Statement of Scott E. Harrington
Alan B. Miller Professor
The Wharton School
University of Pennsylvania

On "Review of the Affordable Care Act Health Insurance CO-OP Program"

Before the
Permanent Subcommittee on Investigations
Committee on Homeland Security and Government Affairs
U.S. Senate

March 10, 2016

Chairman Portman, Ranking Member McCaskill, and members of the subcommittee:

I am pleased to provide testimony today on the Consumer Operated and Oriented Plan (CO-OP) program established by the Patient Protection and Affordable Care Act (ACA). I am the Alan B. Miller Professor and Chair of the Health Care Management Department of the University of Pennsylvania's Wharton School. During my nearly 40-year academic career I have published extensively on the economics and regulation of insurance, including analyses of pricing and price regulation, capital and insolvency risk, the causes of insolvencies, solvency prediction and regulation, risk-based capital requirements, and state guaranty funds. I have conducted several previous analyses of the CO-OPs' financial condition and performance based on data reported in CO-OPs' statutory financial statements.[1]

In preparing this testimony I have reviewed a variety of documents for closed CO-OPs in Iowa/Nebraska, New York, South Carolina, and Tennessee, including original applications to the CO-OP program, business plans, feasibility studies, pro forma financials, actuarial pricing analyses, additional funding requests, and reviews for the Center for Medicare and Medicaid Services (CMS) conducted by Deloitte LLC. I have also reviewed selected financial

[1] See The Financial Condition and Operation of CO-OP Plans, Leonard Davis Institute of Health Economics and Robert Wood Johnson Foundation, February 2015, http://www.rwjf.org/en/library/research/2015/02/the-financial-condition-and-performance-of-co-op-plans.html; Effects of the ACA's 3Rs on the Bottom Line, Part II, July 30, 2015, http://ldi.upenn.edu/effects-aca%E2%80%99s-3rs-reinsurance-risk-adjustment-and-risk-corridors-bottom-line-part-ii; How the Largest Obamacare CO-OP Went Broke, http://www.forbes.com/sites/realspin/2015/10/12/how-the-largest-obamacare-co-op-went-broke/#57d6f09d71c7; Financial Status of ACA CO-OPs, American Enterprise Institute CO-OP Briefing, October 22, 2015.

information for the closed CO-OPs that has been provided to the Permanent Subcommittee on Investigations (PSI). I have not received or reviewed any information on enhanced oversight or correction action plans instituted by CMS for any of the CO-OPs.

The CO-OP program was intended to promote competition in health insurance by non-profit, consumer-focused, and consumer-governed insurers that would provide an alternative to traditional insurance companies—whether for profit or not for profit—and focus on financing and delivering high quality medical care with improved care coordination and integration. The program ultimately awarded $2.44 billion of federal loans to 23 CO-OPs in the form of startup loans ($358 million) and solvency loans ($2.09 billion) to be disbursed over time to meet state regulatory capital requirements.

Twelve of the 23 CO-OPs that began selling policies in 2014 have closed. As I elaborate below, very little, if any, of the $1.24 billion in federal startup and solvency loans to establish those CO-OPs will be repaid, and at least several will be unable to meet all of their obligations to policyholders and health care providers. Some closures in states with guaranty fund coverage will likely require significant state guaranty fund assessments. The future of the 11 CO-OPs still providing coverage in 2016 is uncertain, but future closures seem likely.

The CO-OPs faced significant challenges as new entrants during a time of extraordinary uncertainty. Operational challenges included product design, development of distribution and claims administration systems, and contracting with provider networks, including efforts to promote greater coordination and integration of care.[2] The ACA reforms effective in 2014 posed major challenges and risk associated with pricing coverage in view of uncertain takeup and utilization of coverage by the previously uninsured, as well as uncertainty as to the rate and scope of transition of previously insured people to policies complying with the ACA's new rules.

The CO-OPs had none of their own experience and data to consider in pricing. They were plausibly more prone to a "winner's curse" phenomenon, where CO-OPs with prices too low in relation to expected medical and administration costs would grow rapidly and lose money,

[2] According to a Department of Health and Human Services Office of Inspector General (OIG) study, Early Implementation of the Consumer Operated and Oriented Plan Loan Program, OEI-01-12-00290, July 2013, all CO-OPs reported major challenges in hiring staff, obtaining licensure, marketing plans, and enrolling consumers within 18 to 24 months of being awarded funding.

especially in an environment of strong political and public pressure for affordable health insurance. Pricing uncertainty remained high for 2015 premium rates, which had to be filed with state regulators in the summer of 2014, when CO-OPs still had relatively little data to assess claim experience and the adequacy of their 2014 rates. Compared with many established players, the CO-OPs had very little ability to diversify pricing and claims risk across geographic regions and different health insurance products.

The challenges and risks confronting CO-OPs notwithstanding, the April 2011 report of the 15 member advisory board to CMS on the design of the CO-OP program argued that it was fundamentally important for CO-OPs to begin operating on January 1, 2014 to capture market share during the "critical first open enrollment period".[3] Several CO-OP business plans and feasibility studies I reviewed also stressed the importance of establishing a market presence in 2014. It was believed that the ACA's risk stabilization programs—risk adjustment, reinsurance, and risk corridors (the "3Rs")—would help protect CO-OPs in the event of inadequate pricing and higher than expected medical and administrative costs.

Capital and Insolvency Risk

Insurance companies need to hold substantial capital—assets in excess of liabilities—to achieve a high probability of meeting their obligations to policyholders and other claimants. The scholarly literature on capital and insolvency risk for insurers and other financial institutions stresses that firms' incentives for solvency and achievement of high financial ratings depend on the amount of owners' capital at risk, on the value of the firm as a going concern (from previous investments in infrastructure and building a customer base and brand) that could be lost in the event of financial distress, on the sensitivity of customers' demand to insolvency risk, and on the extent of external monitoring by lenders and other counterparties. Solvency regulation, including risk-based capital requirements, is broadly intended to promote greater capitalization and reduce insolvency risk in cases where firms' incentives otherwise could be insufficient to promote a high probability of solvency.[4]

[3] Report of the Federal Advisory Board on the Consumer Operated and Oriented Plan (CO-OP) Program, April 15, 2011, Center for Consumer Information and Insurance Oversight, p. 5.

[4] As is the case for banking, the scholarly literature on insurance capital and insolvency risk has considered potential moral hazard that could arise from state insurance guaranty fund protection and how such protection increases the

Viewed on these dimensions, the financial strength of CO-OPs should have been a central focus from the program's inception. CO-OPs faced considerable pressure to capture early market share. They had (almost) no private capital, no going-concern value, and no financial ratings, and it was likely that many potential CO-OP customers would not be sensitive to insolvency risk.[5]

Moreover, the history of insurance company insolvencies indicates that—due to inadequate incentives for financial strength, bad decisions, bad luck, or some combination thereof—insolvent companies often charged low prices and grew rapidly, with inadequate reported claim reserve liabilities, ultimately producing claim costs much larger than reported in their pre-insolvency financial statements. There also is always a risk that insurers facing significant financial stress will try to sell their way out of trouble, hoping (or gambling) that claim costs will turn out to be lower than projected. Early detection of such behaviors is a major goal of solvency regulation. But early detection is often difficult given lags in receiving information and inherent uncertainty in projecting a company's claim costs. This history and context also suggest that the financial strength of CO-OPs and the potential consequences of rapid enrollment growth should have been a central focus from their inception.

CO-OP Capitalization

The approved CO-OP applications to CMS contained and were accompanied by detailed business plans and feasibility studies, including actuarial projections of growth, profitability, and ability to repay government loans. Deloitte reviewed the applications and supporting materials for CMS. Low interest startup loans awarded to CO-OPs were to be disbursed over time with a five-year term for each disbursement. Low interest solvency loans with a 15-year term were to be disbursed over time to fund growth while meeting regulatory capital targets.

---

need for solvency regulation. My own analyses of this issue have stressed that the moral hazard problem is much smaller for insurance than banking.

[5] The ACA specified that evidence of private support was one of three selection criteria to be given priority in awarding CO-OP loans (along with providing integrated care models and offering statewide coverage). An OIG study, The Center for Medicare & Medicaid Services Awarded Consumer Operated and Oriented Plan Loans in Accordance with Federal Requirements, and Continued Oversight is Needed, A-05-12-00043, July 2013, p. 4, reported that investigators "saw little evidence of private support in any of the 16 applications reviewed."

CO-OPs were required to report startup loan amounts as debt on their regulatory financial statements. (As I discuss below this later changed for some CO-OPs.) In order to meet regulatory capital requirements, solvency loans had to be approved by state regulators as "surplus notes", which are subordinate to all other claims and counted as capital rather than debt for meeting capital requirements. Surplus notes cannot be repaid without the permission of state regulators. Solvency loans essentially accounted for all of CO-OP capital. The amount of solvency loan disbursements generally were set to enable the CO-OP to achieve a projected capital of 500 percent of the National Association of Insurance Commissioners risk-based capital requirement. The 500 percent figure is roughly consistent with the average ratio of capital to risk-based capital among all health insurers.

The actuarial analyses supporting solvency loans and disbursements necessarily relied on numerous pricing, claim cost, and enrollment assumptions over a long projection period. The analyses involved some stress testing, for example, by projecting a baseline (best estimate) scenario, low and high enrollment scenarios, and scenarios with higher claim costs. The documents I reviewed contained what I regard as relatively modest stress scenarios. They did not include a scenario of significantly higher than projected enrollment combined with worse than projected claim costs. The baseline pricing assumptions, however, allowed for the possibility that newly insured enrollees would be sicker on average than previously insured people and for some degree of "pent up demand" by newly insured enrollees.

CO-OP Experience

Exhibit 1 shows the projected 2014 enrollment for the 23 CO-OPs in their award applications, year-end 2014 enrollment reported in their annual regulatory financial statement (3rd quarter 2014 statement for CoOpportunity Health), and enrollment as of June 30, 2015 as reported in their 2nd quarter financial statements (not available for Freelancers, NJ). Exhibit 2 shows, as of June 30, 2015, CO-OPs' cumulative reported net income since January 1, 2014, reported assets (including projected risk corridor receivables), reported obligations (startup loans, solvency loans, and operating liabilities), and the ratio of reported obligations to assets.[6] It also

[6] CoOpportunity Health was in liquidation. The June 30, 2015 financial statement was not available for Freelancers, NJ.

shows the amount of projected risk corridor receivables included in reported assets, which assumed full payment of risk corridor requests.

Some CO-OPs experienced vastly larger enrollment in 2014 than had been projected in their applications and feasibility studies, greatly increasing their need for capital. Those CO-OPs generally had low premium rates compared with competitors. Other CO-OPs, generally with relatively high premium rates, had very low enrollment in 2014.[7] All but one CO-OP reported losing money in 2014 (even assuming full payment of projected risk corridor receivables, if any), with relatively high administrative costs.[8]

Some CO-OPs continued to grow rapidly in 2015, despite significant rate increases in some cases, further increasing their need for capital. Some CO-OPs with low 2014 enrollment lowered their premium rates and grew rapidly in 2015. Three CO-OPs (ME/NH, TN, and WI) reported small operating profits for the first half of 2015.[9]

For the 18 months ending June 30, 2015, only one CO-OP (ME/NH) reported positive net income (Exhibit 2). The 11 closed CO-OPs submitting June 30, 2015 financials reported a cumulative loss of $417.5 million during that period. The 10 CO-OPs still operating with June 30 financials reported a cumulative loss of $202.3 million.

Projected risk corridor receivables, which were much larger for the closed than operating CO-OPs ($441.5 million vs. $69.6 million), are included in reported revenues and assets (along with projected receivables and/or payments for the risk adjustment and reinsurance programs). Without risk corridor receivables, or incorporating only the amounts to be paid for 2014 based on CMS's October 1, 2015 announcement, the reported operating loss and ratio of obligations to assets would be much greater for many of the closed CO-OPs.

[7] The Ohio CO-OP did not offer coverage on the exchange until 2015 but offered coverage off the exchange in 2014.
[8] For further discussion of CO-OPs' 2014 experience, see The Financial Condition of ACA CO-OPs, supra note 1; GAO, Private Health Insurance—Premiums and Enrollment for New Nonprofit Health Issuers Varied Significantly in 2014, GAO-15-304, April 2015; and OIG, 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, A-05-14-00055, July 2015.
[9] Community Health Alliance of Tennessee, which froze enrollment on January 15, 2015, reported a profit of $4,837.

Analysis of reported premiums (which include projected risk corridor receivables), medical expenses, and administrative expenses for 2014 and the first six months of 2015 indicates that reported medical expenses for the CO-OPs (excluding CoOpportunity Health and Freelancers, NJ) equaled 98 percent of premiums for the subsequently closed CO-OPs and 89 percent of premiums for those still operating. Administrative expenses equaled 31 percent of premiums for both groups combined in 2014 and 24 percent of premiums during the first two quarters of 2015.

Additional Loan Awards, Accelerated Loan Disbursements, and Closures

Many commentators praised the substantial enrollments of some CO-OPs in the first half of 2014 as indicators of program success. Instead, enrollment growth and early profit reports for CO-OPs with low premiums should have been a major cause for alarm given the uncertain environment and history of insurance company insolvencies. CO-OP viability was much more likely with slow and steady expansion.

CO-OP enrollment growth was accompanied by additional loan awards for six CO-OPs in 2014 to meet capital targets. Exhibit 3 shows for the 12 closed CO-OPs dates of announced closures, total award amounts, additional awards made in 2014, and, from data supplied to the PSI, total disbursements and the amount and date of the last solvency loan disbursement.[10]

CO-OPs in Connecticut, Iowa/Nebraska, Kentucky, Maine/New Hampshire, New York, and Wisconsin applied for and were approved for $355.5 million in additional solvency loans in the last four months of 2014.[11] The CO-OPs in Iowa/Nebraska, Kentucky, and New York were later closed. The closure of CoOpportunity Health in Iowa and Nebraska was announced in late December 2014, six weeks after disbursement of its additional $32,700,000 solvency loan award approved in September, and following the denial of a late October request for another $55 million. Health Republic of New York requested an additional $70.5 million in late October

[10] Some disbursements were made after the announcement of closure, apparently to permit the CO-OP to continue policies in force until the end of 2015.

[11] Loan Program Helps Support Customer-Driven Non-Profit Health Insurers (updated December 26, 2014), CMS, Center for Consumer Information & Insurance Oversight. In addition, the Massachusetts CO-OP received an additional $66 million solvency loan award in December 2013.

2014, following CMS approval of an additional $90.7 million solvency loan in September. The latter request was denied.

The Wisconsin CO-OP, still operating, received additional solvency loan awards of $28.5 million in September 2014 and $22.7 million in December 2014. The latter award exhausted the CO-OP program's authorized funding of $2.44 billion. CMS did not have the funds to approve the additional requests from CoOpportunity Health, Health Republic of New York, or any other CO-OPs.

CMS therefore lacked funding to make additional solvency loan awards in 2015. With the approval of state regulators, however, CMS permitted seven CO-OPs to convert their startup loans to surplus notes, thus allowing the startup loans to be counted as capital for meeting target capital ratios. Five CO-OPs that subsequently closed converted a total of $82.1 million in startup loans to surplus notes prior to closure (Exhibit 3).

Beyond additional loan awards and startup loan conversions, disbursements of solvency loans from CMS to many CO-OPs were accelerated during 2014 and 2015. According to data reported to the PSI, the disbursements generally were made during and following months in which claim costs were substantially greater than premiums.

Following its announced takeover in December 2014, state regulators determined in January 2015 that CoOpportunity Health (IA/NE) would be liquidated. CoOpportunity Health's award application, business plan, and actuarial feasibility study submitted to CMS in late 2011 projected slow enrollment growth beginning in 2014. Specifically, the October 2011 feasibility study by its actuarial consultant projected 11,142 enrollees in 2014, 31,500 enrollees in 2015, and 76,940 enrollees in 2020. The company's September 30, 2014 financial statement reported 50,746 enrollees as of March 31, 2014, 79,762 enrollees as of June 30, and 91,477 enrollees as of September 30. Thus, by September of its first year of operation, CoOpportunity Health had eight times the originally projected number of enrollees for 2014 and close to 15,000 more enrollees than originally had been projected for the year 2020.

Actuarial projections in 2013 supporting CoOpportunity Health's premium rate filings for 2014 included a 30 percent factor to allow for greater medical costs in the newly insured

population. Even so, the company's individual market rates were the lowest among insurers in three of Nebraska's four rating regions, lowest throughout Nebraska's small group market, lowest for one rating region in Iowa's individual market, and lowest in most rating regions for Iowa's small group market.

CoOpportunity Health's additional solvency loan request of $32.7 million in July 2014, which was supported by its actuarial consultant, reviewed by Deloitte, and approved by CMS, indicated that claims volume had been higher than expected and that a 17 percent average rate increase would be needed. Without additional funding, the company indicated that it would either have to merge with another insurer or freeze enrollment. CoOpportunity Health's October 2014 request (denied) for another $55 million to enable it to keep operating given continued enrollment growth indicated that it would need 40 percent rate increases over time following a 19 percent increase for 2015.

It appears that very little, if any, of CoOpportunity Health's $147 million in startup loans, solvency loans, and accrued interest will be repaid. The Special Deputy Liquidator for the company's liquidation reported that as of June 30, 2015 the estate had assets of $108.7 million, excluding risk corridor receivables, and claim liabilities of $109 million.[12] An update as of December 31, 2015 provided to the PSI showed assets of $61.6 million including CoOpportunity Health's actual $16.4 million risk corridor receivable for 2014, remaining claim obligations of $54.5 million, and a variety of other liabilities apart from federal loans.

Closures of much smaller CO-OPs in Louisiana and Nevada were announced in July and August 2015. Then in was announced on September 25, 2015 that Health Republic of New York, by far the largest CO-OP, would be closed. On October 1, CMS announced that risk corridor payments for 2014 would be limited to 12.6 percent of requests. Seven more CO-OP closures were announced prior to the onset of open enrollment on November 1, and the closure of the Michigan CO-OP was announced a few days later. Although no additional closures have since been announced, eight of the remaining CO-OPs are reported to be operating under CMS corrective action plans. The Illinois CO-OP Land of Lincoln Health limited enrollment in

[12] In the Iowa District Court for Polk County, In Re Liquidation of CoOpportunity Health, Special Deputy Liquidator's Second Status Report. Upon liquidation, the Iowa and Nebraska guaranty associations assumed claim payments pending resolution of the estate.

October 2015 and recently reported a net loss of $90.8 million for 2015 in conjunction with substantial enrollment growth during the year.[13]

Health Republic of New York's closure was a watershed event. Its 2011 application and feasibility studies contained baseline (best estimate) projections of 30,864 enrollees in 2014, 50,535 enrollees in 2015, and 100,323 enrollees in 2020. An alternative "high enrollment" scenario projected 44,492 enrollees in 2014 and 65,179 enrollees in 2015. The company reported 155,402 enrollees at year-end 2014 and 209,136 enrollees on June 30, 2015. Its 2015 enrollment was thus over three times the projected high enrollment scenario for 2015 and more than double its baseline enrollment projection for the year 2020.

Health Republic generally had the lowest 2014 premium rates in the regions it operated. It requested rate increases of 15 percent and 6 percent in the individual and small group markets for 2015. It received increases of 12.9 percent and 3.5 percent, respectively. Its rates remained generally low compared with other insurers.

Health Republic's additional solvency loan request for $90.7 million in July 2014 was based—with permission of New York regulators—on lower state capital standards than the previous target of 500 percent of risk-based capital. Its October 2014 request (denied) for another $70.5 million returned to the 500 percent target. That request projected 8 percent greater enrollment for 2014 and approximately 25 percent greater enrollment in 2015 and 2016 than had been projected four months earlier. A March 2015 study by its actuarial consultant nonetheless projected that the company would be economically viable based on baseline projections that assumed substantial reductions in administrative expenses and claims utilization.

CMS announced on June 30, 2015 that Health Republic was due $58.2 million in reimbursement from the ACA reinsurance program but owed $80.2 million for the risk adjustment program. Health Republic's June 30, 2015 financials projected $243.3 million in risk corridor program receivables. The company reported a cumulative loss of $130.2 million from January 1, 2014 through June 30, 2015 (Exhibit 2), assuming full collection of projected risk

[13] Kristen Schorsch, Crain's Chicago Business, March 1, 2016.

corridor receivables. This represents a loss of about $50 per member per month (three times that amount if projected risk corridor receivables are excluded).

The final tally of any closed CO-OP's deficits will depend on numerous factors including in particular the ultimate amounts owed for medical claims. The December 31, 2015 financial report for Health Republic of New York provided to the PSI makes it clear that none of its federal loans will be repaid. The entity's assets are projected to fall over $200 million short of amounts needed to pay providers and policyholders. New York does not have a guaranty fund or related mechanism for licensed health insurance company obligations.

I also reviewed updated financial data provided to the PSI for the 10 closed CO-OPs in addition to CoOpportunity Health and Health Republic of New York. Reported assets were less than claim and other obligations apart from startup and solvency loans for seven of the 10 CO-OPs and only marginally greater than those obligations in the other three states (Oregon, Tennessee, and Utah). Two of the states (Colorado and South Carolina) project substantial guaranty fund assessments. The data therefore suggest that little, if any, of federal loans will be repaid.

Unanswered Questions

The CO-OP program's experience raises a number of key questions—beyond the fundamental issue of whether the program made economic sense when enacted. When considering these questions, it is important to avoid 20-20 hindsight given the enormous degree and slow resolution of uncertainty concerning the magnitude of insured medical costs with the onset of the ACA's coverage expansion in 2014, as well as inherent uncertainty concerning the likelihood that a given CO-OP experiencing financial stress might achieve viability if allowed to continue operating. The following questions remain despite this caveat:

1. Was it appropriate and prudent to push for the CO-OPs to begin operations in 2014, as opposed to delaying start up for a year or two before selling tens of thousands of policies, in order to permit resolution of some uncertainty concerning the characteristics of the newly insured population and facilitate the development of necessary infrastructure, relationships, and care models?

2. Why were low premium rates charged by some CO-OPs not viewed as a signal of potentially inadequate rates, especially when their rate filings anticipated relatively high provider reimbursement and administrative expenses?

3. Why were some CO-OPs permitted to enroll far more customers than anticipated in financial projections supporting their applications, as opposed to having some formal or informal limits on growth imposed by CMS and/or state regulators?

4. Why didn't CMS delay solvency loan disbursements, or possibly terminate loan agreements, when confronted with enrollments far greater than anticipated and evidence of operating losses?

5. Why was the customary financing timeline seemingly reversed in some cases, with CO-OPs expanding rapidly and then seeking accelerated loan disbursements and/or additional loan awards from CMS to support that expansion, as opposed to obtaining funds in advance to finance anticipated growth?

6. Given the history of insurance insolvencies and the highly uncertain environment, why didn't the actuarial analyses supporting CO-OP applications and subsequent financial projections report a broader range of stress tests, including scenarios where higher than expected enrollment was accompanied by significantly higher than expected claim costs?

Marketing, Risk Stabilization Programs, and Funding Cuts

I believe that many if not most of the major players involved in the formation, funding, and operation of CO-OPs significantly underestimated the challenges and risks of launching new health insurance companies in 2014. The CO-OPs were inherently vulnerable to unpredictably high medical claim costs, including from any adverse selection associated with established carriers renewing pre-2014 policies, especially if enrollee growth outpaced projections.

Some commentators and CO-OP representatives have argued that restrictions on the use of federal loans for marketing undermined CO-OPs' ability to grow and diversify.[14] The loan

[14] A related argument is that program rules constraining CO-OPs' ability to expand into large group health insurance impeded their success. I regard it a more likely that expansion into large group markets would have made some CO-OPs' financial problems worse.

agreements, however, appear to have a relatively narrow interpretation of the term "marketing," which does not preclude activities related to community outreach and membership development. More important, restrictions on spending for marketing did not prevent explosive growth for some CO-OPs at unsustainable prices. Fewer constraints plausibly could have made matters worse.

With respect to the ACA risk stabilization programs, CO-OPs benefitted substantially from the transitional reinsurance program, including CMS decisions to lower the 2014 threshold for reimbursement from $60,000 to $45,000 and pay 100 percent of claims between $45,000 and $250,000 rather than 80 percent. On the other hand, 16 of the 22 CO-OPs subject to the CMS risk adjustment program (Massachusetts has its own system) owed payments for 2014 experience, including Health Republic of New York ($80.2 million), Kentucky Health CO-OP ($23.2 million), and 11 others ranging from $1 million to $8 million.[15] These CO-OPs had lower than average risk scores for their enrollees in their state of operation. Two of the closed CO-OPs were owed risk adjustment payments (Meritus, $0.8 million, and CoOpportunity Health, $4.1 million) due to higher than average risk scores. The risk adjustment formula could have flaws that disproportionately affect small insurers. It also has been argued that CO-OPs were disadvantaged versus established insurers in ensuring that all enrollee health conditions affecting risk scores and risk adjustment were recorded.

As discussed earlier, shown in Exhibit 2, and consistent with large operating losses, a number of the closed CO-OPs had projected substantial risk corridor receivables. They therefore were disproportionately affected by the payment of only 12.6 percent of risk corridor reimbursement requests for 2014 and the likelihood of much smaller reimbursement over time. Some closed CO-OPs' representatives argue that they would have been able to achieve viability if substantially more of their risk corridor requests were paid. But those requests were high in large part because of rapid growth at inadequate premium rates. While perhaps anything is possible, the evidence suggests that using taxpayer funds for greater risk corridor payments

[15] CMS, Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year, June 30, 2015.

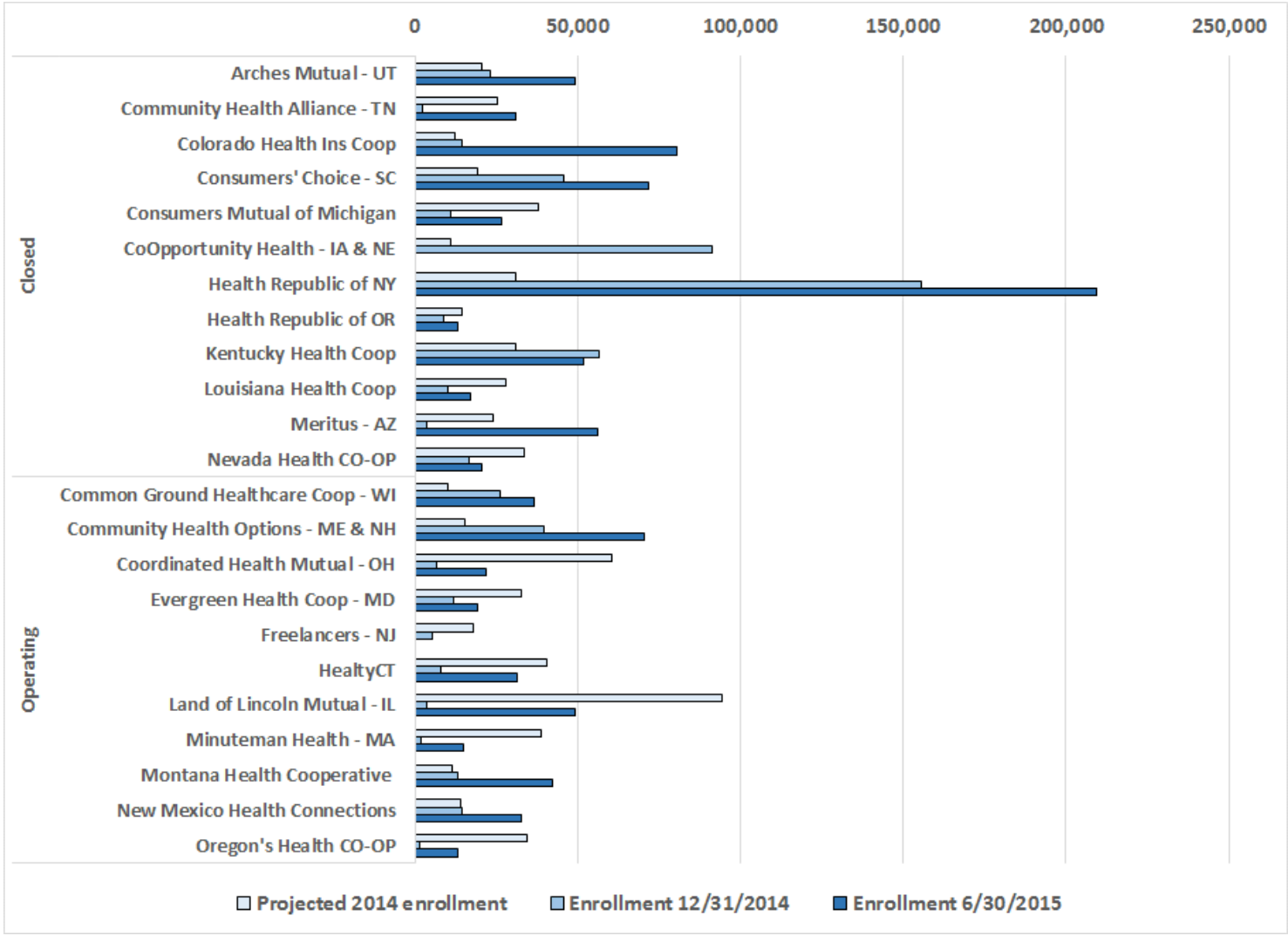
would very likely have risked having some CO-OPs expand even further, with inadequate premium rates and relatively high administrative costs.

Finally, some commentators and CO-OP representatives have blamed closures on Congressional reductions in CO-OP program funding. But by preventing CO-OPs from being established in more states and limiting CMS's ability to provide additional solvency loans to existing CO-OPs, the reductions very likely prevented both the funding of more CO-OPs that would not have been viable and able to repay government loans and the extension of additional funding to at least some CO-OPs that would ultimately fail.

Thank you for the opportunity to testify.

Exhibit 1

CO-OP Projected 2014 Enrollment and Reported Enrollment 12/31/2014 and 6/30/2015



Reported enrollment from 12/31/2014 and 6/30/2015 statutory financial statements; projected 2014 enrollment from OIG A-05-14-00055, July 2015. CoOpportunity Health reported enrollment as of 9/30/14. Freelancers, NJ not available 6/30/2015.

Exhibit 2
CO-OP Reported Financial Results through 6/30/2015

		Reported income, 1/1/14 - 6/30/2015 ($000)	Reported obligations 6/30/2015 ($000)	Reported assets 6/30/2015 ($000)	Reported risk corridor receivables 6/30/2015 ($000)	Obligations / assets 6/30/2015
Closed	Arches Mutual - UT	-$24,160	$108,669	$77,195	$0	141%
	Colorado Health Ins Coop	-$27,633	$146,516	$108,691	$40,540	135%
	Community Health Alliance - TN	-$22,126	$110,048	$78,460	$8,821	140%
	Consumers' Choice Health Ins - SC	-$4,225	$150,728	$135,228	$31,276	111%
	Consumers Mutual of Michigan	-$27,419	$97,596	$60,401	$6,085	162%
	Health Republic of NY	-$130,229	$685,362	$525,301	$243,288	130%
	Health Republic - OR	-$18,690	$82,490	$40,905	$2,504	202%
	Kentucky Health Coop	-$54,399	$252,982	$189,503	$81,600	133%
	Louisiana Health Coop	-$34,832	$92,497	$49,327	$9,714	188%
	Meritus - AZ	-$28,054	$131,686	$72,853	$1,463	181%
	Nevada Health CO-OP	-$45,717	$89,608	$47,923	$16,200	187%
	Total	-$417,484	$1,948,182	$1,385,787	$441,491	141%
Operating	Common Ground Healthcare Coop - WI	-$35,820	$184,269	$141,736	$47,866	130%
	Community Health Options - ME and NH	$9,250	$103,102	$100,884	$0	102%
	Coordinated Health Mutual - OH	-$14,963	$115,956	$79,178	$0	146%
	Evergreen Health Coop - MD	-$20,643	$75,461	$43,512	$0	173%
	HealthyCT	-$37,518	$178,295	$118,258	$0	151%
	Land of Lincoln Mutual - IL	-$43,502	$145,155	$84,570	$515	172%
	Minuteman Health - MA	-$28,778	$103,440	$61,924	$3,449	167%
	Montana Health Cooperative	-$9,979	$101,920	$85,849	$12,070	119%
	New Mexico Health Connections	-$8,716	$88,779	$62,375	$5,414	142%
	Oregon's Health CO-OP	-$11,654	$56,057	$32,770	$320	171%
	Total	-$202,323	$1,152,434	$811,056	$69,634	142%

Obligations include startup and solvency loans. Assets include projected risk corridor receivables as of June 30, 2015 (prior to CMS announcement concerning reduced payment). Data from statutory financial statements. Freelancers, NJ, June 30, 2015 financials not available.

Exhibit 3
Loan Awards and Disbursements for Closed CO-OPs

	Announced Closure	Total Award	Total Disbursed	Additional Award in 2014		Last Solvency Loan Disbursement		2015 Startup Loan Conversion
				Amount	Date	Amount	Date	
CoOpportunity Health - IA & NE	12/23/2014	$145,312,100	$145,312,100	$32,700,000	9/26/2014	$32,700,000	11/14/2014	
Louisiana Health Coop	7/24/2015	$65,790,660	$65,790,660			$9,263,798	11/27/2015	
Nevada Health CO-OP	8/26/2015	$65,925,396	$65,900,396			$5,854,666	6/29/2015	$17,105,047
Health Republic of NY	9/25/2015	$265,133,000	$264,966,400	$90,688,000	9/26/2014	$32,512,852	6/29/2015	
Kentucky Health Coop	10/9/2015	$146,494,772	$144,066,123	$65,000,000	11/10/2014	$45,800,000	12/23/2014	
Community Health Alliance - TN	10/14/2015	$73,306,700	$73,306,700			$34,297,300	2/26/2015	
Health Republic of OR	10/16/2015	$60,648,505	$60,623,505			$8,378,610	4/30/2015	$10,252,005
Consumers' Choice - SC	10/22/2015	$87,578,208	$87,578,208			$36,458,608	2/26/2015	
Arches Mutual - UT	10/27/2015	$89,650,303	$85,637,146			$10,250,000	11/23/2015	
Meritus - AZ	10/30/2015	$93,313,233	$93,313,233			$19,449,102	8/14/2015	$20,890,333
Colorado Health Coop	10/30/2015	$72,335,129	$72,335,129			$4,837,116	2/2015	$15,205,529
Consumers Mutual of Michigan	11/3/2015	$71,534,300	$71,534,300			$5,362,712	11/19/2015	$18,687,000
Total		$1,237,022,306	$1,230,363,900	$188,388,000		$245,164,764		$82,139,914

Award amounts from CMS; disbursement data from PSI.