how several CO-OPs *exceeded* their 2014 initial enrollment projections, an outcome which has proven even more hazardous than lower enrollment for the financial stability of CO-OPs. Several CO-OPs experienced rapid enrollment growth, thus exceeding the CO-OP's capacity to effectively handle administrative aspects of the program such as, paperwork, issuing insurance cards, and maintaining customer service centers.[39] The inability to manage the mounting costs forced these CO-OPs into insolvency. For example, the PPACA's largest CO-OP, Freelancers Health Service Corporation, known as Health Republic Insurance of

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[34] *Id.*
[35] *Id.*
[36] Office of Inspector Gen., Dep't of Health and Human Servs., *The Centers for Medicare & Medicaid Services Awarded Consumer Operated and Oriented Plan Program Loans in Accordance with Federal Requirements, and Continued Oversight is Needed*, Audit no. A-05-12-00043 (July 2013).
[37] Office of Inspector Gen., Dep't of Health and Human Servs., *Actual Enrollment and Profitability Was Lower Than Projections Made By The Consumer Operated and Oriented Plans and Might Affect Their Ability To Repay Loans Provided Under the Affordable Care Act*, Audit no. A-05-14-00055 (July 2015).
[38] Associated Press, *Oregon Health Insurance CO-OP to Shut Down*, KEZI.com, (October 16, 2015), available at: http://www.kezi.com/news/Oregon_Health_Insurance_Co-Op_to_Shut_Down.html; Louisiana Health Cooperative, *News Release: LAHC Forgoes Participation in Open Enrollment,* (July 24, 2015), available at: http://www.mylahc.org/news/NEWS-RELEASE---LAHC-forgoes-participation-in-Open-Enrollment, Nevada Health COOP, *Nevada Health CO-OP in Receivership,* (October, 14, 2015), available at: http://nevadahealthcoop.org/
[39] *See* Office of Inspector Gen., *supra* note 37.

New York, enrolled over 155,000 individuals in 2014, exceeding projections by 500 percent.[40] Despite its massive enrollment, New York state authorities ordered the CO-OP to stop writing new policies after determining the CO-OP was financially insolvent.[41]

B. PPACA's Premium Stabilization Directly Caused Several CO-OPs to Cease Operations

The premium stabilization programs in the PPACA – particularly the Risk Adjustment and Risk Corridor programs caused financial strain to the CO-OPS. In an effort to safeguard insurance companies against various financial risks associated with implementation of the law, the PPACA established premium stabilization programs to all non-grandfathered[42] health plans in the individual and small group markets, inside and outside the State-Based Exchanges and the Federally-Facilitated Exchanges. The Risk Corridor program is intended to balance costs from insurance companies that experience deficits from issuer losses. The Risk Adjustment program is intended to balance costs of insurance companies that provide coverage to sicker patients.

1. The Risk Corridor Program

Section 1342 of the PPACA requires HHS to set up a temporary[43] Risk Corridor program to help reduce pricing uncertainty in the new health insurance exchanges.[44] The program allows the federal government, specifically HHS, to share risk with insurers.[45]

Under the Risk Corridor program, if the CO-OP's actual claims exceed at least three percent of its projected claims, HHS is responsible for reimbursing the CO-OP for half of the excess through Risk Corridor transfer payments.[46] If the actual claims for the CO-OP exceed eight percent beyond what was projected, HHS is responsible for covering 80 percent of the

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[40] Anna Wilde, Mathews, *Regulators to Shut Down Health Republic Insurance of New York: Officials Cite Likelihood that Health Cooperative Would Become Financially Insolvent,* WALL STREET J., September 25, 2015, available at: http://www.wsj.com/articles/regulators-to-shut-down-health-republic-insurance-of-new-york-1443222742

[41] *Id.*

[42] Grandfathered health plans are insurance policies that were purchased on or before March 23, 2010, and are exempted from PPACA rules such as Risk Adjustment. *See*, Center for Consumer Info. & Ins. Oversight, *Amendment to Regulation on "Grandfathered" Health Plans under the Affordable Care Act,* Centers for Medicare & Medicaid Serv., available at: https://www.cms.gov/CCIIO/Resources/Files/factsheet_grandfather_amendment.html.

[43] The temporary risk corridors program protects qualified health plans from uncertainty in rate setting from 2014 to 2016 by having the federal government share risk in losses and gains. *See*, Center for Consumer Info. & Ins. Oversight, *Premium Stabilization Programs,* Centers for Medicare & Medicaid Serv., available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/

[44] *See* 42 U.S.C. § 18062-Establishment of Risk Corridors for Plans in Individual and Small Group Markets

[45] American Academy of Actuaries, *Fact Sheet: ACA Risk-Sharing Mechanisms, The 3Rs (Risk Adjustment, Risk Corridor, and Reinsurance) Explained,* 2013), *available at:* http://actuary.org/files/ACA_Risk_Share_Fact_Sheet_FINAL120413.pdf

[46] *Id.*

excess.[47] If actual claims fall below expected claims by more than three percent, the CO-OP pays HHS at least 50 percent of the excess.[48]

FINDING: CMS paid approximately $2.5 billion less than anticipated in Risk Corridor payments.

The CO-OP's costs exceeded the amount that they anticipated and therefore CO-OPs were left in a financial deficit and were entitled to receive Risk Corridor payments.[49] However, on October 1, 2015, CMS announced that Risk Corridor payments would be only 12.6 percent of the initial calculated amounts. Accordingly, CMS paid out $2.5 billion *less* than what CO-OPs were expecting.[50]

Not surprisingly, the decision to pay only 12.6 percent of estimated costs proved disastrous for a number of CO-OPs. For example, in 2014, the Kentucky CO-OP's losses were approximately $50 million, and decreased to $4 million during the first half of 2015.[51] Kentucky expected to reach financial solvency toward the end of year 2016, however, after CMS announced they could only pay 12.6 percent of Risk Corridor transfer payments, the CO-OP announced plans to shut down.[52]

Kentucky was not the only CO-OP to immediately shut its doors after CMS announced the Risk Corridor program was not fully funded. Prior to CMS' announcement, a CO-OP serving the state of Colorado, Colorado HealthOP, was in a financially strong position with cash reserves and flourishing enrollment.[53] The CO-OP was even projected to make a profit in 2016. However, after learning that risk corridor payments were less than expected, the CO-OP's solvency plummeted overnight and it ultimately shuttered its operations.[54] As a result, Colorado taxpayers and consumers suffered significant ramifications – approximately 40 percent of Coloradans who purchased insurance through the exchange in 2015, were forced out of the coverage they chose.[55] In addition, the shutdown caused the CO-OP to default on $72 million in federal start-up and solvency funding – all of which the CO-OP was on track to pay if they could continue to operate.[56]

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[47] *Id.*
[48] *Id.*
[49] Per PPACA's Risk Corridor Program, if the CO-OP's actual claims exceed at least three percent of its projected claims, HHS is responsible for reimbursing the CO-OP for half of the excess, through Risk Adjustment transfer payments. If the actual claims for the CO-OP exceed eight percent beyond what was projected, HHS is responsible for covering 80 percent of the excess.
[50] Hurman, Bob, *Feds Short Insurers $2.5 Billion on Exchange Plan Losses,* Modern Healthcare, October 1, 2015.
[51] King, Robert, *Kentucky Insurer Shuts Down,* Washington Examiner, (October 9, 2015), available at: http://www.washingtonexaminer.com/kentucky-insurer-shuts-down/article/2573818
[52] *Id.*
[53] Colorado HealthOP Press Release, *Colorado HealthOP Vows to Fight for Member Interests After Division of Insurance's Closure Decision,* (October 16, 2015), *available at*: https://cohealthop.org/health-cooperative-closure-press-release/
[54] *Id.*
[55] *Id.*
[56] *Id.*

Moreover, several CO-OPs filed lawsuits against the federal government after learning they would receive millions less than promised in Risk Corridor payments. Before shutting its door, Land of Lincoln Health, the CO-OP serving the state of Illinois, filed a lawsuit against the Government on June 23, 2016. The CO-OP is seeking approximately $73 million for risk corridor payments the Government failed to deliver as promised.[57] On February 24, 2016, Health Republic Insurance Company, the CO-OP serving Oregon, filed a complaint against the federal government, stating it is owed $7.1 million in risk corridor payments for 2014, and $15 million for 2015.[58] In addition, the Insurance Commissioner for the state of Iowa, Nick Gerhard, filed a lawsuit against the government on May 3, 2016, alleging that the government owes Iowa CO-OP, Co-Opportunity, over $113.6 million in risk corridor payments, which it is unable to pay because they exceed the amount that can be collected from insurers that owed money to the program.[59] Gerhard argues that if the funds promised to the CO-OPs from the government were made available, the CO-OP could have covered the claims of its participants and repay loans owed to the federal government.[60]

FINDING: HHS and Congress designed the Risk Corridor program to be budget neutral.

Congress has been criticized for CMS's decision to limit Risk Corridor payments to 12.6 percent because a provision in the 2015 Omnibus Appropriations bill which codified the Risk Corridor program as "budget neutral."[61] However, well before the adoption of this provision, CMS had already indicated its intention to make the program budget neutral, based on other similar programs. In January 2014, Aaron Albright, a spokesperson for CMS confirmed that the Risk Corridor program was, in fact, designed and modeled to be budget neutral since its inception:

> The temporary risk corridor provision in the Affordable Care Act is an important protection for consumers and insurers as millions of Americans transition to a new coverage in a brand new marketplace. The policy, modeled on the risk corridor provision in [Medicare] Part D that was supported on a bipartisan basis, ***was established to be budget neutral, and we intend to implement it as designed***.[62]

[57] Carla Johnson, *Illinois Insurance CO-OP Sues Feds Over Health Law Payments,* The Courier, June 23, 2016, *available at*: http://www.lincolncourier.com/news/20160623/illinois-insurance-co-op-sues-feds-over-health-law-payments

[58] Bell, Allison, *Oregon CO-OP sues for $5 billion in risk corridor cash,* Life Health Pro, Feb 25, 2016, *available at*: http://www.lifehealthpro.com/2016/02/25/oregon-co-op-sues-for-5-billion-in-risk-corridors

[59] Keenan, Chelsea, *Iowa Insurance Division Files Lawsuit Against Federal Government: Iowa Seeks $20 Million Connected with CoOpportunity Failure,* The Gazette, (May 3, 2016), available at: http://www.thegazette.com/subject/news/health/iowa-insurance-division-files-lawsuit-against-federal-government-20160503

[60] *Id.*

[61] Consolidated and Further Continuing Appropriations Act, Pub. L. 113–235, 128 Stat. 2130 (Dec. 16, 2014).

[62] Louise Radnofsky and Jennifer Corbett Dooren, *Explaining 'Risk Corridors,' The Next Obamacare Issue,* WALL STREET J., January 22, 2014, *available at*: http://blogs.wsj.com/washwire/2014/01/22/explaining-risk-corridors-the-next-obamacare-issue/ (Emphasis added).

On April, 2014, CMS issued a memorandum which confirmed Mr. Albright's statement:

> "[I]n the HHS Notice of Benefit and Payment Parameters for 2015 final rule (79 FR 13744) and the Exchange and Insurance Market Standards for 2015 and Beyond NRPM (79 FR 15808), HHS indicated that it intends to implement the risk corridor program in a budget neutral manner."[63]

Thus, the 2015 Omnibus Appropriations bill should be viewed as confirming the approach the Administration had already committed to take.

2. The Risk Adjustment Program

The Risk Adjustment program is another premium stabilization program which attempts to balance costs for insurance companies faced with paying high insurance claims for insuring sicker patients. The Risk Adjustment program requires insurance companies with lower-risk or healthier individuals to distribute funds to plans with higher-risk or sicker individuals.[64] Risk Adjustment is a concept applied to other health insurance programs, yet its application and formula vary depending on the program.[65]

For the CO-OP program, each insurance plan receives a health insurance risk score, based on the average risk scores assigned to each individual enrolled into the plan.[66] Risk scores indicate how costly an individual is anticipated to be for a plan to insure (i.e., a relative measure of the individual's actuarial risk to the plan). Plans are responsible for uploading individual enrollment and claims data into a CMS server, which generates the plans' risk score calculation. CO-OPs were not required to make Risk Adjustment transfer payments until 2016, because prior diagnosis data to calculate Risk Adjustment was not made available from CMS. [67]

The PPACA authorized HHS to utilize criteria and methods similar to those utilized under Medicare Part C or D to implement risk adjustment.[68] However, unlike the Medicare Part C and D programs, in which Risk Adjustment was calculated using previous diagnosis data from other Medicare programs, the Risk Adjustment data for PPACA's individual and small group markets was unknown.[69] HHS had to assume several figures, which ultimately affected the

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[63] Dep't of Health and Human Serv., Centers for Medicare & Medicaid Serv., Center for Consumer Information & Insurance Oversight, *Risk Corridors and Budget Neutrality*, (April 11, 2014), available at: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq-risk-corridors-04-11-2014.pdf

[64] *See* Kaiser Family Foundation, *Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors*, Kaiser Family Foundation: Health Reform, (Jan. 22, 2014), available at: http://kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/

[65] Medicare Advantage, plans on the State Based Exchanged and Federally Facilitated Exchange all use various risk adjustment formulas to compensate for claims from higher-risk individuals.

[66] Individual risk scores are comprised of diagnosis codes, which are categorized into Hierarchical Category Codes (HCCs). Each HCC carries a specific numeric value- the more complex a diagnosis, the higher the HCC value, and therefore, a higher risk score is generated. CMS determines sets the HCCs numeric value.

[67] *Id*. at 61

[68] Dep't of Health and Human Serv., Centers for Medicare & Medicaid Serv., Center for Consumer Information & Insurance Oversight, *March 31, 2016, HHS-Operated Risk Adjustment Methodology Meeting*, CMS Discussion Paper, (March 24, 2016).

[69] *Id*.

actuarial risk in the market.[70] The HHS Risk Adjustment transfer payments did not account for various differences across plans, and forced a majority of CO-OPs to make Risk Adjustment payments, rather than receive such payments to offset costs from insuring sicker patients.

In March 2016, CMS issued a white paper addressing the Risk Adjustment methodology, and acknowledged how various parameters set by the PPACA ultimately hindered the Risk Adjustment methodology from offsetting premium risk.[71] Specifically, CMS cited how the fact that "[t]he Affordable Care Act established four tiers of plan actuarial value, or 'metal levels' plus catastrophic plans, which are risk adjusted in a separate risk pool" complicated HHS' Risk Adjustment methodology. CMS explained:

> The presence in the market of plans with different actuarial values posed a challenge for the risk adjustment methodology - how to preserve premium differences that reflect differences in generosity of plan coverage. Risk adjustment transfers should counteract the effects of risk selection…[72]

If the Risk Adjustment methodology allocated for differences in various plans established by the PPACA, transfer payments would not have required certain plans, such as CO-OPs in a rural areas or those with a smaller population base, to pay higher Risk Adjustment payments.

On June 30, 2016, the date HHS first released risk adjustment scores for the 2015 benefit year, the data indicated that all but one of the CO-OPs was responsible for making substantial risk adjustment payments. In many cases, these payments exceeded the amount of the CO-OPs capital, and as a result, the Risk Adjustment Program jeopardized the financial solvency of the CO-OPs. The following table shows the net income for each CO-OP before having to make risk adjustment payments, and their net income after having to pay into the risk adjustment program:[73]

[70] *Id.*
[71] *Id.*
[72] *Id.*
[73] Katherine Hempstead, *Risk Adjustment and Co-Op Financial Status,* Robert Wood Johnson Foundation, July 11, 2016, *available at*: http://www.rwjf.org/en/library/research/2016/07/risk-adjustment-coop-finance-status.html

Table 3. Changes in Net Income and Margin After Revision in Risk Adjustment

	Before Adjustment		After Adjustment	
	Net income (loss)	Margin	Net income (loss)	Margin
HRI of New Jersey	$ (17,560,987)	-7.5%	$ (46,741,178)	-22.7%
Evergreen Health Cooperative (MD)	$ (10,833,616)	-13.7%	$ (35,044,450)	-64.1%
Land of Lincoln (IL)	$ (90,800,169)	-61.6%	$ 106,705,305)	-81.1%
New Mexico Health Connection	$ (22,999,537)	-23.9%	$ (33,270,033)	-38.7%
Minuteman (MA and NH)	$ (42,746,420)	-133.5%	$ (41,751,600)	-126.4%
Healthy CT	$ (27,638,345)	-15.5%	$ (33,024,692)	-19.1%
Common Ground (WI)	$ (28,254,788)	-20.7%	$ (29,865,888)	-22.2%
Maine Community Health Options	$ (74,016,344)	-25.8%	$ (73,309,434)	-25.5%
Oregon's Health Cooperative	$ (18,437,082)	-34.3%	$ (15,183,456)	-26.6%
Montana Health Cooperative	$ (40,665,491)	-29.8%	$ (40,195,378)	-29.4%

Rather than providing increased payments to health insurance issuers that attract higher-risk populations, the flawed methodology caused CO-OPs to make Risk Adjustment payments. The methodology that CMS used to implement this program, however, was widely criticized for being unpredictable and favoring large insurance companies over newer entrants like CO-OPs.[74] CMS acknowledged this in its interim final rule:

> Based on our experience operating the 2014 benefit year risk adjustment program, HHS has become aware that certain issuers, including some new, rapidly growing, and smaller issuers, owed substantial risk adjustment charges that they did not anticipate.[75]

Further, CMS noted its plan to update and improve the risk adjustment methodology, and encouraged states to examine ways to "ease this transition" for new entrants to the health insurance market, like CO-OPs:

> We encourage States to examine whether any local approaches, under State legal authority, are warranted to help ease this transition to new health insurance markets. Additionally, we will also continue to seek ways to improve the risk adjustment methodology. We updated the risk adjustment models in the 2017 Payment Notice, and we are exploring future improvements to the HHS risk adjustment methodology.[76]

This new rule, however, simply acknowledges that the agency's current methodology harms smaller issuers like CO-OPs, promises to improve the methodology going forward, and encourages states to alleviate the harm to smaller insurers through local mechanisms, if possible.

[74] 45 C.F.R. Parts 155 and 156 (2016).
[75] *Id.*
[76] *Id.*

CMS did not actually make any concrete changes to the risk adjustment methodology that would help CO-OPs before the next open enrollment period.

While CMS has taken important steps to give CO-OPs additional resources to stay afloat, CMS's delay in issuing this rule – after 17 CO-OPs have already failed – may prove it to be pointless. CMS has been aware of issues surrounding SEPs, private capital, and the risk adjustment methodology since the programs' inception. Unfortunately, reports from the HHS OIG and direct pleas from CO-OP leadership have not been enough to spur CMS to take timely action. Now that CMS has taken steps to help CO-OPs succeed, it may be too late. CMS has not acted in the interest of CO-OPs or of federal taxpayers.

This past June, Evergreen Health, the CO-OP serving Illinois, filed a lawsuit claiming that private insurers have gamed the system to avoid making risk adjustment payments.[77] Evergreen's CEO, Peter Beilenson, argued that Evergreen was unfairly labeled as healthier because private insurers encouraged their less healthy enrollees visit physicians in order to make individuals appear to be less healthy.[78] As a result of risk adjustment, Evergreen is expected to owe between $18-22 million in risk adjustment payments.[79]

[77] Stephanie Armour, *Maryland's Health CO-OP Sues Over Health Law's Risk-Adjustment Formula*, WALL STREET J., June 13, 2016, *available at*: http://www.wsj.com/articles/marylands-health-co-op-sues-over-health-laws-risk-adjustment-formula-1465847988.
[78] *Id.*
[79] *Id.*

VI. State Regulators Led Oversight Efforts Despite the Shared Responsibility with CMS

The oversight of the CO-OPs is shared between CMS and the state regulators. CMS's responsibilities include setting the eligibility standards, loan terms, policies, determining loan recipients, disbursing funds, monitoring CO-OP financial controls, and ensuring compliance with statutory and regulatory requirements.[80] More recently, CMS has issued CAPS or enhanced oversight plans to the CO-OPs when problems were identified with the CO-OP. These plans were intended to provide technical assistance or withhold loan disbursements if necessary. This will be discussed further in Section VII.

State regulators have their own set of responsibilities when it comes to the CO-OPs. Primarily, they are responsible for "licensing, monitoring financial solvency and market conduct, and approving premium rates and contract forms."[81] Further, state regulators are primarily responsible for winding down operations when CO-OPs close.[82] Because state regulators are primarily tasked with protecting the interests of consumers in their states, state regulators are forced to make tough decisions between encouraging competition in state markets and protecting consumers from financially unstable CO-OPs.

FINDING: State regulators notified CO-OPs of violations of state laws, requested enrollment freezes, and weighed in on potential loan conversions.

In Colorado, state regulators made the unpopular decision to shut down a CO-OP with a large number of enrollees, prompting a lawsuit. One of the two CO-OPs in Colorado, HealthOP, insured 80,000 individuals, almost 40 percent of Coloradans who had health insurance through the state exchange in 2015.[83] CMS awarded HealthOP over $70 million in loans and projections estimated that the CO-OP was on track to be profitable in 2016.[84] When CMS announced that insurance companies would only be receiving 12.6 percent of what they requested through the Risk Corridor program, Colorado's HealthOP only received $2 million, instead of an expected $16.2 million.[85]

With the shortfall in what HealthOP expected to receive from the Risk Corridor program, the HealthOP was forced to default on the $72 million in loans received from CMS.[86] On October 16, 2015, Colorado's Division of Insurance (DOI) made the executive decision to shut

[80] Timothy Jost, *ACA Round-Up: CO-OP Oversight And Reconciling Cost-Sharing Reduction Payments (Update)*, Health Affairs Blog, March 18, 2016, *available at*: http://healthaffairs.org/blog/2016/03/18/aca-roundup-co-op-oversight-and-reconciling-cost-sharing-reduction-payments/.
[81] *Id.*
[82] *Id.*
[83] Kristen Wyatt, *Largest Health Insurer On Colorado Exchange Collapses*, CBS Denver, Oct. 16, 2015, *available at*: http://denver.cbslocal.com/2015/10/16/largest-health-insurer-on-colorado-exchange-collapses/.
[84] Nat Stein, *Here's What Happened to Colorado HealthOP*, The Colorado Independent, Oct. 23, 2015, *available at*: http://www.coloradoindependent.com/155753/heres-what-happened-to-colorados-health-co-op.
[85] *Id.*
[86] *Id.*

HealthOP down due to fear of whether or not the CO-OP would be able to remain financially stable through the next enrollment period.[87]

In response to the DOI announcement, Colorado HealthOP CEO Julia Hutchins released a statement describing DOI's decision as "irresponsible and premature."[88] She stated:

> We are astonished and disappointed by the Colorado Division of Insurance's decision. It is both irresponsible and premature. Colorado HealthOP is a profitable start-up insurance company that is in a strong financial position and, for two years, has served the critical needs of Coloradans by enhancing competition in the Colorado insurance market, driving down prices in the state health insurance marketplace and offering new, innovative choices to its more than 80,000 members throughout Colorado. By choosing this course of action, the Division has let local and national politics hurt Coloradans' access to low-cost healthcare options and assessed Colorado taxpayers with significant avoidable costs. For this reason, Colorado HealthOP will continue its fight, pursuing all possible remedies, to serve Colorado.[89]

In response to HealthOP's disappointment, the Colorado Insurance Commissioner pointed the finger at the Risk Corridor shortfall, and emphasized the state's responsibility to protect consumers from the confusion that arises when a CO-OP fails after enrolling customers for the year. In a formal release, Colorado Insurance Commissioner Marguerite Salazar stated:

> Our decision is a direct result of this shortfall by CMS, and I sympathize with the HealthOP, but the Division has requirements and it has to protect consumers… It is a key function of Colorado Division of Insurance to make sure that insurance carriers are financially stable enough to pay the claims of their policyholders. While Colorado HealthOP can continue to pay claims for the rest of 2015, we cannot allow it to sell or renew policies on the exchange for 2016.
>
> …
>
> It is truly unfortunate, but the Division had to act now, before open enrollment gets started November 1st. To delay any longer would undermine the open enrollment process, impacting the entire health insurance market in Colorado and negatively impacting Colorado

[87] Colorado HealthOP Press Release, *Colorado HealthOP Vows to Fight for Member Interests After Division of Insurance's Closure Decision*, (Oct. 16, 2015), available at: https://cohealthop.org/health-cooperative-closure-press-release/.
[88] *Id.*
[89] *Id.*

> consumers. And it would have been even more costly to consumers if this action had to take place once 2016 started.[90]

HealthOP filed a lawsuit, in response to the Insurance Commissioner's order, and requested that the court issue an injunction on the Division of Insurance's decision to shut down the CO-OP.[91] An injunction would have permitted HealthOP to sell plans through the Colorado state exchange while the court considered the merits of HealthOP's claim. The court denied the injunction and HealthOP eventually closed its operations.[92]

While state regulators have little to no control over federal policies like the Risk Corridor program, state regulators do exert some influence over CMS. Tennessee's Department of Commerce and Insurance Commissioner Julie Mix McPeak contributed heavily to CMS's considerations of the loan conversion and enrollment caps regarding Tennessee's CO-OP, Community Health Alliance (CHA). CHA received startup loans totaling over $73 million dollars and insured approximately 27,000 customers.[93]

Due to its low-cost plans CHA attracted more consumers than expected, creating severe financial challenges for the CO-OP. After struggling financially, CHA attempted to convert start-up loans to surplus notes, which would make it artificially appear that the CO-OP had more capital. Unlike startup loans, CO-OPs could record and report surplus notes as capital, rather than as debt in their financial filings. Several other CO-OPs had adopted this practice, pursuant to a memo CMS issued to CO-OPs in July of 2015.[94]

At the committee's November 5, 2015, hearing, Tennessee's Insurance Commissioner McPeak explained her concerns about CHA's request for a loan conversion. She testified:

> [Community Health Alliances'] only ability to cure its net worth deficiency was to increase surplus with additional contributions. The Company asked the Department if the $18.5M startup loan could be counted as surplus if the loan terms were changed to be identical to the terms of the CMS solvency contributions. The Department did not think that option was appropriate but told the Company that Statutory Accounting Principles would require the

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[90] State of Colorado, Colorado Department of Regulatory Agencies, Press Release, *Division of Insurance moves to protect Colorado consumers, takes action against HealthOP*, October 16, 2015, available at: https://www.colorado.gov/pacific/dora/node/116051.

[91] Mark Harden, *Colorado HealthOP sues state over pending shutdown*, Denver Business Journal, Oct. 19, 2015, *available a*t: http://www.bizjournals.com/denver/news/2015/10/19/colorado-healthop-sues-state-over-pending-shutdown.html.

[92] John Daley, *Colorado HealthOP Shuts Down After Failed Resurrection Bid,* Colorado Public Radio, Oct. 20, 2015, *available at*: https://www.cpr.org/news/newsbeat/colorado-healthop-shuts-down-after-failed-resurrection-bid

[93] Jamie McGee, *Community Health Alliance ending coverage for 27K enrollees*, The Tennessean, Oct. 14, 2015, *available at*: http://www.tennessean.com/story/money/2015/10/14/community-health-alliance-ending-coverage-27k-tennesseans/73928626/

[94] Memorandum from Kelly O'Brien, Centers for Medicare & Medicaid Serv. CO-OP Division Director to CO-OP Project Officers, *Amending CO-OP Loans Agreement to Apply Surplus Notes to Start-up Loans*, (July 9, 2016), *available at*: http://www.cagw.org/sites/default/files/users/user98/Converting%20Start-up%20Loans%20to%20Surplus%20Notes%20Guidance%207-9-15%20final.pdf.

> loan money to be classified as surplus if CMS and CHA bilaterally altered the loan agreement terms. CMS, after review with the Department, ultimately concluded that the loan conversion was not prudent given the competitive market in Tennessee and the financial struggles at the company and refused to allow the loan to be re-characterized.[95]

Despite the CO-OP's request for CMS to convert the loans, due to concerns from Commissioner McPeak, CMS did not allow CHA to convert its start-up loans to surplus notes. In addition expressing concerns about the loan conversion, in a January 8, 2015, letter to HHS Secretary Burwell, Commissioner McPeak requested an enrollment freeze for Tennessee's CO-OP due to the company's financial condition:[96]

> Dear Secretary Burwell:
>
> As Commissioner of the Tennessee Department of Commerce and Insurance (TDCI), I respectfully request that the Department of Health and Human Services (HHS) place an immediate enrollment freeze on Community Health Alliance (CHA), a Tennessee-domiciled consumer oriented and operated plan pursuant to the Affordable Care Act (ACA). The immediate enrollment freeze and corresponding suppression of Federally Facilitated Marketplace (FFM) files is necessary due to the company's current tenuous financial condition.

As a result of Commissioner McPeak's letter, HHS pulled the CO-OP's plans off the federal exchange on January 15, 2015, so that individuals were no longer allowed to sign up for plans offered through CHA. In October 2015, the Tennessee Department of Commerce and Insurance made the decision to wind down CHA and policy holders would have to seek new health insurance coverage in 2016.[97]

In addition to making decisions about CO-OP closures and regulating enrollment caps, state regulators have also issued corrective orders and notices when CO-OPs violate state laws. In October of 2014, the New Jersey Department of Banking and Insurance (DOBI) issued an Executed Consent Order against the New Jersey CO-OP, Freelancers Consumer Operated and Oriented Program of New Jersey, d/b/a Health Republic of New Jersey (HRNJ).[98] The Executed Consent Order stated that HRNJ did not comply with several state laws including: (1) submitting erroneous certificates of compliance, (2) failed to provide detailed disclosures to members, (3)

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[95] H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations, *Examining the Costly Failures of Obamacare's CO-OP Insurance Loans*, 114th Cong. (Nov. 5, 2015), available at: http://docs.house.gov/meetings/IF/IF02/20151105/104146/HHRG-114-IF02-Wstate-McPeakJ-20151105.pdf.

[96] H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations, *Examining the Costly Failures of Obamacare's CO-OP Insurance Loans*, 114th Cong. (Nov. 5, 2015), *available at*: http://docs.house.gov/meetings/IF/IF02/20151105/104146/HHRG-114-IF02-Wstate-McPeakJ-20151105.pdf

[97] McGee, Jamie, *Community Health Alliance ending coverage for 27K enrollees*, The Tennessean, (Oct. 14, 2015), *available at*: http://www.tennessean.com/story/money/2015/10/14/community-health-alliance-ending-coverage-27k-tennesseans/73928626/.

[98] State of New Jersey, Department of Banking and Insurance, Order No. E14-124, (October 16, 2014), *available at* http://www.state.nj.us/dobi/division_insurance/enforcement/e14_124.pdf.

posted inaccurate information about plans to its website. DBOI levied a $400,000 fine because of the violations.[99]

Maine's CO-OP, Maine Community Health Options (CHO), came under regulatory supervision of the Maine Bureau of Insurance (BOI) after the CO-OP reported a $17.2 million loss during the third quarter.[100] According to a statement by the Maine BOI, the CO-OP was under the "highest level possible" of supervision.[101] In addition, the BOI requested that CHO cap enrollment, but CMS could not remove CHO's plans from the website until December 27, 2015. The BOI stated:

> With CHO's report in October 2015 of its third quarter loss, the BOI increased its level of regulatory supervision to the highest level possible short of a judicial proceeding. The BOI also asked CHO to stop writing new underpriced individual health insurance as soon as possible but CMS and the FFM could not "suppress" CHO on the website until December 27, 2015. Consequently, individual health insurance membership continued to increase beyond the levels expected in CHO's 2016 plan.[102]

While state regulators assume some responsibility for the oversight of CO-OPs, state commissioners operate to protect consumers in their states, to ensure that CO-OPs are financially sound to sell health care insurance plans for the entire year and pay the entirety of their claims. The state regulators' primary responsibility is not the success of CO-OPs so that taxpayers can recoup their investments. That responsibility lies solely with CMS.

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[99] State of New Jersey, Department of Banking and Insurance, Order No. E14-124, (October 16, 2014), *available at* http://www.state.nj.us/dobi/division_insurance/enforcement/e14_124.pdf.
[100] Maine Bureau of Insurance, Dep't of Professional & Financial Regulation, *Bureau of Insurance Statement Regarding Maine Community Health Options*, (March 14, 2016), *available at*: http://www.maine.gov/pfr/insurance/ACA/BOI_Statement_on_Community_Health_Options.pdf.
[101] *Id*.
[102] *Id*.

VII. CMS Failed to Act to Mitigate CO-OP Failures

As detailed in the previous discussion, in some cases, the law was not written in a way to allow the CO-OPs to succeed. However, CMS failed to act where there were opportunities to help the CO-OPs succeed. The committee's oversight has determined that CMS did not effectively manage and oversee the CO-OP program. Regardless of the flaws in the law itself, CMS failed to mitigate the problems faced by CO-OPs and failed to safeguard taxpayer dollars that they loaned out to these CO-OPs. By reviewing the CAPs issued by CMS to the CO-OPs, the committee found that CMS' oversight was perfunctory and based on the oversight of outside entities such as HHS OIG or state regulators. CMS also failed to enforce the terms of the loan agreement which allowed CMS to terminate the agreement if it was determined the CO-OP was not viable. Further, when the viability of CO-OPs was in question in late 2014, CMS awarded an additional $350 million taxpayer dollars to six CO-OPs; four of which have since failed.

A. CMS Oversight of CO-OPs Is Ineffective

Section 1322 of the PPACA established the CO-OP program and authorized HHS to disburse loans to establish and operate CO-OPs. CMS is responsible for implementing the CO-OP program and overseeing the expenditure of federal funds pursuant to the CO-OP loan agreements. In the subcommittee's hearing on the management of the CO-OPs program on November 5, 2015, CMS Chief of Staff Mandy Cohen described CMS' responsibilities and activities regarding the CO-OP program. She testified:

> In implementing the CO-OP program as required by statute and with the funds available, CMS has been engaged in evaluating applications, monitoring financial performance, conducting oversight, and supporting state departments of insurance, which serve as the primary regulator of insurance issuers in the states.[103]

CMS has utilized one main oversight mechanism – the CAP.[104] When CMS has identified an issue concerning a CO-OP's finances, compliance with federal or state laws, operations or management, CMS has placed that CO-OP under a CAP. The purpose of the CAP is to resolve the problem that necessitated the CAP through a collaboration between CMS and the CO-OP. However, from documents reviewed by the committee, it appears that CAPs have had little, if no, positive effect on CO-OP outcomes.

In July 2013, the HHS OIG issued a report that evaluated CMS' early implementation of the CO-OP program, including CMS' oversight policies regarding the CO-OPs. The HHS OIG conducted the audit, titled "Early Implementation of the Consumer Operated and Oriented Plan Loan Program," because of the "financial and operational challenges" that CO-OPs would likely

[103] H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations, *Examining the Costly Failures of Obamacare's CO-OP Insurance Loans*, 114th Cong. (Nov. 5, 2015).
[104] CMS also has placed CO-OPs on "Enhanced Oversight" plans, which appear to be substantially similar to Corrective Action Plan, in that it identifies concerns with the CO-OP and requests additional information and documents to address those concerns.

face in the insurance market, and because of the short time frame allowed to implement the CO-OP program.[105] At the time of the audit, CMS had awarded $1.98 billion to 24 CO-OPs. From interviewing CMS officials and staff, the HHS OIG concluded that the CMS oversight strategy included "frequent monitoring" and "early intervention." Specifically, the report stated:

> CMS established a prospective oversight system to safeguard CO-OP funding and ensure timely implementation of the program. CMS described its oversight as an "early warning system" to address problems before they undermine a CO-OP's progress.[106]

Despite the HHS OIG's findings at the outset of the program, the committee found that CMS' oversight system is ineffective in practice. CMS' monitoring of the CO-OPs, while perhaps frequent, has not resulted in meaningful improvements to the CO-OPs' fortunes. Further, rather than an "early warning system" to address problems as they emerged, CMS has been late to identify problems, as well as possible solutions, to help CO-OPs succeed. One of CMS' most touted oversight mechanisms, the CAP, has not been an effective tool.

1. CMS CAPs Were Reactionary, Contained Errors, and Did Not Result in Meaningful Oversight

FINDING: CMS issued CAPs in response to oversight conducted not by CMS, but rather State regulators and the HHS OIG.

Through the course of its investigation, the committee obtained 11 of the CAPs issued by CMS, as well as the responses sent back to CMS from the CO-OPs. The committee has also reviewed the CAPs for CO-OPs still in operation. Despite CMS' stated goals of proactively monitoring CO-OPs and maintaining early warning systems to identify problems before they progress, the committee found that CMS issued many CAPs just months before CO-OPs closed down. Further, it appears CMS issued CAPs either in reaction to letters sent to CO-OPs by state regulators notifying them of state law violations, or in reaction to an HHS OIG report that was issued in July 2015, warning that CO-OPs' profitability was lower than projections and they might be unable to repay taxpayer-funded loans.[107] Two CO-OPs failed less than a month after receiving a CAP from CMS, and five CO-OPs that failed in 2015 never received a CAP.

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[105] H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations, *Examining the Costly Failures of Obamacare's CO-OP Insurance Loans*, 114th Cong. (Nov. 5, 2015).
[106] Office of Inspector Gen., Dep't of Health and Human Services, *The Centers for Medicare & Medicaid Services Awarded Consumer Operated and Oriented Plan Program Loans in Accordance with Federal Requirements, and Continued Oversight is Needed*, Audit no. A-05-12-00043 (July 2013).
[107] Office of Inspector Gen., Dep't of Health and Human Services, *Actual Enrollment and Profitability Was Lower Than Projections Made By The Consumer Operated and Oriented Plans and Might Affect Their Ability To Repay Loans Provided Under the Affordable Care Act*, Audit no. A-05-14-00055 (July 2015).

For the CO-OPs that have closed, see the chart indicating the date CMS issued a CAP, and the date of the CO-OP closure:

Name of Former CO-OP	Date Corrective Action Plan Issued by CMS	Date of Closure Announcement
CoOportunity Health - Iowa and Nebraska	No CAP	January 23, 2015
Louisiana Health Cooperative, Inc.	January 2, 2015	July 24, 2015
Nevada Health Cooperative	No CAP	August 25, 2015
Health Republic Insurance of New York	No CAP	September 25, 2015
Kentucky Health Care Cooperative - Kentucky and West Virginia	September 18, 2015	October 9, 2015
Community Health Alliance Mutual Insurance Company - Tennessee	February 3, 2015	October 14, 2015
Colorado HealthOP	September 10, 2015	October 16, 2015
Health Republic Insurance of Oregon	September 22, 2015	October 16, 2015
Consumers' Choice Health Insurance Company - South Carolina	No CAP	October 22, 2015
Arches Mutual Insurance Company – Utah	No CAP	October 27, 2015
Meritus Health Partners – Arizona	September 28, 2015	October 31, 2015
Consumers Mutual Insurance – Michigan	September 22, 2015	November 4, 2015
InHealth Mutual – Ohio	September 28, 2015	May 26, 2016
HealthyCT – Connecticut	October 5, 2015	July 5, 2016
Oregon Health's CO-OP – Oregon	September 23, 2015	July 8, 2016
Land of Lincoln Health – Illinois	May 24, 2016	July 12, 2016

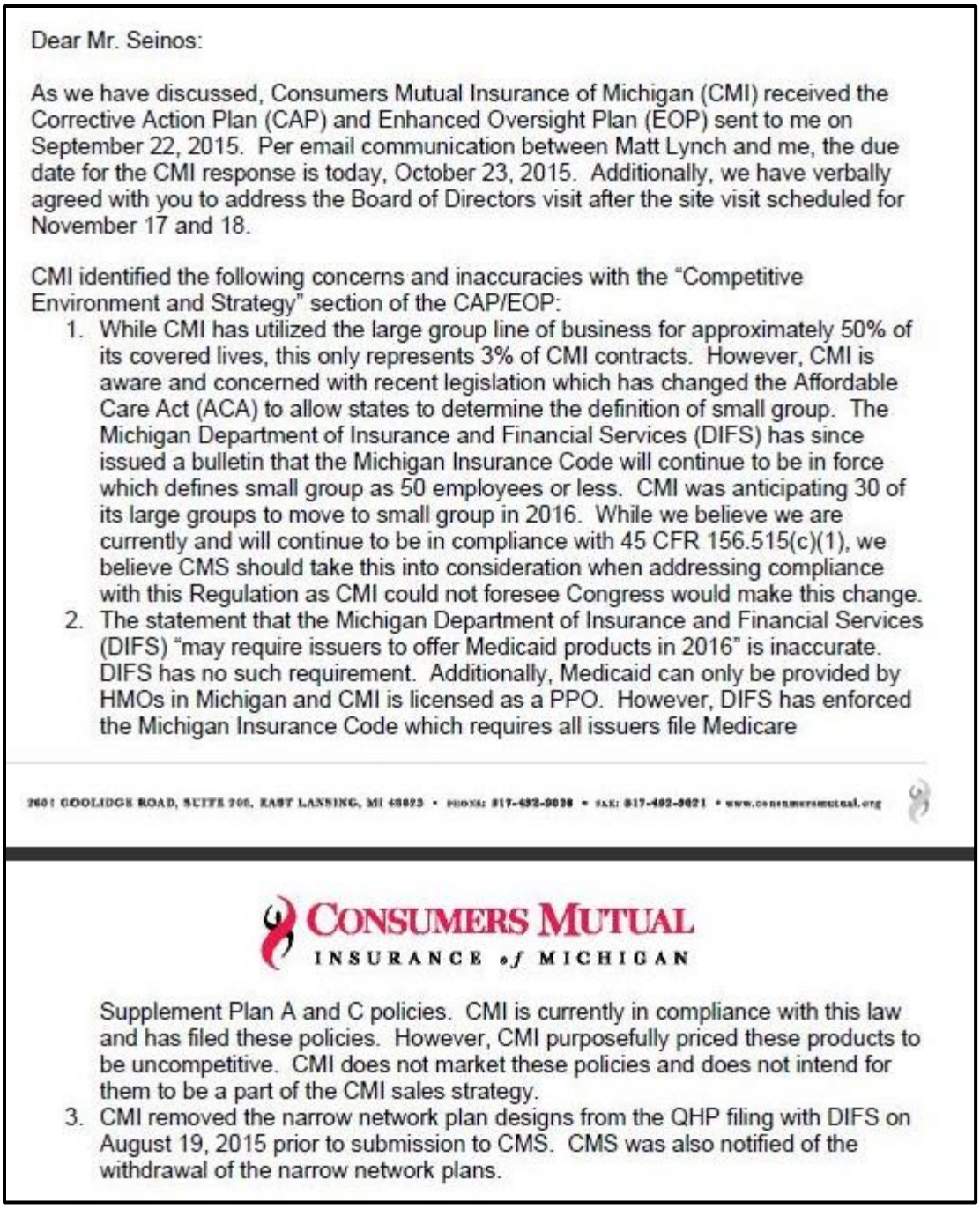
In the two instances that CMS issued CAPs before the HHS OIG report was released, those CO-OPs had received letters from the state insurance regulators that indicated the CO-OP had violated state laws. It appears CMS issued those CAPs in direct response to the state regulator letters. In all instances, therefore, CMS issued CAPs in reaction to an outside force – either the HHS OIG or state regulators. This suggests that CMS's own oversight processes were so deficient that they could not identify the significant problems that CO-OPs faced, until another regulator or auditor brought them to light.

FINDING: CMS issued CAPs that contained obvious errors and outdated information.

When CMS did issue a CAP, it often contained errors or cited outdated information. This shows that CAPs were not a priority for CMS, and that CMS lacked a meaningful understanding of the true problems that the CO-OPs faced. The numerous errors also suggest that the meetings and communications between CO-OPs and CMS were not substantive and that the CAPs were an ineffective oversight mechanism. This section includes numerous examples of problematic CAPs. For those CO-OPs that are still in operation, the committee has redacted the names of the CO-OPs.

A CAP issued on September 22, 2015 to Consumers Mutual Insurance of Michigan (CMI) contained inaccuracies regarding state requirements for Medicaid and network plan designs. CMI noted those errors in its October 23, 2015 response to CMS.[108]

[108] Letter from Consumer's Mutual Insurance of Michigan, to Mr. Seinos, Centers for Medicare & Medicaid Serv. (October 23, 2015).



Dear Mr. Seinos:

As we have discussed, Consumers Mutual Insurance of Michigan (CMI) received the Corrective Action Plan (CAP) and Enhanced Oversight Plan (EOP) sent to me on September 22, 2015. Per email communication between Matt Lynch and me, the due date for the CMI response is today, October 23, 2015. Additionally, we have verbally agreed with you to address the Board of Directors visit after the site visit scheduled for November 17 and 18.

CMI identified the following concerns and inaccuracies with the "Competitive Environment and Strategy" section of the CAP/EOP:

1. While CMI has utilized the large group line of business for approximately 50% of its covered lives, this only represents 3% of CMI contracts. However, CMI is aware and concerned with recent legislation which has changed the Affordable Care Act (ACA) to allow states to determine the definition of small group. The Michigan Department of Insurance and Financial Services (DIFS) has since issued a bulletin that the Michigan Insurance Code will continue to be in force which defines small group as 50 employees or less. CMI was anticipating 30 of its large groups to move to small group in 2016. While we believe we are currently and will continue to be in compliance with 45 CFR 156.515(c)(1), we believe CMS should take this into consideration when addressing compliance with this Regulation as CMI could not foresee Congress would make this change.
2. The statement that the Michigan Department of Insurance and Financial Services (DIFS) "may require issuers to offer Medicaid products in 2016" is inaccurate. DIFS has no such requirement. Additionally, Medicaid can only be provided by HMOs in Michigan and CMI is licensed as a PPO. However, DIFS has enforced the Michigan Insurance Code which requires all issuers file Medicare

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Supplement Plan A and C policies. CMI is currently in compliance with this law and has filed these policies. However, CMI purposefully priced these products to be uncompetitive. CMI does not market these policies and does not intend for them to be a part of the CMI sales strategy.

3. CMI removed the narrow network plan designs from the QHP filing with DIFS on August 19, 2015 prior to submission to CMS. CMS was also notified of the withdrawal of the narrow network plans.

CMS relied upon outdated information regarding the narrow network plan designs, and CMI had to remind CMS that the agency had been "notified of the withdrawal of the plans" previously.[109] This suggests that the CMS staff responsible for issuing the CAPs may not be in receipt of the most updated information, or that CMS staff may not be coordinating as needed across departments.

[109] Consumers Mutual Insurance of Michigan, document on file with Committee.

Another CO-OP that received a CAP from CMS noticed obvious errors. The CAP letter noted "concerns regarding [contractor's] performance have been raised by state regulators since 2014, and include issues such as billing errors, a claims backlog, and consumer complaints."[110] CMS continued: "CMS is concerned about [CO-OP's] operations and ability to meet the demanding needs of large groups given your current challenges with [contractor's] performance."[111]

In its response to the agency, the CO-OP corrected CMS' mistaken notion that the CO-OP received consumer complaints:

> The [state insurance department] is the regulatory agency that oversees Consumer Complaints and they have stated the [CO-OP] does not have an issue in this area… As far as the CAP letter response and based on discussions with the CMS team, no additional details (milestones, strategies for resolution, etc.) are required at this time.[112]

The CO-OP noted another error in the CAP regarding medical management:

> With regard to effective medical management, the [CO-OP] team asked again for specifics. To [CO-OP's] knowledge, there have been no previous discussions of any issues on this topic and this is an area where [CO-OP] excels…[113]

In this case, CMS demonstrated a lack of targeted analysis and detail when it comes to evaluating the needs of the individual CO-OP. Given the errors in this particular CAP, it appears CMS used outdated information or failed to do research on the specific needs of the CO-OP.

Another CO-OP noted serious deficiencies and errors in its CAP. In a CAP letter sent in September 2015, CMS indicated problems with the CO-OP's medical management and recent enrollment growth. In a response letter to the agency, the CO-OP stated:

> [CMS'] letter stated 'for example, [CO-OP] does not generate ongoing medical management performance reports nor does it provide claims-based reporting to its providers including prescription drug costs.'
> Correction: [CO-OP] does review ongoing medical management reports. They are generated quarterly and a copy of the most recent reports were provided to CMS/Navigant prior to the site visit.[114]

[110] CMS Corrective Action Plan to [Redacted CO-OP], document on file with Committee.
[111] *Id.*
[112] Response Letter from [Redacted CO-OP] to CMS, document on file with Committee.
[113] *Id.*
[114] Response Letter from [Redacted CO-OP] to CMS, document on file with Committee.

The CO-OP leadership further noted:

> I agree with the statement that [CO-OP's] significant enrollment growth has caused 'unexpected financial challenges' and your recognition of 'actions to mitigate financial risk.' However, I strongly disagree with the assumption made in your letter that 'robust marketing' toward maintaining our current enrollment levels will somehow help us out of this situation… A more responsible route is to reduce our enrollment.[115]

Here, the CO-OP strongly disputed not only the errors within the CAP, but the strategies CMS suggested to address the CO-OP's enrollment levels.

Finally, the CAPs were not only error-ridden, but also unhelpful to the CO-OPs. In briefings with committee staff, leaders of various CO-OPs communicated dissatisfaction with CMS' oversight, particularly the CAP process. Instead of providing technical expertise, CAPs focused on less important factors, such as job-searching to fill open positions on the CO-OP leadership team.[116] CO-OPs also expressed frustration that the CAPs were not solution-oriented but rather stated the obvious about the struggles the CO-OPs face.[117] Given the lack of detail and in-depth analysis, as well as outright errors, to date, CAPs appear to be a perfunctory process that gives little, if no value to the CO-OPs.

2. CMS Failed to Notify CO-OPs about Risk Corridor payment shortage

The Risk Corridor program was created with the intention of aiding insurers in a volatile market. However, the design of the program was fundamentally flawed as PPACA did not anticipate losses by a majority of insurers, nor take into consideration full market conditions.[118] While CMS is not responsible for the poor design of the Risk Corridor program, CMS was in charge of implementing both the Risk Corridor and CO-OPs programs.[119]

FINDING: CMS failed to notify CO-OPs before October 1, 2015 that Risk Corridor payments would be less than CMS' initial calculations.

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[115] *Id*.
[116] National Alliance of State Health CO-OPs, Briefing with Committee Staff, August 10, 2016.
[117] *Id*.
[118] The Risk Corridor program was intended to offset losses resulting from inadequate premium setting, by requiring profitable insurers to make Risk Corridor payments to insurers experiencing deficits. In the event that the insurers' deficits reached a certain percentage, HHS was responsible for issuing Risk Corridor payments. A majority of insurers experienced deficits, and therefore, the Risk Corridor was not fully funded. Additionally, the Risk Adjustment methodology was established using unavailable data, negatively impacting actuarial risk estimated by insureds.
[119] *See* Stephanie Armour, *More Health Co-OPs Face Collapse: Colorado's CO-OP and One in Oregon are Folding, Joining Six Others; Coalition Considers Legal Action*, WALL STREET J., Oct.16, 2015, *available at:* http://www.wsj.com/articles/more-health-co-ops-face-collapse-1445034912; Robert Laszewski, *Crocodile Tears Over the Failing Obamacare Co-Ops: The Canaries in the Obamacare Coal Mine*, Forbes: Healthcare, Fiscal, Tax, Oct. 26, 2015, *available* at: http://www.forbes.com/sites/robertlaszewski2/2015/10/26/crocodile-tears-over-the-failing-obamacare-co-ops-the-canaries-in-the-obamacare-coal-mine/#5de152846803.

The committee learned that CMS failed to provide timely notification to CO-OPs when the Risk Corridor program lacked sufficient funding to make transfer payments. As a result, the CO-OPs had a limited window of time to make adjustments causing some to immediately close.

Prior to making its 12.6 percent announcement on October 1, 2015, CMS continuously represented to CO-OPs that the Risk Corridor program was fully funded, and that CO-OPs would receive projected Risk Corridor payments.[120] CMS had planned to publish preliminary estimates for the Risk Corridor program on August 14, 2015.[121] Citing material differences in the data, CMS postponed the announcement by nearly six weeks, to October 1, 2015. During this time, CMS did not give CO-OPs any insight into the shortfall in Risk Corridor payments. The delay of announcement and the lack of notification from CMS blindsided the CO-OPs, leaving no opportunity to prepare for this financial setback.

Worse still, the committee learned that prior to CMS's announcement, several CO-OPs attempted to ask CMS for updates on the Risk Corridor payments, and CMS maintained that the CO-OPs could expect the Risk Corridor payments to be paid in full. For example, the Illinois CO-OP, Land of Lincoln, informed the committee that CMS continuously maintained the Risk Corridor program was fully funded, and that the CO-OP would be paid as planned. In response to the committee's May 2016 letter, Land of Lincoln stated:

> [L]and of Lincoln Health learned that the risk corridor payment would be 12.6 percent on October 1, 2015 when CMS released its official announcement on the matter. Prior to that date, CMS continually maintained that the risk corridor program would be fully funded and paid as planned. ***As late as September 26, 2015, CMS representatives informed a room full of executives of the CO-OP program at the annual NASHCO conference in Denver, Colorado that they expected the program would be paid in full.*** Several CO-OPs learned the very next week that this was not true for 2015 and were forced to close almost immediately.[122]

Another CO-OP informed the committee that they asked CMS to confirm calculated risk corridor payments owed to the CO-OP for months, yet never received any feedback until CMS' announcement on October 1, 2015:

> [CO-OP] learned that the risk corridor payment would be 12.6% of the calculated amount on 10/1/2015. ***[CO-OP] had been asking for months to get confirmation on the risk corridor payout due to reports that the collection of risk corridor payments in would not meet the requested***

[120] *See e.g.* Letter from Jason Montrie, Land of Lincoln Mutual Health Insurance Company, to Hon. Fred Upton, Chairman, Oversight and Investigations Subcommittee for the House Commit. Energy and Commerce, (May 31, 2016).
[121] Centers for Medicare and Medicaid Services, Press Release: *The Three Rs: An Overview*, (Oct. 1, 2015), *available at*: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-01.html
[122] Letter from Jason Montrie, Land of Lincoln Mutual Health Insurance Company, to Hon. Fred Upton, Chairman, Oversight and Investigations Subcommittee for the House Commit. Energy and Commerce, (May 31, 2016). (Emphasis Added).

> ***payments out***. No confirmation was provided to communicate that the payment would be less than 100% of the calculated amount until [CO-OP] received the letter from CMS on 10/1/2015.[123]

Another CO-OP informed the committee that they expected to receive $44 million form the Risk Corridor program, but only received $5.7 million—creating a $38.3 million deficit.[124]

3. CMS Failed to Provide Technical Assistance Amidst Risk Adjustment Concerns

FINDING: CMS failed to provide technical assistance as CO-OPs raised Risk Adjustment concerns.

The CO-OPs informed the committee that they raised several concerns regarding the impact of Risk Adjustment payments, before shutting down. Despite these concerns, CMS failed to provide CO-OPs with technical assistance. For example, Connecticut's CO-OP, HealthyCT, informed the committee that they identified several scenarios that hindered its ability to repay loans, and continually made CMS aware of its financial position as it relates to risk adjustment:

> [H]ealthy CT has continually made CMS aware of its financial position as it relates to the risk adjustment program. Although no formal discussions related to closures have taken place, CMS remains aware the the continued administration of the risk adjustment program in the format prescribed has the potential to cause major financial implications to HealthyCT.[125]

On July 5, 2014, the state of Connecticut's insurance department, announced that HealthyCT, Connecticut's CO-OP, was placed under an order of supervision, prohibiting the company from writing new business or renewing existing business in Connecticut effective immediately.[126] The Connecticut state Commissioner provided the following statement citing reasons for the CO-OP's wind down:

> Unfortunately HealthyCT's financial health is unstable, having been seriously jeopardized by federal requirements issued June 30, 2016 that it pay $13.4 million to the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services as part of the Affordable Care Act's Risk Adjustment Program," the Commissioner said. As a result, it became evident that this risk adjustment mandate would put the company under significant financial strain. This order of supervision provides for an

[123] Letter from [Redacted CO-OP] to the Committee, document on file with the Committee. (Emphasis Added).
[124] Letter from [Redacted CO-OP] to the Committee, document on file with the Committee.
[125] Letter from Kenneth Lalime, CEO, Healthy CT, to Hon. Fred Upton, Chairman, Oversight and Investigations Subcommittee for the House Commit. Energy and Commerce, (June 17, 2016).
[126] Connecticut Insurance Department, *Insurance Department Places HealthyCT Under Order of Supervision,* (July 5, 2016), available at: http://www.ct.gov/cid/cwp/view.asp?a=1269&Q=582452.

> orderly run-off of the company's claim payment under close regulatory oversight.[127]

Another CO-OP informed the committee that CMS failed to provide technical assistance and identify ways to improve its performance, "[C]MS has not provided technical assistance with improving [CO-OP's] performance or discuss [CO-OP's] current financial status or ability for loan repayment."[128] Illinois's CO-OP, Land of Lincoln, also informed the committee that CMS neglected to facilitate discussions on improving the CO-OPs performance, or provide technical assistance:

> [N]o specific discussions on the subjects of technical performance assistance or technical finance assistance have been initiated by CMS to date other than enhanced oversight procedures and general performance reviews conducted by third party consulting firms.[129]

In contrast to these statements by the CO-OPs, in a response letter to the committee, CMS stated that the agency took several measures to improve finances for the CO-OPs, including technical assistance with respect to the risk adjustment submissions:

> You asked specifically about the actions we are taking to improve the CO-OPs' finances. CMS is focused on increasing the capital options available to CO-OPs. On January 27, 2016, CMS released guidance indicating that we are exploring ways 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. Additionally, CMS is interested in considering improvements to the risk adjustment methodology and has announced a March 31, 2106 meeting to solicit feedback from stakeholders. CMS is providing technical assistance to the CO-OPs to improve the completeness and accuracy of their risk adjustment submissions.[130]

Numerous obstacles contributed to the ultimate demise of the failed CO-OPs, including inadequate enrollment margins that crippled CO-OPs ability to manage costs, and ineffective premium stabilization programs, which, rather than helping, financially devastated a number of CO-OPs.

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[127] *Id*.
[128] Letter from [Redacted CO-OP] to the Committee, document on file with the Committee.
[129] Letter from Jason Montrie, Land of Lincoln Mutual Health Insurance Company, to Hon. Fred Upton, Chairman, Oversight and Investigations Subcommittee for the House Commit. Energy and Commerce, (May 31, 2016).
[130] Letter from Andrew Slavitt, Administrator, CMS, to Hon. Tim Murphy Chairman, Subcommittee on Oversight and Investigations, (Feb. 11, 2016).

B. CMS Delayed Rulemakings That Could Have Helped CO-OPs Survive

After years of turmoil and criticism of its management of the CO-OPs program, on May 11, 2016, CMS issued an interim final rule to change the rules surrounding Special Enrollment Periods, outside investments and composition of the Boards of Directors, and the implementation of the risk adjustment program. These three issues are among the most critical for CO-OPs survival. These changes, however, may come too late as only six CO-OPs remain, and CMS has not addressed these three issues in full.

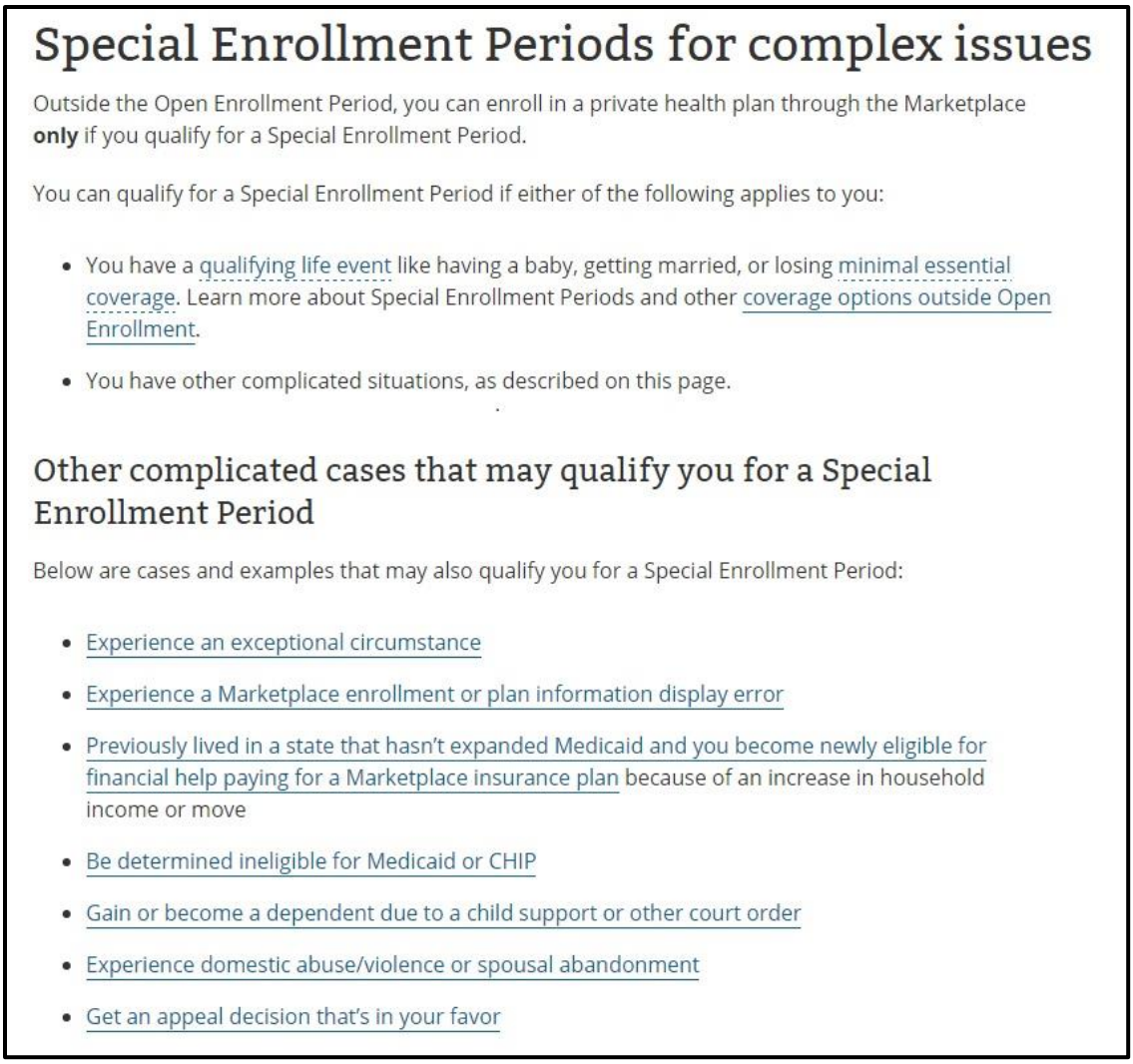
While CMS' failure to enforce its already-permissive rules surrounding special enrollments have harmed all insurers, as new fledgling companies, CO-OPs have less ability to absorb the losses of individuals who abuse special enrollment periods and only obtain insurance coverage when they become sick. In addition, CO-OPs have long requested that CMS allow them to seek outside investors to make the CO-OPs more viable. While CMS eased those restrictions in the interim final rule, CO-OPs may not have time before open enrollment to secure outside investors. Finally, CMS acknowledged that its Risk Adjustment methodology needed to be improved. Its methodology had been criticized for one, its unpredictability, and two, unfair treatment of newer entrants into the market, like CO-OPs.

1. CMS Tightened Some Provisions Governing Special Enrollment Periods After Complaints from Insurers

In 2012, HHS issued regulations creating Special Enrollment Periods (SEP) for the federal and state exchanges selling individuals health care insurance plans.[131] If an individual qualifies for a special enrollment period, that individual can sign up for health care insurance on the federal or state based exchanges established under the PPACA, outside of the open enrollment period that generally runs from late fall through early winter. While the SEPs have changed year to year, the current regulation provides for SEPs under the following circumstances:[132]

[131] 45 C.F.R. § 155.420

[132] Healthcare.gov, *Special Enrollment Periods for Complex Issues, available at*: https://www.healthcare.gov/sep-list/ (last visited Aug. 31, 2016).



Special Enrollment Periods for complex issues

Outside the Open Enrollment Period, you can enroll in a private health plan through the Marketplace **only** if you qualify for a Special Enrollment Period.

You can qualify for a Special Enrollment Period if either of the following applies to you:

- You have a qualifying life event like having a baby, getting married, or losing minimal essential coverage. Learn more about Special Enrollment Periods and other coverage options outside Open Enrollment.
- You have other complicated situations, as described on this page.

Other complicated cases that may qualify you for a Special Enrollment Period

Below are cases and examples that may also qualify you for a Special Enrollment Period:

- Experience an exceptional circumstance
- Experience a Marketplace enrollment or plan information display error
- Previously lived in a state that hasn't expanded Medicaid and you become newly eligible for financial help paying for a Marketplace insurance plan because of an increase in household income or move
- Be determined ineligible for Medicaid or CHIP
- Gain or become a dependent due to a child support or other court order
- Experience domestic abuse/violence or spousal abandonment
- Get an appeal decision that's in your favor

To enroll in health insurance during a SEP, an individual must fall under one of the above categories, but CMS has not enforced this rule.

FINDING: CMS has not enforced the rules on SEPs, contributing to unpredictable enrollment figures.

Individuals have been able to sign up for coverage during a SEP without showing any documentation that the individual qualifies for that SEP.[133] Many insurers have voiced concerns that these permissive policies destabilize the markets and drive up premiums.[134] For CO-OPs, which have slimmer margins and smaller enrollee populations than more established providers, abuse of SEPs creates uncertainty and financial instability.

[133] Robert Pear, *Insurers Say Costs Are Climbing as More Enroll Past Health Act Deadline*, N.Y. TIMES, Jan. 9, 2016, *available at*: http://www.nytimes.com/2016/01/10/us/politics/insurers-say-costs-are-climbing-as-more-enroll-past-health-act-deadline.html?_r=2

[134] *Id*.

In February 2016, CMS announced an initiative to enforce SEPs in the 38 states that use HealthCare.gov by requiring documentation for some SEP events, such as loss of coverage, a permanent move, and birth of a child.[135] However, these enforcement mechanisms do not apply to the 12 state-based exchanges and do not cover all categories of SEPs. Further, the individual is placed on temporary coverage until CMS receives the documentation, which entitles qualified individuals to subsidies under entitlement programs like the Advanced Premium Tax Credit and the Cost Sharing Reduction Program.

In May 2016 interim final rule, CMS narrowed one SEP factor that was a potential cause for abuse – the "permanent move" category. This new rule requires individuals requesting a SEP because they have moved out of state to have minimal essential coverage for one or more days in the 60 days preceding the permanent move, unless they moved from outside of the U.S. or a U.S. territory.[136] CMS noted that the change would ensure "individuals are not moving for the sole purpose of obtaining health coverage outside of the open enrollment period."[137]

It is unfortunate that CMS has taken over two years to enforce any aspects of the SEPs given the substantial number of individuals who utilize SEPs. For example, from February 23, 2015, to June 30, 2015, 943,934 individuals enrolled through a SEP using HealthCare.gov.[138] Given the lack of guidance and enforcement, it is likely that individuals have misused the SEP, whether purposefully or inadvertently. Further, there are significant gaps in CMS' new enforcement actions, such as providing temporary coverage for the individual before CMS verifies the individual qualifies for the SEP. If CMS enforced the SEPs when the exchanges opened in January 2014, it is likely insurers, especially vulnerable insurers like the CO-OPs, would have suffered less financial hardship and uncertainty.

2. CMS Loosened Requirements for Composition of Boards of Directors, Permitting Outside Investors for the First Time

Under previous HHS regulations, each CO-OP must be governed by a Board of Directors, and each board member must be elected by a majority vote of a quorum of the CO-OP members that are 18 or older. In addition, the board members must be members of the CO-OP.[139] This provision essentially prohibits fledgling CO-OPs from leveraging outside investors or capital, because prospective business partners will be reluctant to invest if they cannot sit on the Board. This problem was well-known to CMS as far back as mid-2013. In the July 2013 report that evaluated the CMS' early implementation of the CO-OP program, HHS OIG noted that "11 of 16 CO-OPs reported estimated startup expenditures in their applications that exceeded the

[135] Centers for Medicare & Medicaid Serv., *Fact Sheet: Special Enrollment Confirmation Process* (Feb. 24, 2016), available at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-24.html.
[136] 45 C.F.R. Parts 155 and 156 (2016).
[137] *Id.*
[138] *See* Centers for Medicare & Medicaid, *supra* note 135.
[139] 45 CFR 156.515(b)(1)

total startup funding provided by CMS."[140] HHS OIG cited limited private monetary support and budget startup expenditures as a factor that would hinder the CO-OPs' ability to meet startup costs.[141]

During the subcommittee's November 5, 2015, hearing on the management of the CO-OP program, representatives of two CO-OPs testified that CMS should remove restrictions that prevent CO-OPs from raising outside capital. Peter Beilenson, CEO and President of the Evergreen Health Cooperative, highlighted this point in his written testimony. He stated:

> A possible solution is to allow individual CO-OPs to raise capital to meet these solvency needs. CMS has recently indicated they may entertain this potential solution, and it would seem to be an important step in the right direction. In fact, the ability to obtain private capital was one of the measures by which the original CO-OP applications were judged. CMS could amend the loan agreements as this prohibition on obtaining additional capital is not required under ACA Section 1322.[142]

Likewise, in his written statement submitted for the record, John Morrison, Co-Founder and Former President of the National Alliance of State Health CO-OPs, stated that access to private capital is one of many steps CMS could take that would help CO-OPs succeed.[143]

In the May 2016 interim final rule, CMS finally loosened some of the restrictions that had previously prohibited CO-OPs from accessing outside capital. The CMS rule states:

> We are amending these standards to require that only a majority of directors be elected by the members and to remove the requirement that a majority of voting directors be members of the CO-OP. **This revision allows entities offering loans, investments, and services to participate on the board of directors, as is common practice in the private sector, while maintaining the overall control of the board by the members of the CO-OP.** We are making this change in response to program experience demonstrating that the inability to grant designated board positions to prospective partners or investors may create obstacles to potentially favorable business arrangements for CO-OPs.[144]

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[140] Office of Inspector Gen., Dep't of Health and Human Servs., *The Centers for Medicare & Medicaid Services Awarded Consumer Operated and Oriented Plan Program Loans in Accordance with Federal Requirements, and Continued Oversight is Needed*, Audit no. A-05-12-00043 (July 2013).
[141] Office of Inspector Gen., Dep't of Health and Human Servs., *The Centers for Medicare & Medicaid Services Awarded Consumer Operated and Oriented Plan Program Loans in Accordance with Federal Requirements, and Continued Oversight is Needed*, Audit no. A-05-12-00043 (July 2013).
[142] H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations, *Examining the Costly Failures of Obamacare's CO-OP Insurance Loans*, 114th Cong. (Nov. 5, 2015).
[143] H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations, *Examining the Costly Failures of Obamacare's CO-OP Insurance Loans*, 114th Cong. (Nov. 5, 2015).
[144] 45 CFR Parts 155 and 156 (emphasis added).

Since CMS released the rule in May, the remaining six of 23 CO-OPs have only four months to secure outside investors and formalize legal agreements with business partners before state regulators determine which CO-OPs may offer plans on the markets during open enrollment starting November 1, 2016.

FINDING: By delaying rulemaking, CMS gave CO-OPs only four months to secure outside investors.

If a CO-OP is not deemed to be financially secure, state regulators may shut down the CO-OP before open enrollment begins on November 1. State regulators generally approve insurance plans in late summer.[145] While large investment deals generally take at least six months, CO-OPs must operate on an accelerated timeline of only three to four months, from mid-May to the end of August.[146] In addition, CMS must approve certain aspects of the deal, such as conflict of interest provisions, which lengthens the amount of time of the deal. In a briefing with the committee, several CO-OPs were skeptical that few, if any, CO-OPs would be able to secure outside investors on this abbreviated timeline granted by CMS.[147] If CMS had approved this financial structure years ago, it is possible the CO-OPs would have secured outside financing and been able to repay taxpayer-funded loans that were otherwise forfeited.

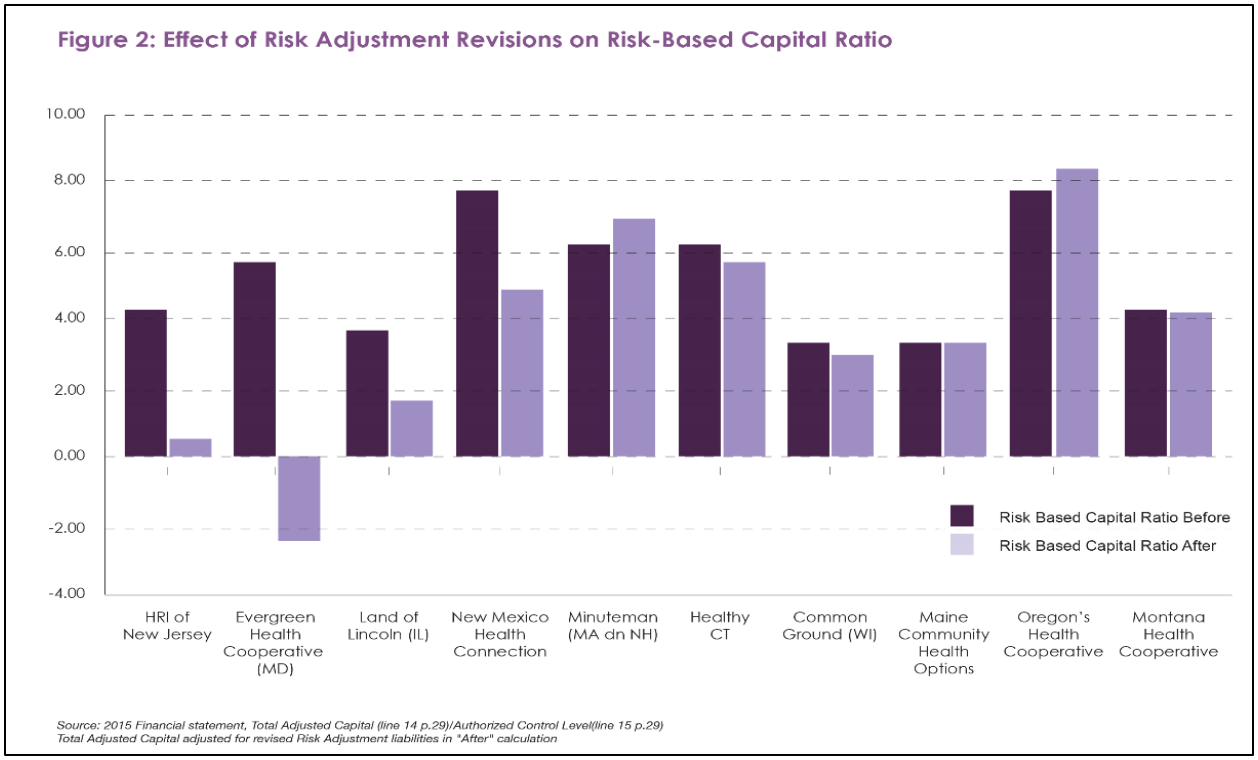
[145] National Association of Insurance Commissioners, *State Insurance Regulation: History, Purpose and Structure*, (last updated June 13, 2016), available at: http://www.naic.org/cipr_topics/topic_risk_based_capital.htm
[146] Briefing with National Alliance of State Health CO-OPs, August 10, 2016.
[147] *Id*.

VIII. The Future of the Remaining CO-OPs is Uncertain

To date, and as discussed in previous sections, 17 of the original 23 CO-OPs have ceased operations, leaving only six CO-OPs operational in eight states. As CO-OPs are now responsible for making substantial risk adjustment payments and experience deficits from less-than-projected risk corridor payments, the financial solvency of the remaining CO-OPs is a concern.

While six CO-OPs remain operational, four have fallen into categories of potential financial insolvency according to a recent analysis of their risk-based capital (RBC).[148] RBC estimates the minimum amount of capital needed to support the issuer's business operations, and is a measurement used to forecast the financial sustainability of an insurance carrier.[149] The RBC can be expressed as either a percentage or a ratio, and consists of an insurance carrier's total risk-based capital divided by the sum of its total risk-weighted assets and adjustments to risk-weighted assets.[150] CMS required CO-OPs to maintain an RBC of 500 percent, but allowed for lower levels to increase the long-term sustainability of some CO-OPs.[151] The following chart illustrates risk-based capital ratios before and after risk adjustment payments for CO-OPs that were operational as of July 11, 2016.[152]

[148] Katherine Hempstead, *Risk Adjustment and Co-Op Financial Status*, Robert Wood Johnson Foundation, July 11, 2016, *available at*: http://www.rwjf.org/en/library/research/2016/07/risk-adjustment-coop-finance-status.html
[149] National Association of Insurance Commissioners, *Risk-Based Capital*, The Center for Insurance Policy and Research, (last updated June 13, 2016), available at: http://www.naic.org/cipr_topics/topic_risk_based_capital.htm
[150] *Id*.
[151] U.S. Dep't of Health & Human Serv., Office of Inspector General, *Conversions of Startup Loans Into Surplus Notes by Consumer Operated and Oriented Plans Were Allowable But Not Always Effective*, A-05-1600019, (August 2016).
[152] Katherine Hempstead, *Risk Adjustment and Co-Op Financial Status*, Robert Wood Johnson Foundation, July 11, 2016, *available at*: http://www.rwjf.org/en/library/research/2016/07/risk-adjustment-coop-finance-status.html



FINDING: Operational CO-OPs are not likely to pay back loans because of potential insolvency.

Findings from a recent HHS OIG report on the conversions of CO-OP startup loans indicate that despite receiving increased levels of capital through federal government loans, the risk based capital percentages for the remaining CO-OPs were at levels below the CMS requirement.[153] As of December 31, 2015, RBC for four of the then-eight operating CO-OPs, Wisconsin, Montana, Maine, and Illinois, fell below 500 percent.[154] Consequently, HHS OIG determined that these CO-OPs are less likely to pay back loans issued to them due to becoming insolvent. CMS has agreed with HHS OIG's request to quantify the likely impact on the federal government's ability to recover loan payments: [155]

[153] U.S. Dep't of Health & Human Serv, Office of Inspector General, *Conversions of Startup Loans Into Surplus Notes by Consumer Operated and Oriented Plans Were Allowable But Not Always Effective,* A-05-1600019, (August 2016).
[154] *Id.*
[155] *Id.*

OIG Recommendation

The OIG recommends that CMS quantify the likely impact on the Federal Government's ability to recover loan payments.

CMS Response

CMS concurs with this recommendation. The process described in the July 9, 2015 memo includes consideration of the potential impact of the change in the priority of the loan in relation to other obligations. Before issuing the July 9 memo, CMS revised the credit risk profile of start-up loans to assess the overall impact of accepting surplus notes for start-up loans. CMS will continue to assess the overall impact of accepting surplus notes for start-up loans in the future if additional CO-OPs request a conversion.

While CMS has agreed to assess the overall impact on the federal government's ability to recover loan payments, the committee questions CMS' capability to deliver based CMS' attempted oversight efforts that ultimately lead to the failure of 17 CO-OPs.

The examples outlined in this report have demonstrated how fundamental flaws from the premium stabilization programs, in addition to inadequate oversight from CMS can dismantle the viability of CO-OPs overnight. Colorado HealthOP, the former CO-OP serving Colorado, demonstrated how even the strongest of CO-OPs can quickly shut operations overnight due to financial insolvency. For example, Colorado HealthOP managed to maintain cash reserves and was projected to make a profit in 2016. However, after learning that Risk Corridor payments were less than expected, the CO-OP's solvency plummeted overnight and ultimately shuttered operations.[156] This abrupt shutdown caused approximately 40 percent of Coloradans who purchased insurance through the exchange in 2015, and were forced out of the coverage they chose.[157] In addition, the shutdown caused the CO-OP to default on $72 million in federal start-up and solvency funding – all of which the CO-OP was on track to pay if they could continue to operate.[158] HHS OIG's recent report, which examined the risk based capital of remaining CO-OPs provides yet another indicator, that a majority of the operational CO-OPs are projected to be insolvent.

[156] *Id.*
[157] *Id.*
[158] *Id.*

IX. Consequences of the CO-OP Failures

The failure of 17 CO-OPs has created confusion and contributed to marketplace volatility. In addition to its impact on the markets, CO-OP failures have also negatively affected individuals enrolled in plans offered by the CO-OPs. These failures also represent a loss of millions of taxpayer dollars since it is unlikely that any of the failed CO-OPS will repay any of their federally funded loans. Of the 17 CO-OPs that failed, CMS had awarded those CO-OPs over one billion dollars collectively.

A. CO-OPs That Failed in the Middle of the Year Left Others Responsible to Pay Claims

In June 2014, when all 23 CO-OPs were still operational, there were 486,552 individuals covered by health insurance plans provided by a CO-OP.[159] The two CO-OPs with the highest enrollment numbers—CoOportunity Health, which served Iowa and Nebraska, and Health Republic Insurance of New York—failed after individuals had already enrolled in plans for the following year, forcing consumers to quickly find another health care insurance plan to prevent gaps in coverage. At the time of the closures, it was estimated that CoOportunity enrolled 120,000 individuals and it was estimated that Health Republic Insurance of New York had enrolled over 200,000 individuals. The experiences of these two CO-OPs illustrate how the closure of CO-OPs can create uncertainty for individuals and providers.

Iowa and Nebraska - CoOportunity Health

CoOportunity, a CO-OP operating in Iowa and Nebraska, enrolled over 120,000 individuals in 2014,[160] amounting to one fifth of CO-OP enrollees nationally. CoOportunity grew to become the second largest CO-OP in the nation and had far exceeded its enrollment projection of 15,000.[161]

Of the $145 million in federal loans CoOportunity received, CMS awarded $32.7 million of additional solvency funding in September 2014, just three months before the state of Iowa took possession of the CO-OP's assets.[162] Despite having the second highest enrollment numbers in the nation, on January 23, 2015, CoOportunity closed after it was determined "that the [CO-

[159] Office of Inspector Gen., Dep't of Health and Human Services, *Actual Enrollment and Profitability Was Lower Than Projections Made By The Consumer Operated and Oriented Plans and Might Affect Their Ability To Repay Loans Provided Under the Affordable Care Act*, Audit no. A-05-14-00055 (July 2015).
[160] Steve Jordan, *Troubled Iowa Insurer CoOportunity Health May be Liquidated, Omaha World-Herald*, Dec.24, 2014, *available at:* http://www.omaha.com/money/troubled-iowa-insurer-cooportunity-health-may-be-liquidated/article_825f0962-8b7d-11e4-b6d3-ef7555754633.html
[161] *Iowa, Nebraska Officials Seek to Close Insurance Co-Op*, Insurance Journal, Jan. 25, 2015, *available at*: http://www.insurancejournal.com/news/midwest/2015/01/25/355274.htm.
[162] U.S. Dep't of Health & Human Serv, Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight, "Loan Program Helps Support Customer-Driven Non-Profit Health Insurers", Dec. 16, 2014, https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html

OP's] medical claims would exceed its cash on hand."[163] On March 2, 2015, an Iowa district court found that the CO-OPs operating losses were over $163 million and it had $50 million more in liabilities than assets.[164] The court ultimately filed a final order of liquidation and request for other relief authorizing the Commissioner of Insurance, Nick Gerhart, to liquidate the CO-OP.[165] As a result, Commissioner Gerhart was directed to take possession of all assets and administer those assets with supervision by the court.[166]

Initially, CoOportunity customers has just two weeks to find another plan, in order to avoid gaps in coverage or face penalties under law, because the 2015 open enrollment period for the PPACA closed on February 15, 2015.[167] Because of the narrow timeframe, CMS set up a "special enrollment period," allowing former CoOportunity customers until April 29, 2015, to select a plan through the PPACA.[168]

In addition to consumers left scrambling to find new coverage, providers were left wondering how the millions of dollars in outstanding claims would be paid, if at all. Ultimately, Iowa's Insurance Commissioner, Nick Gerhart, deemed that the special insurance-guarantee fund, a fund administered by a state to protect policy holders in the event that an insurance company defaults on benefit payments or becomes insolvent, would pay the outstanding claims.[169] CoOportunity did not pay back any of its federal loans to CMS.

New York - Freelancers Health Service Corporation d/b/a Health Republic Insurance of New York

CMS awarded a CO-OP in New York, Health Republic of New York, more than $265 million dollars, which includes the additional $90 million in solvency funding that CMS awarded on September 26, 2015.[170] Health Republic had the highest enrollment numbers in the nation,

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[163] *Iowa, Nebraska Officials Seek to Close Insurance Co-Op,* Insurance Journal, Jan. 25, 2015, available at: http://www.insurancejournal.com/news/midwest/2015/01/25/355274.htm.

[164] State of Iowa, ex. rel. Nick Gerhart, Commissioner of Insurance v. CoOportunity Health, Inc. Case Number EQCE077579, Final Order of Liquidation, March 2, 2015. *available at:* http://www.iid.state.ia.us/sites/default/files/press_release/2015/03/02/final_order_of_liquidation_pdf_17399.pdf

[165] State of Iowa, ex rel. Nick Gerhart, Commissioner of Insurance v. CoOportunity Health Inc., Case Number EQCE077579, Final Order of Liquidation, March 2, 2015. *available at*: http://www.iid.state.ia.us/sites/default/files/press_release/2015/03/02/final_order_of_liquidation_pdf_17399.pdf

[166]Website of CoOportunity Health, "Notice of Liquidation of CoOportunity Health," *available at:* http://www.iid.state.ia.us/sites/default/files/press_release/2015/03/02/liquidation_notice_pdf_60339.pdf

[167]Website of CoOportunity Health, "CoOportunity Health Liquidation: Updated Frequently Asked Questions for Individuals," March 2, 2015, *available at:* http://www.iid.state.ia.us/sites/default/files/press_release/2015/03/02/cooportunity_health_liquidation_frequently_asked_q_79570.pdf

[168] Anna Wilde Mathews, *State Regulator to Shut Down Insurer CoOportunity Health*, WALL STREET J., Jan. 23, 2015, *available at*: http://www.wsj.com/articles/state-regulator-to-shut-down-insurer-cooportunity-health-1422052829.

[169] David B. Caruso, *Sudden Collapse of Health Co-Op in N.Y. Leaves Doctors Owed Millions,* Insurance Journal, (Nov. 30, 2015), *available at*: http://www.insurancejournal.com/news/east/2015/11/30/390214.htm.

[170] Dep't of Health & Human Serv., Centers for Medicare & Medicaid Serv., Center for Consumer Information & Insurance Oversight, "Loan Program Helps Support Customer-Driven Non-Profit Health Insurers," Dec. 16, 2014, *available at*: https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html.

insuring more than 200,000 individuals.[171] Health Republic of New York enrolled 19 percent of the people who purchased plans through New York State Exchange. Despite high enrollment numbers, Health Republic of New York lost $35 million in 2014, and $52.7 million in the first half of 2015.[172] Facing severe financial problems, state regulators made the decision for the CO-OP to shut down by the end of November 2015.

New York's Department of Financial Services (DFS), and agency responsible for allowing Health Republic to sell health insurance in the state, faced criticism for not acting on the warning signs that signaled Health Republic was struggling financially.[173] For months, it was clear that Health Republic did not have rates sufficient to remain financially viable. DFS claimed that Health Republic's finances were much worse than what was reported to the state. Based on the information provided to the state, it was believed that Health Republic would be viable through 2015, however the finances were such that it would not be able to stay open through the end of November.[174]

Members of Congress called for an independent investigation to examine whether the CO-OP's failure was the result "of incompetence or dishonesty on Health Republic's part, or negligence on the part of DFS."[175] A three-month investigation by *Crain's New York Business* found that Health Republic was unsteady since its creation in 2012. The investigation found that management deliberately set low premium rates to attract more consumers, regulators approved the low rates and then did not allow Health Republic to raise the rates once it was realized that the low rates threatened the company's solvency. In addition, there were numerous management changes resulting in bad decisions made by inexperienced individuals, and the CO-OP also received poor services from outside vendors.[176]

Similar to the situation in Iowa and Nebraska, consumers had to quickly find new health insurance to avoid a gap in coverage. New York consumers were left with very little time to find a new plan in order to maintain coverage in the month of December. The mid-year shut down also left medical providers, who treated the more than 200,000 patients covered by the CO-OP, with outstanding claims of over $200 million dollars.[177]

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[171] David B. Caruso, *Sudden Collapse of Health Co-Op in N.Y. Leaves Doctors Owed Millions*, The Big Story, Nov.30, 2015, *available at*: http://www.insurancejournal.com/news/east/2015/11/30/390214.htm.
[172] Louise Norris, *CO-OP Health Plans: Patients' Interests First*, healthinsurance.org, Aug. 3, 2016, *available at*: https://www.healthinsurance.org/obamacare/co-op-health-plans-put-patients-interests-first/.
[173] Dan Goldberg and Josefa Velasquez, *Cuomo says health co-op collapse, and aftermath, isn't all on state*, POLITICO, Nov.6, 2015, *available at*: http://www.politico.com/states/new-york/albany/story/2015/11/cuomo-says-health-co-op-collapse-and-aftermath-isnt-all-on-state-027658.
[174] *Id*.
[175] *Id*.
[176] Michael Waldholz, *The Short and Chaotic Life of an Obamacare Darling*, Crain's New York Business, April 17, 2016, *available at*: http://www.crainsnewyork.com/article/20160417/HEALTH_CARE/160419890/a-crains-investigation-shows-how-health-republic-insurance-of-new-york-the-company-that-was-supposed-to-be-about-people-not-profits-misled-its-customers-and-ran-itself-into-the-ground.
[177] David B. Caruso, *Health CO-OP Failure in NY Leaves Doctors Owed Millions*, The Big Story, Nov. 24, 2015, http://bigstory.ap.org/article/5d10ae825dc748b89be3ffa07dcdd86d/health-co-op-failure-ny-leaves-doctors-owed-millions

B. CMS' Oversight Did Not Protect Taxpayer Dollars

In addition to the shortcomings cited above, there is little evidence to suggest that CAPs have resulted in any concrete outcomes. Through the loan agreements entered into between the CO-OPs and CMS, both parties have the authority to terminate the loan agreement for various reasons. CMS outlined the reasons the agency could terminate the CO-OP loans in its CO-OP "Funding Announcement Opportunity":[178]

> a. Fail to meet quality and performance standards, including implementation milestones, enrollment targets, consumer governance and responsiveness, as specified in the Loan Agreement, or any other contractual obligation with CMS;
> b. Are not in compliance with one or more provisions finalized in 45 CFR part 156 subpart F.
> c. Engage in improper use of Federal funds;
> d. Fail to reinvest profits for the benefit of the members;
> e. Are unable to effectuate any changes as prescribed by subsequent regulation during the agreement period after given the opportunity to comply with the regulatory change;
> f. Engage in material noncompliance, or demonstrate a pattern of noncompliance with reporting requirements;
> g. Fail to submit an approvable corrective action plan (CAP), fail to implement an approved CAP, or fail to improve performance after the implementation of a CAP;
> h. Violate any applicable laws, rules, or regulations that are relevant to the loan recipient's operations; or
> i. Knowingly submit to CMS false, inaccurate, or misleading data or information related to the CO-OP program application, governance information, quality data, financial data, and enrollment data.

These factors are generally vague and broad, giving CMS leeway to take corrective action, terminate loans and protect taxpayer funds that are endangered by a CO-OP with a precarious financial position.

In many of the CAPs, CMS used boilerplate language that threatened to terminate the CO-OP's loan agreement:

> The CAP and EOP requirements are critical to CMS's ability to evaluate whether CMS can remain confident that MHP will meet its obligations under the CMS CO-OP loan agreement. In accordance with section 16.2 of the Loan Agreement, a CO-OP's viability remains in the sole and absolute discretion of CMS. Thus, CMS may terminate your Loan Agreement if CMS receives additional information that indicates it is unlikely MHP will maintain a viable and sustainable CO-OP that serves the interests of its community and the goals of the CO-OP Program.

[178] U.S. Dep't of Health & Human Serv., Centers for Medicare and Medicaid Services, Consumer Operated and Oriented Plan Program, Invitation to Apply, Loan Funding Opportunity Number: OO-COO-11-001 CFDA: 93.545, (Dec. 9, 2011).

Despite the language in the loan agreements and CAPs, CMS has never terminated a loan, even when CO-OPs did not comply with the terms of the loans as required, or when the CO-OPs violations fell squarely into the categories outlined by CMS' in Funding Opportunity Announcement. The agency's failure to terminate CO-OP loans before state regulators shut down the CO-OPs, prevented CMS from recovering taxpayer dollars from CO-OPs that would have failed anyway. Even worse, CMS awarded *additional* loans in December 2014 to struggling CO-OPs.

CMS awarded loans totaling more than $350 million to six CO-OPs in late 2014. See the chart of the loan awards these CO-OPs received:

CO-OP	**Additional Award Amount**
Health Republic of New York	$90,688,000
Kentucky Health Care Cooperative	$65,000,000
Maine Community Health Options	$64,810,000
Common Ground Health Cooperative (Wisconsin)	$51,117,899
HealthyCT (Connecticut)	$48,427,000
CoOportunity Health	$32,700,000

Of those six CO-OPs, four have since failed. One of the two remaining CO-OPs is Maine Community Health Options, which has been put under supervision by state regulators. By awarding additional loans to struggling CO-OPs, failing to enforce the terms of the loan agreement, and failing to terminate loans when it would have been prudent to do so, CMS did not exercise good judgment to protect taxpayer dollars.

X. Conclusion

Despite numerous warnings about the weaknesses of the CO-OPs before their implementation, HHS approved and moved forward with the program. Less than three years into the program, only six CO-OPs remain operational in eight states. The large number of failures and an increase in lawsuits filed from both failed and operational CO-OPs indicates the design and application of the program were inherently flawed, and various provisions to assist CO-OPs were not effectively implemented. Moreover, a review of the remaining CO-OPs risk-based capital demonstrates how CO-OPs' risks far outweigh their assets and therefore, CO-OPs are likely to become insolvent.

As more and more CO-OPs shutter due to insolvency, the CO-OP program creates the very problem it was intended to solve – reducing the number of uninsured individuals while fostering healthy competition in the health insurance marketplace. Each CO-OP that winds down leaves hundreds of thousands of individuals scrambling for coverage, while costing taxpayers millions of dollars. Given CMS' ineffective oversight and failure to improve the program, the committee is gravely concerned about the viability of the remaining CO-OPs, and the likelihood to recover federal taxpayer loans awarded through the program.

XI. Recommendations

1. **Monitor CMS' oversight for remaining CO-OPs.** Request that the Department of Health and Human Services Office of the Inspector General conduct evaluations and inspections on CMS' oversight mechanisms for the CO-OPs, specifically the Corrective Action Plans and Enhanced Oversight Plans.

2. **Exempt individuals from the individual mandate penalty if their coverage under a plan offered by a CO-OP is terminated due to the failure of the CO-OP.** Individuals who make a good faith effort to comply with the individual mandate should not be punished as a result of their plan no longer being offered.

3. **Alter Risk Adjustment Formula by Imposing Limits on Risk Adjustment Payables.** CMS should impose limits on risk adjustment transfers for CO-OPs, in which payments are no more than a certain percentage of a CO-OP's gross premium. This recommendation will alleviate smaller CO-OPs that face high payments exceeding their smaller premium base, thus, creating insolvency.

4. **Require transparency from CMS for Risk Corridor Transfer Payment Availability.** CMS needs to regularly notify and inform remaining CO-OPs about the availability of funds for the Risk Corridor program, in order to allow appropriate budgeting for CO-OPs.

XII. Appendix

The following pages in the Appendix are copies of a letter sent by the Committee on Energy and Commerce on May 16, 2016.

The Committee on Energy and Commerce sent the same letter to all 11 of the CO-OPs that were still in operation as of the date of the letter.

FRED UPTON, MICHIGAN
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FOURTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE
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Minority (202) 225–3641

May 16, 2016

Cathy Mahaffey
Chief Executive Officer
Common Ground Healthcare Cooperative
120 Bishop's Way
Suite 150
Brookfield, WI 53005

Dear Ms. Mahaffey:

Pursuant to Rules X and XI of the U.S. House of Representatives, the Committee on Energy and Commerce is continuing to conduct oversight over the Community Oriented and Operated Plans (CO-OPs) established under the Patient Protection and Affordable Care Act. As part of its continued oversight, the Committee is requesting Common Ground Healthcare Cooperative provide information and documents to help it better understand the financial challenges CO-OPs are facing.

The CO-OP program—established by Section 1322 of the Patient Protection and Affordable Care Act—envisioned giving consumers more heath plan choices and increasing competition among insurers.[1] The Centers for Medicare and Medicaid Services (CMS) awarded taxpayer-funded loans to create new non-profit health insurance issuers.[2] CMS awarded over $2.4 billion dollars in federal loans to CO-OPs in 23 states.[3] Of the 23 CO-OPs that sold insurance through federal and state marketplaces, however, 12 have already closed and will not be offering plans for 2016.

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[1] Patient Protection and Affordable Care Act of 2010 § 1322 (2010).
[2] Dep't of Health and Human Serv., Centers for Medicare & Medicaid Serv., Center for Consumer Information & Insurance Oversight, *Loan Program Helps Support Customer-Driven Non-Profit Health Insurers*, *available at* https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html (last visited Oct. 29, 2015).
[3] One CO-OP in Vermont failed to obtain a license to sell health insurance in the state, and closed its doors before open enrollment.

On November 5, 2015, the Subcommittee on Oversight and Investigations held a hearing to examine the reasons so many CO-OPs have failed.[4] At this hearing, regulators and representatives of CO-OPs testified about the challenges they have faced to keep CO-OPs in business. These challenges included unpredictable enrollment numbers, management and leadership challenges, and inflexible standards imposed by CMS. The Committee is concerned that the remaining 11 CO-OPs are facing similar circumstances and may not survive when federal loan money runs out.

CMS has placed at least eight of the remaining 11 CO-OPs on "Enhanced Oversight" or "Corrective Action" Plans. These additional oversight plans were intended to assist CO-OPs that are struggling financially and/or may not be able to repay their federal loans. After reviewing these oversight plans, the Committee is concerned that CMS has not taken the appropriate steps to ensure that the remaining CO-OPs will be financially solvent for the remainder of the year. Federal taxpayers have invested over $1 billion into the remaining 11 CO-OPs. Especially considering this substantial taxpayer investment, the Committee wants to ensure CMS is taking the necessary and appropriate steps to keep these CO-OPs afloat.

To assist with our oversight of the CO-OP program, please provide the following documents and information by **May 30, 2016:**

1. Provide a copy of Common Ground Healthcare Cooperative's loan application, and any additional applications or requests for additional funding.

2. Provide a list of all the loans awarded from CMS, including the date the loan was awarded and the amount of the loan.

3. Explain what CMS has communicated to Common Ground Healthcare Cooperative regarding the following issues, from July 2015 to the present:

    a. Altering the Risk Adjustment Formula;

    b. Reconsidering limits on outside investors or capital; and

    c. Allowing CO-OPs to cap enrollment.

4. What administrative or regulatory changes could CMS make to better improve Common Ground Healthcare Cooperative's ability to succeed? Please explain.

    a. Have you made these suggestions to CMS? If so, has CMS made any of these changes?

5. When did Common Ground Healthcare Cooperative learn that risk corridor payments would be 12.6 percent of the requested amount? Did Common Ground Healthcare

[4] H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations, *Examining the Costly Failures of Obamacare's CO-OP Insurance Loans*, 114th Cong. (Nov. 3, 2015).

Cooperative employees, agents, or contractors have any indication from CMS or HHS that payments would be lower than requested?

6. Did Common Ground Healthcare Cooperative have any communications with CMS regarding payments through the Transitional Reinsurance program? If yes, please explain the nature of any communications, including any discussion of the issue of prioritizing payments to insurers over the U.S. Treasury, and any discussion of CMS making early reinsurance payments.

7. Provide copies of all Corrective Action Plans and/or Enhanced Oversight Plans created at CMS' request.

8. What month and year will Common Ground Healthcare Cooperative begin to repay its loans to CMS? Please explain the repayment plan.

9. Did Common Ground Healthcare Cooperative have any communications with CMS regarding the possible or potential closing of Common Ground Healthcare Cooperative? If so, please describe these communications.

10. Describe the methodology Common Ground Healthcare Cooperative used when analyzing its financial condition, and ability to repay CO-OP loans. Specifically, how did the CO-OP measure adequacy of capital and quality of its assets?

    a. Did Common Ground Healthcare Cooperative's asset determination include uncertain payments, such as payments from the ACA Risk Corridor?

    b. What percentage of capital derived from the actual CO-OP start-up loan?

11. What was the composition of the enrollee's health risk score upon enrollment? After being awarded a CO-OP loan, did anyone at Common Ground Healthcare Cooperative identify potential challenges/issues regarding underperforming or having difficulty meeting program milestones that were initially proposed to CMS in the loan application? If so, were these concerns expressed to CMS?

    a. If yes, who was made aware of these concerns at CMS?

12. Did anyone within Common Ground Healthcare Cooperative identify challenges with (1) meeting quality and performance standards as expressed in the loan agreement, (2) financial conditions of the CO-OP which could hinder the CO-OP's ability to repay the loan, or (3) Third Party Administrators, *before* CMS asked your company to provide a Corrective Action Plan?

    a. If yes, were these concerns reported to anyone at CMS? If so, who at CMS, or what division within CMS received these notifications about concerns and problems? What was reported?

13. Did CMS ever provide technical assistance with improving the performance of the CO-OP or discuss the CO-OP's current financial status or ability for loan repayment?

    a. If so, when did these discussions occur? Before or after being asked to provide a Corrective Action Plan?

14. Did Common Ground Healthcare Cooperative provide CMS with financial reports, enrollment data, governance and election information, annual independently audited financial statements, or other reports at any point after being awarded into the CO-OP program?

    a. If so, when? How frequently were such reports provided?

    b. Was Common Ground Healthcare Cooperative asked to provide these reports from CMS, or did your company provide these voluntarily?

An attachment to this letter provides additional information about how to respond to the committee's request. If you have any questions regarding this request, please contact Emily Felder, Jessica Donlon, or Brittany Havens with the majority committee staff at (202) 225-2927.

Sincerely,

Fred Upton
Chairman

Joseph R. Pitts
Chairman
Subcommittee on Health

Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

cc: The Honorable Frank J. Pallone, Jr., Ranking Member

The Honorable Gene Green, Ranking Member
Subcommittee on Health

The Honorable Diana DeGette, Ranking Member
Subcommittee on Oversight and Investigations

Attachment