# REVIEW OF OBAMACARE CONSUMER OPERATED AND ORIENTED PLANS (CO-OPS)

## **HEARING**

BEFORE THE

SUBCOMMITTEE ON HEALTH CARE, BENEFITS AND ADMINISTRATIVE RULES OF THE

## COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM HOUSE OF REPRESENTATIVES

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### REVIEW OF OBAMACARE CONSUMER OPERATED AND ORIENTED PLANS (CO-OPS)

#### Thursday, February 25, 2016

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH CARE, BENEFITS, AND
ADMINISTRATIVE RULES,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, D.C.

The subcommittee met, pursuant to call, at 2:01 p.m., in Room 2154, Rayburn House Office Building, Hon. Mick Mulvaney presiding.

Present: Representatives Jordan, Walberg, DesJarlais, Meadows, Mulvaney, Walker, Hice, Carter, Cartwright, and DeSaulnier.

Mr. MULVANEY. [Audio malfunction in hearing room] things a little bit differently this morning. First, we are going to turn on the microphones.

There is a little bit of disarray in our schedule, as you may have found out in the last couple of minutes. We expect a vote on the Floor any minute now. So the proposed way to proceed is that I will give an opening statement. I will try to allow Dr. Cohen to give her opening statement, Mr. Redmer, yours. And if we can get that far, that is great. We will then recess and we will go over and vote. If votes are called in the middle of that, we will have to recess earlier, and then we will pick up where we left off.

It is slightly unusual to begin the committee hearing without a Democrat present, but we have cleared it with the staff. Mr. Cartwright knows that we are starting without him, and he has asked for the ability to give his opening statement immediately upon our return.

So with that being said, I will get us started.

I think it is fairly obvious why we are here today. It shouldn't be a surprise to anybody as to why you are in front of this committee. Twelve of these 12 CO–OPs have failed. I think it has cost taxpayers so far about \$2.4 billion, including in my State, where we have had a CO–OP fail.

Based on the track record, we are here today to try and find out what the future holds for the remaining CO–OPs and what the future holds for the people who are counting on those CO–OPs to provide them with health insurance. Consumers have lost \$1.2 billion in the failed CO–OPs, and I don't think it is fair to anyone that we just sit around and not have hearings like this.

Perhaps just as discouragingly, there is a subtext here today. In addition to dealing with the merits of why the previous CO–OPs have failed and the condition of the current CO–OPs is our inabil-

ity to get information out of your organizations. It is our job to do oversight into the CO-OPs. Is it our job to ask difficult questions. It is our job to ask you to come here today and provide us with information. It is also our job to ask you for documents that might help us in our oversight function, and we are going to have some hopefully straightforward conversations today about why those documents have not been provided to Congress.

I reject the notion the administration is able to hide information from us, especially since Congress created these things, Congress is involved in the oversight, and for the executive branch to deny Congress of its ability to do its job, I think, is something that merits a very close look. It makes it look like the administration is simply trying to prevent us from doing our job. Again, we will get into

our inability to get documents as we go through there.

It is even stranger that CMS is worried about the public having information about these when we know ones have already failed, and there is concern, public concern about other ones failing. You would think that the public-Mr. DesJarlais, myself, I am on the exchanges. My staff is on the exchanges. Don't we have the right to know when we go on the exchanges what the financial condition

is of the CO-OPs that we might choose to sign up with?

You all have a tough job here today. I fully recognize that. I am sorry that you are the ones that have to do this, but you are the ones that the administration sent over. But you have got two jobs. You have to convince the public that they shouldn't know everything about the CO-OPs that they might want to sign up with, and you have to convince us that you are not obstructing our ability to oversee the programs. So I don't envy you those positions, but we will try to make it as congenial as we possibly can.

Mr. Mulvaney. So with that, I will recognize Dr. Cohen from

CMS for 5 minutes for her opening statement. Hold on a second. See, we don't swear them in, Financial Services, so-all right. I am pleased to welcome Dr. Mandy Cohen, Chief Operating Officer and Chief of Staff for the Centers for Medicare and Medicaid Services at the U.S. Department of Health and Human Services; and Mr. Al Redmer, Jr., Commissioner of the Maryland Insurance Administration. We welcome you both.

Pursuant to our rules, we do swear all witnesses in this committee before you testify. So if you please rise and raise your right

 $[{
m Witnesses\ sworn.}]$ 

Mr. Mulvaney. Thank you. Please be seated. Let the record reflect that both witnesses answered in the affirmative.

So with that, Dr. Cohen, and I think you have done this before so you know about the 5-minute rule. We are not going to strictly enforce it, so if you need a few extra minutes, please take that time and go ahead and begin now.

#### WITNESS STATEMENTS

#### STATEMENT OF MANDY COHEN

Dr. COHEN. Well, thank you very much. Thank you, Vice Chair Mulvaney. I will thank Ranking Member Cartwright when he returns. And members of the rest of the subcommittee, I appreciate the opportunity to discuss the Consumer Operated and Oriented Plan program. CMS takes its commitment both to CO-OP consumers and taxpayers seriously.

As you know, CO-OPs were created to stimulate new competition in an industry that has a long history of being very difficult for small companies to enter with some entering markets that hadn't

seen new competitors in decades.

CMS's principal role is to award and oversee loans and then to maximize the likelihood that Federal taxpayer funds are returns. We are in close context with the State Departments of Insurance as they, of course, have authority over all the issuers of their State and oversee the rules that the CO-OPs operate under.

As with any new set of business ventures, some CO-OPs have succeeded while others have encountered challenges. Successful CO-OPs have provided consumers in their State an additional choice of health insurance and have improved competition. But there have also been CO-OPs that, for a number of reasons, have faced technical, operational, and financial difficulties.

In addition, Congress has made a number of substantial rescissions to the initial \$6 billion in funding for the CO-OP program, impacting program operations and available funding. In the face of multiple pressures, it is not surprising that some new entrants

have struggled to succeed.

Protecting consumers affected by CO–OP closures is a top priority. In each case, when a CO–OP is no longer offering coverage on the marketplace, we work closely with the CO–OP and the State regulators to facilitate a smooth transition for consumers to retain access to coverage. Each of the consumers in the CO–OPs that close at the end of last year maintain coverage until the end of the year. And after dozens of communications with CO–OP consumers, three-quarters of those CO–OP marketplace consumers have continued their coverage in a new plan.

CMS plays a dual role as the loan-holder for the CO-OP program providing both oversight and support of these nascent small businesses. In our oversight capacity, CMS, along with the State Departments of Insurance, which serves as the primary regulator of insurance in the States, work aggressively to ensure that CO-OPs are well run and financially sound. Every CO-OP is subject to standardized ongoing program oversight activities. In 2015 we conducted over two dozen financial and operational reviews, numerous in-person visits, and had many formal communications, not to mention hundreds of phone calls.

When concerns are identified, CMS, in coordination with State Departments of Insurance, place CO-OPs on enhanced oversight or corrective action plans. These tools are commonly used by State Departments of Insurance to identify and fix correctible problems to ensure the viability of insurance products they oversee in their State

In CMS's role to support to the CO-OPs to maximize the likelihood that Federal taxpayer dollars are returned, CMS is working to make it easier for CO-OPs to attract outside capital or merger partner if the board chooses. We've released clarifying guidance and are exploring further steps to ease that path to outside funding

for CO–OPs and investors, while still preserving the fundamentally member-driven nature of the CO–OP program.

Even with the oversight and support provided by CMS and the Departments of Insurance, the single biggest factor for the future success of the CO-OPs will come from the action of the companies themselves. As new small businesses, they need to rapidly mature the fundamentals of their financial systems, tighten their operating disciplines, and hold their vendors accountable. Through—though the challenges that they CO-OPs have faced, they have every opportunity to be successful and be long-term market participants.

CMS appreciates and understands this committee's oversight responsibilities, and has provided—and has worked to provide you with the information needed to fulfill these responsibilities. I understand why the subcommittee is interested in the experiences of these private businesses, our lessons learned, and our expectations for the future. CMS has made a concerted effort to answer the committee's questions and provide relevant and responsive information, including providing thousands of pages of documents, as well as briefing by a key executive from the CO–OP management staff.

Because some of the materials you've requested contain marketsensitive information, we have made a limited number of the CO– OP documents responsive to your investigation available through confidential review.

As part of our fiduciary duty as the lender and stewards of taxpayer money, CMS has worked hard to accommodate the committee's request for information while responsibly protecting the competitiveness of the loan recipients and safeguarding the CO–OPs' ability to repay Federal loans.

Since the enactment of the Affordable Care Act, CMS has worked to increase access to quality, affordable coverage through the marketplaces while being responsible stewards of taxpayer dollars. CMS will continue to work closely with the subcommittee, with CO–OPs and State Departments of Insurance to provide the best outcome for consumers and taxpayers. We appreciate the subcommittee's interest and happy to answer any questions.

[Prepared statement of Dr. Cohen follows:]

#### STATEMENT OF

MANDY COHEN, MD, MPH
CHIEF OPERATING OFFICER & CHIEF OF STAFF
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

"REVIEW OF OBAMACARE CONSUMER OPERATED AND ORIENTED PLANS (CO-OPS)"

### BEFORE THE

UNITED STATES HOUSE COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

SUBCOMMITTEE ON HEALTH CARE, BENEFITS & ADMINISTRATIVE RULES

FEBRUARY 25, 2016

# "Review of Obamacare Consumer Operated and Oriented Plans (CO-OPs)" U.S. House Committee on Oversight and Government Reform Subcommittee on Health Care, Benefits & Administrative Rules February 25, 2016

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

CMS's priority is to provide Marketplace customers with access to quality, affordable coverage. In the years since the passage of the Affordable Care Act, we have seen increased competition among health plans and more choices for consumers.<sup>1</sup> During the third Marketplace Open Enrollment, nine out of ten returning customers were able to choose from three or more issuers for 2016 coverage, up from seven in ten in 2014.<sup>2</sup> The CO-OPs have played an important role in the Marketplace, particularly in the early years of the Affordable Care Act by providing additional options for access to affordable health coverage from local, non-profit health insurers.

Moving forward, CMS is eager to build on the progress in reducing the number of uninsured Americans – an estimated 17.6 million Americans gained coverage since the Affordable Care Act's coverage provisions have taken effect,<sup>3</sup> and the Nation's uninsured rate is below 10 percent for the first time since data collection began over five decades ago.<sup>4,5</sup> During the third open enrollment that concluded at the end of January, 12.7 million Americans selected affordable, quality health plans for 2016 coverage through the Marketplaces.<sup>6</sup>

<sup>&</sup>lt;sup>1</sup> www.hhs.gov/about/news/2015/07/30/competition-and-choice-in-the-health-insurance-marketplace-lowered-premiums-in-2015.html

<sup>&</sup>lt;sup>2</sup> www.hhs.gov/about/news/2015/07/30/competition-and-choice-in-the-health-insurance-marketplace-lowered-premiums-in-2015.html

<sup>&</sup>lt;sup>3</sup> http://aspe.hhs.gov/health-insurance-coverage-and-affordable-care-act-aspe-issue-brief-september-2015

<sup>4</sup> http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201508.pdf

http://www.edc.gov/nchs/data/nhsr/nhsr017.pdf

<sup>6</sup> https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-04.html

#### CMS Implementation of the CO-OP Program

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

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

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

<sup>&</sup>lt;sup>7</sup> https://www.cms.gov/CCHO/Resources/Funding-

Opportunities/Downloads/final premium review grant solicitation with disclosure statement.pdf

<sup>8</sup> https://www.gpo.gov/fdsys/pkg/FR-2011-12-13/pdf/2011-31864.pdf

<sup>9</sup> https://www.cms.gov/CCIIO/Resources/Files/Downloads/coop faca finalreport 04152011.pdf

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

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

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

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

<sup>10</sup> http://oig.hhs.gov/oei/reports/oei-01-12-00290.pdf

<sup>&</sup>lt;sup>11</sup> Including 34 applications that were not subject to a full review process, but were subsequently denied due to funding rescissions.

<sup>12</sup> https://www.cms.gov/CCHO/Resources/Files/Downloads/coop faca finalreport 04152011.pdf

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

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

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

#### **CO-OP** Accomplishments and Challenges

CO-OPs have provided health insurance coverage to more than one million consumers, helping people access needed medical care. This program has increased competition and provided more consumer choices and control in choosing health insurance coverage. For example, Maryland's CO-OP (Evergreen Health) was the first new issuer to enter the state's market in 25 years, <sup>14</sup> and

<sup>14</sup> http://www.nytimes.com/2015/09/16/business/health-cooperatives-find-the-going-tough.html? r=0

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

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

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

http://docs.house.gov/meetings/IF/IF02/20151105/104146/HHRG-114-IF02-Wstate-MorrisonJ-20151105.pdf http://www.pressherald.com/2014/09/30/maine-insurance-co-operative-accelerates-plans-to-cover-new-

hampshire/

17 http://www.inhealthohio.org/shop-for-insurance/individuals-and-families/2016-enrollment-material-individual-family-benefits

<sup>18</sup> https://newjersey.healthrepublic.us/smoking-cessation/smoking-cessationtobacco-harm-reduction-faq/

<sup>19</sup> http://oig.hhs.gov/oei/reports/oei-01-12-00290.pdf

<sup>20</sup> https://www.cms.gov/CCIIO/Resources/Files/Downloads/coop faca finalreport 04152011.pdf

by new entrants into the market, including having to outsource important functions, in particular network contracting, limited information about existing provider practices and referral habits, and initial enrollment that diverged from expectations.<sup>21</sup>

#### CMS Oversight

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

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

Second, CMS monitors the CO-OPs' overall financial condition using several factors of the Federal Deposit Insurance Corporation's Uniform Financial Institutions Rating System. CO-OPs have monthly, semi-annual, and annual reporting requirements, including financial statements, balance sheets, income statements, statements of cash flow, and enrollment statistics. Last year,

<sup>&</sup>lt;sup>21</sup> http://www.commonwealthfund.org/~/media/files/publications/fund-report/2015/dec/1847\_corlette\_why\_are\_many\_coops\_failing.pdf?la=en

CMS increased the data and financial reporting requirements for CO-OPs. Each CO-OP is required to provide a semi-annual statement of its compliance with all relevant State licensure requirements, and, if necessary, an explanation of any deficiencies, warnings, additional oversight, or any other adverse action or determination by DOIs received by the CO-OP. If the CO-OP is experiencing compliance issues with State regulators, the CO-OP is required to describe the steps being taken to resolve those issues. CMS meets monthly with the state insurance regulators regarding each CO-OP. This additional financial data collection has helped CMS to identify underperforming CO-OPs and gives CMS the opportunity to work with the CO-OPs and DOIs to help correct issues that are identified.

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

Finally, CMS can terminate its loan agreement with a CO-OP if we determine it is no longer viable, sustainable, or serving the interests of the community. CMS works closely with DOIs and shares information to assist in their assessments of CO-OPs. If a loan agreement is terminated, CMS works with the state DOI and the CO-OP board to wind down operations in an orderly way to mitigate impact to the consumer. While it is too early to tell how much money may be recovered, CMS has begun the recovery process, and once the wind down of these CO-OPs is complete, we will use every available tool to recoup Federal funding, based on applicable law and the loan agreements. During closeout, most CO-OPs exiting the market were placed into a receivership or supervisory status that controls assets, expenses, and contractual rights and obligations including ongoing operating costs and claims payment. These arrangements help protect remaining funds.

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

#### **Moving Forward**

Since the enactment of the Affordable Care Act, CMS has worked to increase access to quality, affordable coverage through the Marketplaces and to be responsible stewards of taxpayer dollars. The CO-OP program was designed to give consumers more choices, promote competition, and improve quality in the health insurance market. Though not all CO-OPs have continued to offer coverage, consumers continue to have a variety of affordable health insurance coverage choices that meet the health care needs of their families. While CO-OPs are primarily responsible for their own success, CMS will continue to help them identify and correct issues and make improvements. CMS is committed to continuing its work with the CO-OPs offering coverage this year to facilitate progress and expand into new markets when appropriate. CMS has also clarified our policies on important topics<sup>23</sup> and is exploring what changes could be made to help CO-OPs diversify their boards and grow and raise capital, while still preserving the fundamentally member-run nature of the CO-OP program. Working with state DOIs and the CO-OPs, CMS will continue its rigorous ongoing monitoring and oversight processes in order to prevent consumers from experiencing potential disruption in health insurance coverage. Additionally, we will use every tool available to recoup Federal dollars, where appropriate. We appreciate the Committee's interest and I am happy to answer your questions.

<sup>&</sup>lt;sup>22</sup> Does not include consumers who enrolled in new plans outside the Marketplace.

<sup>&</sup>lt;sup>23</sup> https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/CO-OP-Questions-Final-1-27-16.pdf

Mr. MULVANEY. Thank you, Dr. Cohen.

Before you begin, Mr. Redmer, we have had a little change in logistics, not unusual around here. It looks like we won't be voting until three o'clock. So we should have a chance to get through at least the first round of questions.

Mr. Redmer, after your opening statement, we are going to allow Mr. Cartwright to have his, and then we will move into the questions. So, Mr. Redmer, you have 5 minutes.

#### STATEMENT OF AL REDMER, JR.

Mr. REDMER. Okay. Thank you, Mr. Chairman, members of the committee. It's —

Mr. Mulvaney. Mr. Redmer, if you would hit the button in front

of you, turn the microphone on.

Mr. Redmer. Sorry. Mr. Chairman, members of the committee, I appreciate the invitation to be here today. My name is Al Redmer. I'm the insurance commissioner in the State of Maryland, and I'm here today to offer my views on the risk adjustment program based on section 1343 of the Affordable Care Act and its impact on a CO-OP incorporated in Maryland but just as importantly as well as other CO-OPs and small insurance carriers around the country.

Evergreen Health Cooperative is a Maryland-based CO-OP created under the Affordable Care Act. It's been in business since 2014, and if you look at the Affordable Care Act and the reason that these organizations were created, Evergreen is a compelling story. If you look at the objective of increasing competition focusing on medical outcomes, improving the health outcomes of patients, medical management, disease management, it is a success story.

For example, Evergreen offers a value-based product for diabetic patients that removes virtually all financial barriers for the patient—no copays, no coinsurance, no deductibles—to help folks be treated to prevent the onset and the increased problems with the disease.

Any small carrier in—any company, any new company in any industry has a challenge. They have to reach a certain size to pay for the infrastructure to run that business, and Evergreen and these CO–OPs are no different. They need to reach scale. Evergreen's enrollment as of January of this year is 36,000 compared to just under 20,000 in July of 2015.

Additionally, they have diversified their portfolio. They're not just on the exchange. They do business throughout the individual market. They're in the small group market. They are also in the large group market. And their medical loss ratio is favorable. It's been running between 80 and 85 percent. Based on current enrollment trends, Evergreen is on track to reach their 2016 enrollment goals and turn a profit by the end of this year.

Over the past few years, around the country we've seen new—excuse me—innovative health insurance plans that have been created that are providing enhanced competition and patient care. And it's working. For example, at the end of 2004 our largest indi-

vidual carrier in Maryland had a 91 percent market share. Today, it's down to 57 percent due in part to a more competitive market-place. These new carriers have the ability to continue, but their

ability is severely jeopardized by the adverse and potentially fatal effect—financial effect caused by the technical shortcomings of the current risk adjustment and risk corridor programs. The failure of these plans would be disruptive to the marketplace, and State insurance regulators believe that a competitive marketplace benefits

and protects policyholders.

The risk adjustment formula is specifically of concern because it's proven that newer carriers have a distinct advantage. And I point out new carriers whether they're a CO-OP or not CO-OP. For example, the risk adjustment formula quantifies an enrollee's health status based on their age, sex, and diagnoses recorded during the course of the year. New carriers have limited ability to get that information on the health status and previous claims history for the applicants. So you can imagine a new small carrier. They don't have the infrastructure, they don't have the staff, they don't have the technology that these large carriers that have doing—been doing business for decades possess. Therefore, the carrier's population may appear to be healthier than it actually is if some diagnoses are not captured, which may result in improper risk adjustment payments.

And let's contrast that with the risk corridor. So the risk corridor last year resulted in our CO-OP receiving 12 cents on the dollar. So the plans established, we booked this amount of money, but they received 12 cents on the dollar. Now, with the risk adjustment formula, they're going to have to write a check at 100 cents on the dollar. Any business that's going to collect 12 cents on the dollar and pay 100 cents on the dollar, that math does not work. And when you take that math and you add it to the Affordable Care Act that mandates a certain medical loss ratio, they can't raise their rates and collect it with premium because if they do, they'll bump below the medical loss ration and they'll have to pay that excess

money back to the customers that they serve.

The NAIC has urged CMS to review the formula and work with carriers and State regulators to make adjustments for 2015 and 2016 to ensure that it's providing appropriate protection for all carriers, but we really can't wait for 2017 or 2018 to enact those reforms. There are several immediate solutions that would provide financial relief while technical corrections are developed. Among these are exempting new and fast-growing plans from the risk adjustment for, say, the first 3 to 5 years or limiting the amount a carrier pays for risk adjustment to perhaps 2 percent of their annual premiums collected in the year.

Mr. Chairman, members of the committee, I appreciate the invitation to speak. I encourage you to consider immediate solutions which would provide stability in the individual and small group market and allow these companies to provide overall benefits to the marketplace, again, across the country. And with that, I'll look for-

ward to your questions.

[Prepared statement of Mr. Redmer follows:]

## Written Testimony for:

Mr. Al Redmer, Jr.

Commissioner

Maryland Insurance Administration

Chairman Chaffetz, Ranking Member Cummings and members of the Oversight & Government Reform Committee, thank you for the invitation to testify today. My name is Al Redmer. I am the Commissioner of the Maryland Insurance Administration. I am here today to offer my views on the risk adjustment program based on Section 1343 of the Affordable Care Act and its impact on a co-op incorporated in Maryland.

Evergreen Health Cooperative Inc. is a Maryland based co-op created under the federal Affordable Care Act to create more competition in the marketplace. Evergreen started writing business in 2014 with a focus on medical management, disease management and improved patient outcomes. For example, Evergreen offers a value-based insurance product for diabetic patients, which removes virtually all financial barriers — co-pays, co-insurance and deductibles — to services, medications and care that are needed to keep a diabetic patient from developing the myriad complications of that disease.

As a start-up insurance company, Evergreen's challenges have been to achieve scale and to compete with more recognizable insurance companies. Evergreen's enrollment as of January 2016 is 36,000 compared to 19,339 as of July 2015. Additionally, they have diversified their portfolio. They currently offer products in the individual, small and large group markets. Evergreen's medical loss ratio has been a reasonable 78%-85% over the last year. Based on current enrollment trends, Evergreen is on track to achieve 2016 enrollment goals and turn a profit at year-end

Over the past few years, new innovative health insurance plans have been created that are providing enhanced competition and patient care. And it is working. For year-end 2014, CareFirst had a 91% market share of the individual market in Maryland. Today, it is 57%, due in part to a more competitive marketplace. These carriers have the potential to continue, but their ability to do so is severely jeopardized by the adverse and perhaps fatal financial impact caused by the technical shortcoming of the current risk adjustment and risk corridor programs. The failure of these plans would be disruptive to the marketplace. State insurance regulators believe that a competitive marketplace benefits and protects policyholders.

The risk adjustment formula is of concern to state regulators because it has proven to place newer carriers at a distinct disadvantage. For example, the risk adjustment formula quantifies an enrollee's health status based on age, sex and diagnoses recorded during the course of the year. New carriers have very limited information on the health status or previous claims history of the applicants. Therefore, the carrier's population may appear healthier than it actually is if some diagnoses are not captured which may result in improper risk adjustment payments. Let's contrast this to the risk corridor mechanism. With risk corridor, carriers around the country received 12 cents on the dollar. If they are required to pay 100 cents into the risk adjustment formula, the math just doesn't work. We are setting up carriers around the country to fail.

The NAIC has urged CMS to review the formula and work with carriers and state regulators to make adjustments for 2015 and 2016 to ensure it is providing appropriate protection for all carriers, and not wait until 2017 or 2018 to enact reforms. There are several immediate solutions that would provide financial relief while technical corrections are developed. Among these are exempting new and fast-growing plans from risk adjustment for the first 3-5 years or limiting the amount a carrier pays for risk adjustment to 2% of the carrier's premium revenue in the year for which the risk adjustment payment is assessed.

I appreciate your invitation to speak today and encourage consideration of the immediate solutions which would provide stability in the individual and small group market, allow companies to compete and provide for the overall benefit of marketplace enrollees across the country.

Mr. MULVANEY. Thank you, Mr. Redmer.

We will now recognize Mr. Cartwright for his opening statement for 5 minutes.

Mr. CARTWRIGHT. Thank you, Mr. Chairman. And thanks for holding today's hearing. I would also like to welcome our witnesses, Dr. Cohen and Commissioner Redmer. I thank you for being here

and appreciate your testimony.

The CO-OP program was established, of course, to bring competition to the health insurance market by encouraging the development of nonprofit consumer-focused insurance companies. Many CO-OPs have done just that, providing quality care to more than 1 million consumers at competitive prices, and accordingly, driving down premiums in those places.

Of course, like any other startup, CO-OPs face challenges. In addition to competing against larger, well-established, some might say entrenched insurance companies that have dominated the market for years, CO-OPs lack the claims experience and the detailed textural knowledge of the markets that insurance—insurers have

to rely on accurately to predict their products.

Coops are also prohibited by law—this interesting—from using loan funding to market their plans. So it is like their ability to speak has been cut, and it is hard to attract new customers when

you can't advertise with all of your resources.

But CO-OPs have also long been the target of Affordable Care Act opponents who view this program as one more opportunity to attack the law. And this is getting tiresome, of course. The ACA authorized \$6 billion for the CO-OP program. The following year Congress cut \$2.6 billion of that \$6 billion authorized. And then the American Taxpayer Relief Act of 2012 further cut the program's remaining \$3.4 billion by 90 percent and put what little was left into a contingency fund, effectively preventing the creation of any new CO-OPs.

So if you are scoring along at home, it adds up like this: Congress has gutted about \$4 billion of the \$6 billion that was originally appropriated for the program, and now we are here to criticize how they did after we cut their legs off at the knees. I hope we are not really here to do that.

On top of these cuts, Congres voted last year to gut the risk corridors, one of the ACA's risk mitigation programs. As a result, insurers will receive only 12.6 percent of the expected payments for 2014, roughly 13 cents on the dollar for every dollar they expected to receive.

Republicans in Congress have always focused more on tearing down the ACA than making it work, and I think that is what we are up to here today. They have taken more than 60 votes to repeal or undermine the ACA, never voting on any kind of replacement of their own. We are hearing today about CO–OPs that are operating under corrective action plans or enhanced oversight plans, but it is important to understand the challenges facing these CO–OPs so that we can learn from this going forward.

Being under a CAP or an EOP does not mean that an insurance company is in imminent danger of failing. In fact, our committee staff, both Democratic and Republican, spoke with the Insurance Departments of States in which CO-OPs currently operate under

a CAP or an EOP, and they have all approved these CO–OPs to offer coverage this year. They have also importantly informed us that there are many other insurance companies, for-profit insurance companies that are not CO–OPs that have also been put under corrective action plans, consent orders, or similar remedial actions at the State level for some of the same issues facing the CO–OPs.

So I understand the argument that consumers have a right to know about their plans, but we shouldn't game the market by selectively targeting only CO-OPs when the larger picture is that they are struggling across the board. If we want consumers to know about their insurance plans, let's look at all of them, not just

the ones you want to call ObamaCare.

Now, I will say I don't believe we should release any of the confidential regulatory information that we have obtained about the remaining CO–OPs in a way that would mislead consumers about the insurance companies in their States or prejudice the ability of CO–OPs to operate going forward. But going forward, I would commit to working with the chairman on a broader comprehensive review of these programs in a way that actually helps consumers make informed decisions.

And I hope we can use today's hearing to learn from our expert witnesses about what is going well in the CO-OP program, what needs to be improved, and how we can work together to make this program succeed.

I thank you, Mr. Chairman. I yield back.

Mr. Mulvaney. I thank the gentleman from Pennsylvania. I would now recognize the gentleman from Tennessee, Dr. DesJarlais, for 5 minutes for questions.

Mr. DESJARLAIS. Thank you, Mr. Chairman. And I thank the wit-

nesses for being here today.

As I continue to listen to the rhetoric from the other side of the aisle, we can pretend that ObamaCare is popular, but it is not. People didn't want ObamaCare; they didn't want socialized medicine when it was crammed down their throat several years ago. So to sit there and demagogue Republicans for just trying to make this into something it isn't is disingenuous. And today's hearing is a great example of one of the reasons this is failing.

Dr. Cohen, what qualified CMS to set up and provide oversight

for these CO-OPs in the first place?

Dr. COHEN. The Affordable Care Act provided the statute and the funding for the CO–OP program.

Mr. DESJARLAIS. Okay. Did CMS have any qualifications or experience in setting up these type of programs and overseeing them?

Dr. Cohen. Well, we do—CMS also obviously runs Medicare, the largest insurer in the country. But in terms of how we decided on the CO—OP programs themselves, obviously they are private businesses. We had a panel of experts both externally and internally, whether it's insurance expert and actuaries and others, who reviewed CO—OP business plans before making decisions about who would be awarded the loans.

Mr. DESJARLAIS. Okay. And I guess at the beginning it was accepted that probably only about 60 percent of these loans at best

were going to be paid back, so I question why weren't they just called grants or at least a majority of the money.

Dr. COHEN. So they are very much loans, and we do very much expect to get taxpayer dollars back for those loans, and that's what we intend to do.

Mr. DESJARLAIS. Okay. How many CO-OPs were initiated?

Dr. COHEN. Twenty-four.

Mr. Desjarlais. Okay. How many of them are still in existence?

Dr. COHEN. Eleven.

Mr. DesJarlais. Eleven, so more than half have failed?

Dr. Cohen. Yes, that is correct.

Mr. DESJARLAIS. And they went —

Dr. Cohen. There is only 11 currently operating.

Mr. DESJARLAIS. And so that little money we are probably not going to recoup, right?

Dr. COHEN. So we are in the process of recouping that the money right now. We ——

Mr. DESJARLAIS. How much money are we talking?

Dr. Cohen. So we've just started that process as most of these CO-OPs have just shut their doors about 6 weeks ago. So we'll go through an extensive process of making sure they continue—first, their claims run out, and then we'll look at their—you know, the excess revenue and then use all the tools available to us through their loan agreements and State and Federal law to pull back Federal tax dollars.

Mr. Desjarlais. Okay. Tennessee had Community Health Alliance, or CHA. By the end of 2014, they'd only had about 2,300 members out of a projected 25,000, resulting in a loss of \$22 million for the year. In 2015 they actually lowered the premiums to try to entice membership, and boy, did it work. It jumped up to 35,000 by May of 2015, but it grew so fast during the open enrollment period that CHA had to suspend enrollment plans. They proposed an increase in premiums because obviously it, you know, was too affordable—kind of a bait-and-switch if you will—of 32 percent, but the regulators asked to increase it to 44 percent. So for these poor people that decided to take a chance on this CO-OP, they came in at a certain rate, had their rates almost double, and then it was determined by the end of the year that it was no longer sustainable and they shut down. So a CAP was imposed on Community Health Alliance on September 29, and then just 2 weeks later, it closed its doors. How can you say that these corrective measures are useful when 50 percent of the CO-OPs subject to CAPs have failed?

Dr. Cohen. So the—we use the corrective action plans when we identify something that we believe is correctable. In the case of Tennessee, obviously, we were identifying problems, and then we saw additional new information that came to light about their finances, about what happened in Q2 of their claims experience. As you were mentioning, they were highly enrolled so they had a lot more—their consumer base was extremely high to their premiums that were coming in. And so we, along with the Departments of Insurance, need to make some tough decisions about one thing to make sure that consumers had continuous coverage and didn't want them to enter the next open enrollment period if they couldn't

make it through the whole next year. And so we, along with the Departments of Insurance, said that they were no longer going to be operating.

Mr. DesJarlais. And this is not just Tennessee. This has hap-

pened in a lot of States, correct?

Dr. Cohen. We have shut down 11 CO-OPs, that's right.

Mr. DesJarlais. Eleven CO-OPs. So what do you tell a person that is going to look for insurance? Why would you recommend anyone looking for insurance or their family to go to a CO-OP?

Dr. COHEN. Well, that's why we did the tough work at the end of last year before the open enrollment period started. We, along with the State Departments of Insurance, took a seriously hard look at these CO-OPs to make sure the ones that would continue forward we had the confidence would make it through 2016 for their consumers.

Mr. DesJarlais. But you say that this CAP program is the solution to fixing these problems. How many programs were under CAPs that have failed?

Dr. Cohen. So I don't think the CAP is the only solution. I think the CO-OPs themselves are really the ones who are going to be the ones to determine whether or not they ultimately will be successful. They have a lot of work to do to rapidly mature their entities, their small businesses, as you know, and they're still getting their foothold on this business. So I think CAPs are one way for us to identify correctable problems, but certainly, the State Departments of Insurance are doing their own work as well.

Mr. Desjarlais. Yes, but bottom line, the CMS was given in excess of \$2 billion to help oversee these, and over half of them have failed, but yet you are asking us to have the confidence to continue to support organizations that are obviously failing. And it is awful difficult, I would think, to attract people. It is a big inconvenience for these people to go sign up for insurance, have their rates jacked, and then told that they are canceled. So, I mean, I think we have got a lot bigger problems here.

I see my time is expired, but maybe we will get to a second round of questioning.

Dr. Cohen. Okay.
Mr. Mulvaney. I thank the gentleman and now recognize Mr. Cartwright from Pennsylvania for 5 minutes, give or take.

Mr. CARTWRIGHT. Thank you, Mr. Chairman.

Well, now, Dr. Cohen, thanks for being here again. And I said some things in my opening, and I want to confirm them with you. One of them is this idea of establishing the CO-OPs. The idea is that we are going to provide competition. And we are all good capitalists in this room, and we know that the more competition there is, the lower prices will be for consumers. Is that a fair statement?

Dr. COHEN. That was the idea for the CO-OP program to not only provide an additional choice for consumer but one that was

consumer-run.

Mr. Cartwright. So a central capitalist principle underlies the whole idea for CO-OPs, right?

Dr. Cohen. That's right, private businesses.

Mr. Cartwright. All right. And the other idea was we were going to help fund the CO-OPs to get on their feet and get going. And how much did the Affordable Care Act appropriate for the CO-OP program in the first—for

Dr. Cohen. Originally, it was \$6 billion.

Mr. CARTWRIGHT. Six billion dollars. And I understand Congress on several occasions has cut the CO-OPs' funding. Am I correct in that?

Dr. Cohen. That is correct.

Mr. Cartwright. Is that four times?

Dr. Cohen. I believe that's right.

Mr. CARTWRIGHT. Four times they have cut. And the year after ACA was passed, Congress voted to cut a total of \$2.6 billion from the program, right?

Dr. COHEN. That's right.

Mr. CARTWRIGHT. And then in 2012 Congress rescinded 90 percent of the remaining \$3.4 billion on the program, right?

Dr. Cohen. That's correct.

Mr. Cartwright. And then finally, sequestration cut an additional \$13 million in funds from the CO-OP program, right?

Dr. Cohen. You can see why they had some challenges.
Mr. Cartwright. Okay. Well, now, Dr. DesJarlais brought up
the fact that some of these CO-OPs have failed. You don't need to be a rocket scientist to say that cutting and cutting and cutting the funding is going to be a big part of why some of these CO-OPs failed. Would that be a fair statement?

Dr. Cohen. That would be a fair statement.

Mr. Desjarlais. Would the gentleman yield just for a quick question?

Mr. Cartwright. Certainly.

Mr. DesJarlais. Okay. You had pointed out the funding at \$6 million. Originally, they were supposed to

Mr. Cartwright. Six billion.

Mr. DESJARLAIS. Six billion. There were originally supposed to be CO-OPs in all 50 States. There are only 23 or 24, so obviously, we did save the taxpayer a fair bit of money by cutting that amount.

Mr. Cartwright. Reclaiming my time, actually, in terms of saving the taxpayers money, this is the loan money, isn't it, Dr. Cohen? And it is coming from CMS. The lender is CMS, your agency, and your plan is to get the money back for the taxpayers, right?

Dr. COHEN. That's right. The money is from the Treasury.

Mr. CARTWRIGHT. But if we kill the CO-OP, it is not going to pay us back, is it?

Dr. Cohen. That's why we want—we are trying to support the

CO-OPs for them to succeed. They succeed, we succeed.

Mr. Cartwright. Right. Thank you. Now, unfortunately, cuts made by the program last year resulted in insurers receiving only about 13 cents on the dollar of payments they were expecting. Commissioner Redmer, I want to direct this to your attention. In your opinion, how have changes to the risk corridors program affected CO-OPs and other small insurance companies?

Mr. REDMER. Well, they've affected them a lot. And let me go back and point out that all of the CO-OPs are not failing. Again, in Maryland we have a successful, compelling story. And I would like to add that this risk adjustment formula that I've chatted about previously is not just affecting CO-OPs; it's going to affect all of these smaller companies around the country, some of which a lot of them have no taxpayer money at all. These are all private

organizations.

But as I mentioned previously, if you are collecting money under the risk corridor and you're paying money out under the risk adjustment formula, any business, if you are going to collect 12 or 13 cents on the dollar and you're going to pay out 100 cents on the dollar, the math just does not work. And that has already proven to be fatal on the corridor's side to some of the CO-OPs, and I'm concerned that if we do impose that 100 cents on the dollar risk adjustment formula, that it may prove to be fatal to other organizations around the country.

Mr. CARTWRIGHT. I appreciate your comments. And, Commissioner Redmer, you have been appointed as insurance commissioner by a Republican Governor, and you are a former Republican State legislator yourself. Why do you think it is important to help

the remaining CO-OPs succeed?

Mr. REDMER. When I walked in, if I could have written the ACA differently, I probably would have. If I could have written the exchange law in Maryland, I probably would have. But I walked in the office January the 21st of last year with a business that was

providing competition to the marketplace.

And if, again, you go back to the Affordable Care Act, and I don't want to re-litigate that, but if you look at the objectives of increased competition, improved medical outcomes focusing on medical management and disease management, this specific organization is a success story. They've got a compelling story to tell. They're insuring 30,000 Maryland citizens. We've seen improved competition, and my perspective is that it's worth the investment of my time and effort to try to help and save that organization.

Mr. Cartwright. Well, thank you, Commissioner Redmer. And 30,000 in Maryland, and, Dr. Cohen, how about nationwide? I have

said it is more than 1 million people who are enjoying the fruits of having health insurance because of the CO-OP program. Am I

correct in that?

Dr. Cohen. It was 1 million people as of last year, yes. Mr. Cartwright. As of last year, 1 million people?

Dr. Cohen. Yes.

Mr. Cartwright. Well, thank you both, and I yield back, Mr. Chairman.

Mr. MULVANEY. I thank the gentleman. You have an extra 24 seconds.

We now recognize the gentleman from North Carolina, Mr. Meadows, for 5 minutes.

Mr. MEADOWS. Thank you, Mr. Chairman.

Dr. Cohen, you are not here to suggest that if the CO-OPs go away that those 1 million people would be uninsured, are you?

Dr. Cohen. No. Luckily, they have other choices that the Afford-

Mr. MEADOWS. Okay. Let's make that clear, Mr. Cartwright.

And so as we look at this, one of my concerns, I guess, that I have, Mr. Redmer, is, as you have gone over this business model, how much longer should the American taxpayer be on the hook to make sure that these fledgling startups -

Mr. REDMER. Sure.

Mr. Meadows.—make a profit?

Mr. REDMER. I can tell you —

Mr. MEADOWS. And since they are nonprofits, I guess that is not

Mr. REDMER. Sure.

Mr. Meadows.—the correct word but ——

Mr. Redmer. The —

Mr. Meadows.—become financially solvent.

Mr. REDMER. The—Evergreen has been profitable on a monthly basis in 2015, 4 months out of 12. Their loss in 2015 was reasonable. They are projected to be profitable——

Mr. MEADOWS. But without the risk corridor, will they be profit-

able going forward?

Mr. REDMER. If we ——

Mr. Meadows. Because I think your testimony ——

Mr. Redmer. Yes.

Mr. Meadows.—would suggest they were not.

Mr. REDMER. No, they would be profitable. If they are left alone in 2016, they will be profitable for 2016. The problem is the risk adjustment formula. If they have to stroke a check for \$1 million or \$2 million or a number like that, that's not going to be an issue.

Mr. Meadows. But wasn't that —

Mr. REDMER. But ——

Mr. Meadows.—part of their business model when they went in? I mean, didn't they—I mean, the ACA has been very clear so ——

Mr. REDMER. Of course.

Mr. MEADOWS.—I mean, that is not like you wake up and you have a shock that this is going away.

Mr. REDMER. You're exactly right. However, also part of the business model was the risk corridor payment, of which they received

12 cents on the dollar. So if they would have —

Mr. Meadows. But again, I would stress that is not new news. This is not breaking news. I mean, we changed the models and we started to look at this, but part of the ACA rollout has been consistent from day one they would have these certain subsidies in certain risk corridor someplace. They would eventually go away once they are there. And I guess my question still remains. How long should we keep everything subsidized in hopes that we have competition?

Mr. REDMER. I don't know that we need to give them subsidies.

I think we need to leave them alone.

Mr. Meadows. All right. So let me ask you maybe a different question. Since you have a very successful CO-OP, how much has that CO-OP affected the premiums? Have premiums gone down on health care overall in Maryland?

Mr. REDMER. The—I believe the premiums are more moderate than they would otherwise be ——

Mr. MEADOWS. Have they gone down?

Mr. REDMER.—but no, I would —

Mr. MEADOWS. Yes, they have not.

Mr. REDMER. I—there has not been any premiums going down.

Mr. MEADOWS. So what you are saying is they may have affected them, the rate of growth?

- Mr. Redmer. Yes.
- Mr. Meadows. Co-ops may have affected the rate of growth?
- Mr. Redmer. Sure.
- Mr. MEADOWS. So how many people do you have insured in Maryland?
  - Mr. REDMER. I don't have a number of the top of my head.
  - Mr. Meadows. What would you guess? Millions?
- Mr. Redmer. I'm going to say—oh, yes, sure.
- Mr. MEADOWS. All right. So how do you think the competition of 30,000 people really affects the premiums of millions of people?
- Mr. REDMER. I'm not going to guess as to what it's going to affect.
  - Mr. Meadows. Well, I am a business guy —
  - Mr. REDMER. It's—sure.
- Mr. MEADOWS. It has got very little impact. And I guess here is what my concern is, Dr. -
- Mr. ŘEDMER. Well, but if I could say that we're talking about 30,000
- Mr. Meadows. If you want to talk business, I am ready all day
  - Mr. Redmer. Sure.
  - Mr. Meadows.—to jump -
  - Mr. Redmer. We're
  - Mr. Meadows.—right in the depths of this.
  - Mr. Redmer. Sure. We're –
  - Mr. Meadows. I would -
  - Mr. REDMER. We
  - Mr. Meadows.—encourage you to probably not go there but —
  - Mr. REDMER. I'm
- Mr. Meadows.—go ahead. Mr. Redmer. I'm trying to answer your question. The 30,000 lives have been there, have grown in the last couple of years compared to insurance companies that have been doing business for decades. So naturally, the—even if you are lower and you're moderating prices, the acceleration of growth is not going to be as significant as if they were all the same size and the same age.
  - Mr. Meadows. Well
  - Mr. Redmer. But you're right, they're not reducing —
  - Mr. Meadows. All right.
- Mr. Redmer.—rates. Mr. Meadows. So, Dr. Cohen, let me come to you because what has been alleged, and certainly you know that I am no fan of ACA, but let's look at the CO-OP as a separate entity at this particular point. You have 11 CO-OPs remaining, is that correct?
  - Dr. COHEN. That's right.
- Mr. Meadows. And so out of those 11 how many of them would have a corrective action plan in place or some kind of enhanced oversight right now out of the 11 remaining?
  - Dr. COHEN. More than half.
  - Mr. MEADOWS. But how many?
  - Dr. Cohen. Seven.
- Mr. MEADOWS. Okay. So we have four CO-OPs out of all the CO-OPs that have been—so we have got one example in Maryland, so, surprise, surprise, we happen to have the one good example.

But four out of most of them, that is not really a successful business model, wouldn't you think, Dr. Cohen?

Dr. Cohen. So when we think about corrective action plans is us trying to identify a correctable problem. So we are working very hard with these CO-OPs, and I know they're working individually

to remedy the issues that we've identified.

Mr. Meadows. All right. So out of those seven, how many of those do you think will be doing business in 2017? Because you were real careful in your response. You said they were going to be able to provide coverage for the rest of this year.

Dr. COHEN. You're right. It's

Mr. MEADOWS. Let me tell you why I am asking you —

Dr. Cohen. Yes.

Mr. Meadows.—is because I don't think CO-OPs necessarily are affecting the market because they're such a small -

Dr. COHEN. Well

Mr. Meadows.—part of it, and the other is, is I have got huge health care providers that are hemorrhaging money under this program because they are trying to figure out the risk and all of that. And as a guy who has started 12 small businesses, this is not one where I would try to wade in and try to compete with the big boys. And I guess what I would ask you to do is to make a realistic assumption, and I will actually agree with Mr. Cartwright that I will not use it to bludgeon the ACA, but I would ask you to get back to this committee on really should we continue the program or not? And with that, I appreciate the indulgence of the chair.

Mr. MULVANEY. I thank the gentleman and now recognize the

gentleman from Georgia, Mr. Hice, for 5 minutes.

Mr. HICE. Thank you, Mr. Chairman.

Well, fortunately, Georgia has not been impacted by the collapse of the CO-OPs, but several of our neighboring States have, South Carolina. Some 67,000 from South Carolina are now trying to seek new insurance; Tennessee, somewhere in the ballpark of 27,000. And as I understand it, predictions are close to three-quarters of a million have already lost their health insurance with little to no notice that this was coming.

And, you know, I am troubled. As you just shared, we have got at least seven more that are in danger. I am troubled with the reality that this same fate is probably going to continue to many more Americans who likewise are probably not going to be notified.

You know, and here we are dealing with people who were forced to get insurance and to go this route, and now all of a sudden it is evaporating and they have no notice whatsoever. They find themselves scrambling around trying to find insurance.

And let me just ask you personally in light of all of this, if you were one of these people, would you want to know, would you want to be notified that your insurance was about to be taken away?

Dr. Cohen. So a couple of things. One is we certainly share your concerns about the small businesses, and that's why we're doing the aggressive work that we are on the oversight side. What I would say is what we are trying to do on the oversight side is a tool that is used by Departments of Insurance all the time to identify correctable problems. And we believe that they are—again, we learn—we get additional data and make different decisions as the

years go by. Our primary goal is to make sure that consumers have—can have continuous coverage, which is why at the end of last year we

Mr. HICE. Well, my question was would you want to be notified

if you were about

Dr. Cohen. So I know that the Department of Insurance is—has the voice of the consumer when they're thinking about when to notify consumers about issues related to CO–OPs

Mr. HICE. So would you want to be notified?

Dr. Cohen. At the appropriate time. I know that the Departments of Insurance are thinking about the

Mr. HICE. Okay. Well, you just mentioned that there are seven that are in danger. At what point is an appropriate time to notify

these people? Which of the seven is most likely to fail next?

Dr. Cohen. So, first I should pause, and my team corrected me that eight are on CAPs. So the number is eight. So the appropriate time is when the Department of Insurance that regulates this process of communication tells us that that's the right time. Again, we're the loan-holders here. The State Departments of Insurance are the primary regulators, and so they sort of govern this space about notification. We don't want to have consumer

Mr. HICE. All right. Well, apparently, the insurance site is not getting the job done either because we have got three-quarters of a million Americans with little to no notice whatsoever lost this, and you are jumping all over the place when it comes to facing any

responsibility that Americans ought to be notified of this.

Which of the eight is most likely next to collapse?

Dr. Cohen. So it's—we are at a very early point in the year. We did some tough work at the end of last year to make sure the consumers could have confidence in the CO-OPs that were continuing for 2016. We are just learning about what the CO-OPs did in terms of enrollment during the open enrollment period -

Mr. HICE. Again, that is not my question. Do you know which

one is in the greatest danger?

Dr. COHEN. I can't say at this point. I don't have that informa-

Mr. HICE. All right. We have got billions of dollars on the line, American taxpayers on the hook for this. Don't the taxpayers deserve to know—you know, if you are making a business decision, is this a business venture you would want to be a part of? I know we have got—from info that I have got, we have got one of the CO-OPs now projecting a \$70 million loss as opposed to what was supposed to be a \$4 million gain. I mean, this is a horrible, horrible

How many of the remaining CO-OPs are actually profitable?

Three? Is that what we are looking at?

Dr. Cohen. So we know that small businesses always struggle to turn a profit in the first few years. It's a matter of in this entrenched business I think as the Congressman mentioned before. These are tough markets to break into. There's a certain amount of loan funding that we can offer from the Federal Government, but what we're trying to do now is encourage these CO-OPs to look for outside capital, additional resources to bring in, thinking about selling in the small group market in addition to the individual market, maybe even the large group market, and again, thinking about how they're going to sustain themselves and be viable over the long term.

Mr. HICE. All right. Last thing, and my time is about up, let's walk through the process of what happens when a CO-OP closes.

Do they continue to draw money from the Federal loan?

Dr. COHEN. So the—when we—when the CO-OP closes, it's a decision between CMS and the Department of Insurance. When that wind-down starts, that doesn't mean the CO-OP is closed. So we started wind-down processes in the September/October time frame, but consumers are able to continue coverage until the end of that year.

Mr. HICE. So they continue drawing Federal loan money?

Dr. COHEN. So the loan money had already been awarded. There's no new dollars that go out the door. All of that loan money

Mr. HICE. So even when they close, loan money continues going out the door?

Dr. Cohen. So—no, there's no—when they close their doors, there's no additional loan money so—because that was already awarded to them. There's obligations of money that they need that they have been—they're on a payment cycle if you will, but that money had already been awarded.

Mr. HICE. Mr. Chairman, thank you as well for your indulgence. Mr. MULVANEY. I thank the gentleman and now recognize the gentleman from North Carolina, Mr. Walker, for 5 minutes for questions.

Mr. Walker. Thank you, Mr. Chairman. I would like to thank Mr. Cartwright from Pennsylvania for being present today. Defending the various components of the ACA I know is difficult, but I would hope that my friends on the other side of the aisle would be concerned about the constituents and the losses here of some of these CO–OPs.

Mr. Redmer, I believe about 10 or 15 minutes ago, if I remember correctly, you said all of the CO–OPs are not failing. Can you tell me what percentage of failing CO–OPs need to take place before you feel like there is a problem?

Mr. REDMER. I didn't say there was not a problem. I said that not all CO-OPs have failed, and we have one in Maryland that is performing reasonably well. And that's the extent of my knowledge and interest is the Maryland CO-OP.

Mr. Walker. Okay. Well, speaking of Maryland, last November, just as the open enrollment period was starting, the CEO of the Maryland CO-OP testified before the Energy and Commerce Committee. He did acknowledge that the CMS has placed the Maryland CO-OP under an enhanced oversight plan. Does CMS have any evidence that the Maryland CO-OP was adversely impacted as a result of that public disclosure? And Mr. Redmer or Dr. Cohen, whoever feels more comfortable in answering the question.

Mr. REDMER. I can't answer whether there was any effects of that being disclosed or not.

Mr. WALKER. Dr. Cohen?

Dr. Cohen. So I'm not aware of that situation.

Mr. Walker. Okay. Well, as a matter of fact, 3 days after his testimony the  ${\rm CO-OP}$  CEO was projecting increased enrollment. That is interesting. Is there anything that is being hid here from the public? I mean, do you have any information regarding what was going on there, Dr. Čohen?

Dr. COHEN. So regarding the Maryland CO-OP? I'm sorry. I'm not following the question.

Mr. Walker. Okay.

Dr. COHEN. I apologize.

Mr. Walker. Let me ask it again. Three days after his testimony, the Maryland CO-OP CEO was in the press projecting an increased enrollment. It seems like there is a continuance to refuse to comply with the committee's duly authorized subpoena. Any evidence of that?

Dr. COHEN. I didn't realize the Maryland CO-OP was under sub-

poena by this committee.

Mr. WALKER. Okay. All right. So let's go a different direction since it sounds like that information did not get to you guys, okay? I want to be fair with that. Let me go back to a question earlier because I didn't know if I heard a definitive answer. Of the taxpayers' money that the administration was loaned out to the CO-OPs, do we have a range, a number, speculation of how much will actually be paid to the taxpayers?

Dr. COHEN. So we're working through that process right now. As mentioned earlier, again, the CO-OPs that wound down at the end of last year are now going through a process of doing their claims round out, understanding what revenue that it has coming in. Some of them are taking actions with their vendors. And then we go through a process based on the loan agreements and the State law to use all the tools at our disposal to get the funding back.

Mr. Walker. Sure. You would understand why the word process is probably overused in this town a good bit. Is there any way that

you can put any kind of numeric value to that?

Dr. COHEN. I can't at this time. It's a really case-by-case process. It's led by the Department of Justice who leads these as—because it's a Federal loan, and so it's a process we'll work through and it's too early to speculate.

Mr. WALKER. Is there a percentage of how much that we would want the CO-OPs—if there is not an exact dollar amount, is there a percentage goal, benchmark? Is there anything like that that has

been

Dr. Cohen. It certainly is -

Mr. Walker.—determined in the process?

Dr. Cohen. It is certainly as much as we possibly can within the confines of the loan agreement and the laws.

Mr. WALKER. Okay. Thank you, Mr. Chairman. I yield back the balance of my time.

Mr. MULVANEY. I thank the gentleman and would now recognize

Mr. Walberg for 5 minutes.
Mr. Walberg. Thank you, Mr. Chairman. And I apologize for being a little late to arrive, so I hope I am not asking some questions that have been asked already.

But to Dr. Cohen, thank you for being here. Major insurers, as we have been aware in the reports in the media, have sustained significant losses on their exchange plans and have been pessimistic about the profitability of their plans. In 2015 and 2016 the records show that United Health expects to lose \$1 billion on exchange plans. The company's CEO has even stated that entering the exchange was "for us a bad decision." United might quit exchanges altogether in 2017. Aetna has lost money on plans sold through the exchanges, and its CEO said, "We continue to have serious concerns about sustainability of the public exchanges." Humana's losses might drive it from the exchanges. Most major insurers seem unable to make a profit on the exchange. If that is the case, if major insurers can't make it on exchanges, why should we be optimistic that CO-OPs will?

Dr. Cohen. Well, we are very confident about the fact that the marketplace grew over the last open enrollment period with 12.7 million consumers in the marketplace now. And if you look at Kaiser, Centene, Molina, others, they are seeing strength in the marketplace and looking to expand. And so we think that it's a growing

market.

We share your concerns about the CO-OPs and their ability to be successful in an entrenched market. They certainly have a lot of barriers that they needed to overcome, and so that's why we're doing as much work as we can on the oversight side to make sure that they are making good decisions with taxpayer dollars.

Mr. WALBERG. Well, I guess that time will tell on that, but we're talking of significant organizations that have seen that it has been

a bad investment, so hopefully, it will be a turnaround.

The administration has requested more than \$1.8 billion in emergency funds to combat Zika; \$828 million would go to the CDC, \$200 million would go to NIH and FDA. A separate committee investigation into this administration's ObamaCare spending has revealed that during the Ebola crisis HHS propped up ObamaCare by taking money from CDC and NIH and giving it to CMS, over \$14 million from CDC and over \$75 million from NIH if the records are correct. By HHS's accounting, over \$1 billion in ObamaCare funding has come from the systematic raiding of funds from other programs utilizing the Secretary's transfer authority and nonrecurring expense fund.

Based on that track record, Dr. Cohen, how can we be confident that any Zika funds would be spent on their intended purpose and used to prop up CO-OPs or other pieces of not instead

ObamaCare?

Dr. COHEN. So I can't speak to the Zika funding and how that will be spent, but what I can say about the funding for the marketplaces is that now that we are on stable footing with the 12 million and more consumers, we are able to charge user fees to the issuers through that, and that is what sustains the marketplace in terms of its viability to cover the—its operational costs.

Mr. Walberg. I yield back.

Mr. Meadows. Would the gentleman yield for a second? Mr. Walberg. I would yield.

Mr. Meadows. What was the breakeven point? You say now that we are 12 million consumers that you are self-sustaining

Dr. Cohen. No. I said that is the funding that we used to —

Mr. MEADOWS. That is the -

Dr. Cohen.—cover the marketplace operations —

Mr. Meadows. Well, but

Dr. Cohen.—for

Mr. Meadows.—to the gentleman's point, he said are we going to reprogram the money, and you said that now we are 12 million we don't need

Dr. Cohen. That's not what -

Mr. Meadows. So maybe I misunderstood, but I am just trying to get a clarification

Dr. Cohen. Well, what I said is -

Mr. Meadows.—on the gentleman's point.

Dr. COHEN. I don't know about the funding for the Zika program

and who it's getting funded through. It's

Mr. Meadows. No, his point was is that other monies had been reprogrammed and shifted to prop up ObamaCare. That is his point. And what you are saying is because you—is your testimony here today that there will be no shifting of funds to prop up any part of ObamaCare from here on out?

Dr. Cohen. So I think what you were asking is would the Zika

funding be used to prop up the marketplace —— Mr. WALBERG. Well, that was an example of how Zika funding has been used. It has been shifted and that is the question.

Dr. Cohen. Well

Mr. WALBERG. If that is the pattern, we are concerned that the dollars aren't there and we will be shifting it from other funds.

Dr. Cohen. Understood. So—and that's why the user fee will cover the marketplace operations. In addition, obviously, the Secretary has at her discretion to move money within the Department to cover whether it's Zika or Ebola or marketplace whatever important action of the moment is needed across the country

Mr. WALBERG. That is concerning. So anyway, I yield back.

Mr. MULVANEY. I thank the gentleman. I will recognize myself for 5 minutes.

Dr. Cohen, during your opening statements you said that one of your jobs was to make these loans to the CO-OPs and to work on getting them back. I understand there is \$1.2 billion outstanding on those—or is it a full \$2.4 billion is outstanding on the loans, isn't it?

Dr. Cohen. Well, they've been—they are making loan payments,

but it—that's in the right ballpark, yes.

Mr. MULVANEY. Let's talk about these loans. What kind of loans are they? Are they secured, are they priority? Tell me, when you loan money to the Maryland-if we use Evergreen for an example—what is the nature of that loan?

Dr. COHEN. I'm—I am not the loan expert, but I can be happy

to follow up and provide that.

Mr. Mulvaney. Is it secured by any of the assets of the entity? Dr. Cohen. So I don't know that I could answer that question.

Mr. Mulvaney. Okay. Do you know the priority of repayment? Dr. Cohen. Yes. So obviously for Federal loans there is—there's an order of payment. I believe that we are at the very top of all of the creditors when we are going back, but that is, I will say, on a case-by-case basis. In different States that is a—there is a different makeup of where the Federal loans and Federal obligations fall in the order of who gets paid back first, which is why it is a case-by-case process that the Department of Justice runs.

Mr. MULVANEY. Okay. So is it your testimony then—because we have had information that indicates that at least on some of the CO–OPs you have allowed them to reclassify the loans as what they call surplus on their balance sheet.

Dr. COHEN. Okay. Got you.

Mr. MULVANEY. Is it your testimony that that is because of State law or have you made a decision to allow that to happen?

Dr. COHEN. So I think you're talking about the loan conversions.

Mr. Mulvaney. It sounds like it.

Dr. COHEN. Those are ones that are requested by the CO-OPs themselves, and if we are going to make a determination to move some of those and convert those loans, we do that in coordination with the State Departments of Insurance. So we don't okay any of those conversions without the State Department of Insurance —

Mr. Mulvaney. When you say conversions—I am sorry to cut you off, but you are using a term that I am not familiar with—

what are you converting them to, from loans to what?

Dr. COHEN. So on their balance sheets, so whether it's—whether they can see it as—I'm going to use the wrong terms because I'm not the financial person, but to show—to be able to show that they have risk-based capital. So it allows them to show that they have more risk-based capital on their balance sheet.

Mr. MULVANEY. Okay. All right. Now you have my attention.

Dr. Cohen. You might want to tell—ask my commissioner —

Mr. MULVANEY. No, I will stay right here for a second.

Dr. Cohen. Yes.

Mr. MULVANEY. You allow certain CO-OPs to use loans from the Federal Government that used to be prioritized loans to count those as capital on their balance sheet for purpose of meeting their risk-based capital requirements?

Dr. COHEN. That's correct.

Mr. Mulvaney. And that doesn't scare the hell out of you?

Dr. Cohen. That's allowed by—under law, and it is something that we do ——

Mr. MULVANEY. What law—okay. And you can ask somebody behind you if you want to. Is there a specific section of the law you want to cite on that one?

Dr. Cohen. I'd be happy to have one of the lawyers follow up with ——

Mr. MULVANEY. All right.

Dr. COHEN.—our authority.

Mr. Mulvaney. Do you agree with me that it undermines the whole purpose of having risk-based capital in the first place by allowing them to count a government loan as capital? You understand the—and ——

Dr. Cohen. Absolutely. Absolutely.

Mr. Mulvaney.—a lot of people don't understand the difference between loans —

Dr. Cohen. Yes.

Mr. Mulvaney.—and capital so ——

Dr. COHEN. Yes. Understood. And we very much hear your concerns in this space, which is why it's quite a rigorous process from the time a CO-OP would request something like this until we would be able to approve it, and it requires a full review of their entire business process and their financials. It involves coordination with the State Departments of Insurance, and so we have turned a number of them down because of that.

But we do want to be flexible, again, for these CO-OPs when, as I've mentioned, if they are successful, we the—we get those taxpayer dollars back, and so we are trying to use our tools to be flexi-

ble and help those CO-OPs out.

Mr. Mulvaney. Let's talk about your efforts to get them back. I have heard from some of the CO-OPs that the payments, the reinsurance payments have slowed up. Are you withholding reinsurance payments from any of the CO-OPs whether they are ongoing, they are winding down, or they are closed in order to offset the loss from the loans?

Dr. Cohen. So each of those are, again, on a case-by-case basis

Mr. Mulvaney. Okay. Does that mean -

Dr. COHEN.—depending on

Mr. MULVANEY.—in some cases the answer is yes?

Dr. Cohen. So most of the time the decision has not yet been made, so I think it's too early to say.

Mr. Mulvaney. Okay. Then, let's talk about when you say most of the time the decision has not been made -

Dr. COHEN. And they have not-

Mr. Mulvaney.—let's talk about the times -

Dr. Cohen. They have not been made.

Mr. Mulvaney. It

Dr. COHEN. They have not been made in the wind downs of the CO-OPs.

Mr. MULVANEY. In any of them?

Dr. Cohen. No.

Mr. Mulvaney. So it is -

Dr. Cohen. That is an ongoing process.

Mr. Mulvaney. It is your testimony here today that you are not withholding any of those payments from any of the winding-down CO-OPs?

Dr. Cohen. So at this time the Department of Justice runs this process. I'm happy to have them come and answer questions about how the process would work, but right now, we are not.

Mr. MULVANEY. When do you think you are going to make a decision on that?

Dr. Cohen. I would have to consult with the Department of Justice on the timing of those decisions.

Mr. MULVANEY. Okay. All right. I understand that Mr. Jordan has joined us, so we are going to have one more questioning in our first round. I will recognize the gentleman from Ohio, Mr. Jordan, for 5 minutes.

Mr. JORDAN. I thank the chairman. And I am not exactly sure where the hearing has gone thus far with the questioning, so let me just jump in with some different things here maybe.

So this all started—it has been in existence for 2 years, right? January 2014 is when the first CO-OP started operation, is that right?

Dr. Cohen. That's correct.

Mr. JORDAN. And you had over 100 applicants but you approved 24?

Dr. COHEN. That's right.

Mr. JORDAN. And out of the 24, 12 have already failed?

Dr. Cohen. Twelve have closed, yes.

Mr. Jordan. Twelve have closed, closed, failed, whatever word you want to use. Okay. And last year, I understand while maybe 24 were still operating, you visited 16 of the CO-OPs, is that accurate, site visits?

Dr. Cohen. That sounds right.

Mr. JORDAN. Sixteen of the 24. Were there still 24 in operation starting January 1 of 2015?

Dr. Cohen. No, there were 23. Vermont never —

Mr. JORDAN. Never got involved?

Dr. Cohen.—got their State license -

Mr. JORDAN. Ökay. So the ones who —

Dr. Cohen.—yes.

Mr. JORDAN.—got approved and actually started insuring American citizens, 23, you visited 16 of the 23 last year?

Dr. Cohen. That's correct.

Mr. JORDAN. Okay. So of the seven you didn't visit, have any of them closed?

Dr. COHEN. I don't have the list of who we visited and who didn't, but I know we prioritized those that we had concerns about.

Mr. JORDAN. Okay. Then let me ask you this way. The 16 you did visit, were all 12 in that 16?

Dr. COHEN. I don't know, but I can follow up and let you know. Mr. JORDAN. All right. Of the 12 who are still in operation, how

many do you anticipate are going to collapse this year?

Dr. COHEN. Again, it's too early to know about what will happen over the course of this year. We did a lot of work at the end of last year with our colleagues at the State Departments of Insurance to make sure that we felt that these CO–OPs could operate

Mr. JORDAN. Let me ask—maybe this has been asked by the chairman or some of the members. Of the 12 still in existence, how many are meeting enrollment projections?

Dr. COHEN. I can't speak to the specifics about any one of the CO-OPs, but that's definitely a factor that we look at. And we're only first getting in the data about how

Mr. JORDAN. Is that one of the things that you look at when you go out on these site visits?

Dr. Cohen. Absolutely.

Mr. JORDAN. But you can't tell me?

Dr. COHEN. So I can't speak to that right now, but I'd be happy to follow up

Mr. Jordan. Are -

Dr. Cohen.—with details.

Mr. JORDAN.—one of the 12 meeting enrollment projections? Are five of the 12? Can you give me some numbers?

Dr. COHEN. I think some of them are over-enrolled, and sometimes that's their concern, and sometimes they're under-enrolled. So it depends on the particular circumstance.

Mr. JORDAN. How many of the 12 still in operation are currently

profitable?

Dr. Cohen. I couldn't say how many are profitable. I think that we know that small businesses are going to struggle to turn a profit in the early years, and it's too early to know what their balance

sheet is going to look like for 2016.

Mr. JORDAN. You don't know if these places that are still—I mean, half of them have already collapsed, closed, your term, costing the taxpayers over \$1 billion. Of the 12 that are left, you can't tell me which ones you have visited or haven't visited, what the enrollment projections are and whether they are meeting their enrollment projections, and whether they are profitable or not? That is the kind of stuff we kind of wanted to know in this hearing.

Dr. COHEN. Understood. And I'd be happy to follow up with those

details.

Mr. JORDAN. I mean, there are only 12. It is one thing if it was 100. There are 12 still operating. You have lost half of them, and I am asking you about those 12 still in operation. Who is making any money, right, who is meeting their enrollment projections, and who did you visit?

Dr. COHEN. I can follow up -

Mr. JORDAN. And you can't tell me out of those 12 -

Dr. COHEN. I don't have that information in front of me on the top of my head, but I would want to—I would be very happy to fol-

low up and get you that.
Mr. JORDAN. Well, we need that information. And that is kind of, frankly, the information you should have had on the top of your head and in front of you when you come to—it is only 12. That is the kind of stuff we need to know. Now

Dr. Cohen. Sure.

Mr. JORDAN.—I understand on the 20th of November and the 23rd of December, we sent you letters requesting documents, and staff had told me earlier this week we had not received those documents. Was the stuff we requested in the document dump you gave us yesterday?

Dr. COHEN. I believe that we have been working with your staff,

prioritized -

Mr. JORDAN. That is not my question.

Dr. Cohen.—what

Mr. JORDAN. I understand we got a bunch of documents last night. I want to know if they specifically-specifically in that dump of documents we got last night, is that what we requested in the November 20 and December 23 letters to you?

Dr. Cohen. So I -

Mr. JORDAN. Because we want that information.

Dr. Cohen. Yes. So I—what were the specific documents that you were referring to, and I can let you know if they were in the document dump? Or at least I'll

Mr. JORDAN. Well, there is a number of things we haven't gotten, the corrective action plans for current operation for some of the current CO-OPs, documents and communications relating to CMS assessment and analysis of these site visits I was trying to ask you about

Dr. Cohen. Got it.

Mr. JORDAN.—so we don't have that information. We want that information, and I want to know did we get it last night or do you still need to get it to us?

Dr. Cohen. So I

Mr. JORDAN. We have also subpoenaed that, by the way.

Dr. COHEN. Yes. So they're—some of those documents are in the document dump that you got from us. Others we have offered in a confidential review. I know that you —

Mr. JORDAN. And if I could, Mr. Chairman, that is what I wanted

to get to. So why an in camera viewing only?

Dr. Cohen. So we feel strongly that we-these documents are market-sensitive, that we have a fiduciary responsibility to the CO-OPs to allow them to operate on a level playing field with their competitors. These are 12 that the State Department of Insurance used with every insurer. If we were to release -

Mr. JORDAN. But what about

Dr. Cohen.—the details of just the CO-OPs, that would put them at a disadvantage and further—make it more unlikely that

we wouldn't return taxpayer dollars.

Mr. JORDAN. But don't you also run the risk that it puts the enrollees at some kind of disadvantage that they are now maybe part of a CO-OP that is in financial trouble, and based on history and experience and the fact that half of them have already failed and many of these, I assume, of these other 12 are in big trouble, you don't think it is important for the enrollees, the actual fellow citizens, to know what is going on?

Dr. Cohen. So we share that information with the two entities that are most important to making the corrections, the CO-OPs themselves and the State Departments of Insurance, which carry

the voice of

Mr. JORDAN. But we are the Congress of the United States. We are an entity that it is kind of important to know about this as

Dr. COHEN. And we want you to know that we are doing our job, which is why we had your staff-and I know they spent hours with those documents so that you know that we are doing our job here and are being pretty tough on the CO-OPs.

Mr. JORDAN. But our job is to stand up and represent the citizens of the country who want to know that information, and frankly, from a market standpoint and an evaluation standpoint, need that

information.

Dr. Cohen. And that's why you can have access to those documents if you need more time to review them.

Mr. JORDAN. Thank you for the time.

Mr. Mulvaney. I now recognize the gentleman from Georgia, Mr. Carter, for 5 minutes.

Mr. CARTER. Thank you, Mr. Chairman. And thank you for being

here, both of you. I appreciate it.

Dr. Cohen, in 2011 the current administration projected that the CO-OP programs would result in significant losses, and that was something that they projected. And it would be losses in taxpayers' dollars. Specifically, when this rule was proposed to implement the CO-OP program they estimated that only about 65 percent of the solvency loans and only about 60 percent of the startup loans would be repaid. You had to be aware of this. Were you aware of that?

Dr. COHEN. So I think you're talking about the repayment time, not the default rate, which is often called the default rate. So it's really about will they pay back in the time allotted, but we knew that the CO-OPs would likely need more time and have it to be

Mr. Carter. All right. Well, you want to limit it to the time. What about the time? How many of them have paid back now?

Dr. Cohen. So they're—as any loan, as you know, they're paying back their loan. For those that have closed, we are working through a process now to recover those funds.

Mr. Carter. You were aware of this. You said you were aware of this because it was part of the proposed rule to implement it. Did you set up any kind of criteria whereas you would assess the financial viability of these CO-OPs?

Dr. Cohen. Absolutely. The terms of the loan agreement themselves have quite an extensive amount of oversight process laid out for it. In addition, we have gone over and beyond that knowing that these

Mr. Carter. When did you do this? When did you —

Dr. Cohen. Doing

Mr. CARTER. When did you set up this criteria?

Dr. Cohen. The criteria—when the loans were let before 2014.

Mr. Carter. You set it up during that time? Dr. Cohen. Yes.

Mr. Carter. It was my understanding that it was developed after the recommendation of the HHS IG.

Dr. COHEN. We certainly went beyond the terms of the loan agreement to do further oversight, and yes, appreciated the OIG work saying that—to do enhanced oversight, which we have. I don't think anyone can fault us for—in terms of how many folks are on corrective action plans or enhanced oversight. We're visiting these folks. We're calling them. We're being pretty hard on them frankly.

Mr. CARTER. The inspector general of HHS, he found that all but one, all but one of the CO-OPs had lost money in 2014. CMS was aware of this, that almost all of the CO-OPs incurred losses in 2014. If you were aware of that and some were already shutting down, why did you continue to award the taxpayer dollars in loans?

Dr. Cohen. So you need it to

Mr. CARTER. I mean, if you know you are on a sinking ship, you know, you have got to-when I first entered the Georgia Legislature, one of the things they told us, when you are in a hole, stop digging. And we are in a hole here. Why are we still digging?

Dr. Cohen. Now, we share your concerns here. These programs certainly have challenges, which is why we've been doing the extensive and aggressive oversight that we have. What I would say is that when we are looking at what the CO-OP is doing, it's a totality. It's what is their business strategy -

Mr. Carter. Well, but when you talk about —

Dr. Cohen.—what is their -

Mr. Carter.—totality, though, 12 of the 23 CO–OPs have already closed, 12 of the  $\overline{\phantom{a}}$ 

Dr. Cohen. Yes.

Mr. CARTER.—23. Anybody in business would pull the plug on that immediately, but you continue it. Why is that?

Dr. COHEN. Well, we look at each individual situation, as my colleggie ——

Mr. Carter. And I hope you look at each individual, and I don't mean to interrupt, but with 12 out of 23, come on.

Dr. Cohen. Right. And that's why we're working hard to make sure the other ones are as strong as they can be, but they are small businesses. As you know, small businesses struggle at the beginning, particularly —

Mr. Carter. I know small businesses—trust me. I own a small

business. I struggled at the beginning.

Dr. COHEN. Yes, it's tough.

Mr. CARTER. But I didn't fail. I continued on.

Dr. Cohen. And that's what we're trying to do with the CO–OPs that are ---

Mr. Carter. Yes, but I ——

Dr. Cohen.—currently in business ——

Mr. CARTER.—met my obligations. I didn't close. I mean, if you have got 12 out of 23 closing, it would appear to me that you have got to say, hey, wait a minute, something is going on here. This just isn't working.

And we are talking about taxpayers' dollars, again, that we in Congress, we are responsible for this. We are the ones who ——

Dr. COHEN. Absolutely.

Mr. CARTER.—have to answer for this. So I am asking you if you have got 12 out of 23 that are closing, why are we continuing this?

Dr. Cohen. And the original reason for the CO-OP program was to provide an additional choice and competition, so where it is working, where they are viable, we want to support them ——

Mr. CARTER. Where are they working?

Dr. Cohen. In the 11 places where they're existing.

Mr. Carter. That is not—are they working in those 11 places?

Dr. Cohen. Well ——

Mr. CARTER. Just because they haven't gone out of business

doesn't necessarily mean they are working.

Dr. Cohen. We agree with you there. They certainly have some challenges, and so we need to stay on top of them, and that's what we're doing.

Mr. Carter. What about the \$1.2 billion in loans —

Dr. Cohen. That's what ——

Mr. Carter.—that were awarded to the 12 closed CO-OPs?

Dr. Cohen. Yes, that's the process we're working through right now—

Mr. Carter. What about it? Where is the \$1.2 billion?

Dr. Cohen. Well, some of that obviously went to pay for actual medical care for the consumers that were enrolled in those —

Mr. CARTER. Are we going to get it back?

Dr. COHEN. We are working to get every penny we can. Mr. CARTER. Are we going to get the \$1.2 billion back?

Dr. Cohen. We're going to use every tool at our disposal —

Mr. Carter. Are we, yes or no? Are we ——

Dr. Cohen. So obviously some of that money was spent on actual medical care for consumers, so —

Mr. CARTER. We are not going to get it back, are we? Dr. COHEN. We're going to try to get every dollar we

Mr. Carter. And do you think we will get half of it back? Do you think we will get —

Dr. Cohen. I —

Mr. CARTER.—a quarter of it back?

Dr. Cohen. I can't say —

Mr. CARTER. Do you have any idea how much of it we will get back?

Dr. Cohen. I can't say at this point.

Mr. Carter. Twelve out of 23.

Dr. COHEN. Understood. That's right. Mr. CARTER. Thank you, Mr. Speaker.

Dr. COHEN. Thank you.

Mr. Mulvaney. I recognize the gentleman from Pennsylvania, Mr. Cartwright, for an additional 5 minutes.

Mr. CARTWRIGHT. Thank you, Mr. Chairman.

And, Mr. Chairman, the last thing I want to do is hold myself out as the adult in the room, but we have ——

Mr. MULVANEY. Certainly not. Can we put it to a vote?

Mr. CARTWRIGHT. We are not going to put that to a vote, Mr.

Chairman. That is right.

But we have had a discussion about the release of confidential information, and I am concerned about that. I would like to reiterate my concern that the committee not release any confidential regulatory information that we have obtained about the remaining CO–OPs in a way that could mislead consumers about the insurance companies in their States. I think empowering consumers through transparency is a good thing, and you don't hear many voices louder than mine on the issue of transparency.

But that is not what we would be accomplishing by releasing this information. In reality, it would be misleading selectively to release information about currently operating CO–OPs that have been placed under corrective actions plans or enhanced oversight plans

by CMS.

Mr. Redmer, I see you nodding your head. And isn't it true that State regulators like yourself frequently do enter into consent orders with health insurance companies to address issues raised by consumer complaints like billing or claims practices, right?

Mr. Redmer. Absolutely, we do, yes.

Mr. CARTWRIGHT. But it is also my understanding that this type of regulatory action is typically kept confidential until a resolution has been reached?

Mr. Redmer. Correct.

Mr. CARTWRIGHT. Okay. And in fact, yesterday, the committee received a letter from the National Association of Insurance Commissioners. You remember that, I take it, Commissioner?

Mr. REDMER. Yes, sir.

Mr. CARTWRIGHT. And here is what the NAIC had to say, and I would like to ask unanimous consent to enter that letter into the record, Mr. Chairman.

Mr. Mulvaney. Without objection,

Mr. CARTWRIGHT. They said this: "For the sake of the 11 CO-OPs that continue to operate in our States, we encourage all congressional members and their staff to heed the confidential nature of some of the financial information that may come to your attention. Divulging information on State actions or the financial status of any plan that is not public could threaten the long-term success of these plans.'

Now, Commissioner Redmer, as a State insurance commissioner, do you think it would be harmful to release information about any

CAP or EOP for the remaining CO-OPs?

Mr. Redmer. I do. It's easy for a competitor to take a nugget of information and throw it out there out of context and create an un-

favorable, adverse effect for that organization.

Mr. CARTWRIGHT. And not to put too fine a point on it, I really don't think I am the only adult in the room, and I look forward to working with the folks across the aisle to be responsible with that information.

And I also want to follow up on the question of recouping funds. Dr. Cohen, roughly \$2.4 billion had been loaned to all the CO-OPs, is that correct?

Dr. COHEN. That's right.

Mr. Cartwright. But only half of that amount has gone to CO-OPs that have wound down. Am I correct in that?

Dr. COHEN. That's right. That's right.

Mr. CARTWRIGHT. Okay. And then the remainder of the loan funding, money that had been lent to the CO-OPs that are still in operation, is still being serviced, right?

Dr. COHEN. Sorry, repeat that?
Mr. CARTWRIGHT. They are making payments on the ——

Dr. COHEN. That's right. Mr. Cartwright.—loans? Dr. COHEN. That's right.

Mr. CARTWRIGHT. And, Dr. Cohen, what is CMS doing to recoup

loan funds from the CO-OPs that have in fact wound down?

Dr. Cohen. To recoup the funding for the CO-OPs that have wound down, we're going through a process right now. We know about our obligations to the taxpayer. The recoupment process is dictated by the terms of the loan agreement, as well as State and Federal law. The Department of Justice leads that process on our behalf.

Mr. CARTWRIGHT. Okay. Now, a fellow named John Morrison, who was a former president of the National Alliance of State Health CO-Ops, testified before Congress on this issue in November, and you are aware of that, I take it?

Dr. Cohen. Yes.

Mr. Cartwright. Now, he suggested that consumers in States with CO-OPs have already saved more money through lower premiums than the total cost of the entire CO-OP program itself. He also noted that these savings are passed along to the Federal Government, the taxpayers, in the form of lower subsidy costs. Now, Dr. Cohen, what do you make of that statement?

Dr. COHEN. So I don't know the data, but again, we agree with the concept.

Mr. Cartwright. Okay. And, Commissioner Redmer, what is your perspective on the capacity of CO-OPs to save consumers and

the Federal Government money?

Mr. REDMER. I believe that competition is a good thing, and, again, to go back to my earlier statement, the broader conversation is not just about CO-OPs. We've got small, new, emerging, privately owned carriers all around the country that could be adversely affected specifically because of the risk adjustment formula that aren't using any taxpayer dollars at all.

Mr. Cartwright. Well, I thank both of you for your testimony

here today.

Dr. COHEN. Thank you.

Mr. MULVANEY. And I am sorry to cut the gentleman —

Mr. Cartwright. I yield back.

Mr. MULVANEY.—off, but we have to go vote on the Cartwright of Pennsylvania amendment, whatever that is. We now recognize the chairman of the subcommittee, Mr. Jordan, for 5 minutes for the final questions.

Mr. JORDAN. And we don't want to miss an opportunity to vote against that wonderful amendment, I am sure. I am kidding you.

So, Dr. Cohen, of the 12 left

Dr. Cohen. Yes.

Mr. JORDAN.—how many of those are under corrective action plan, enhanced oversight?

Dr. Cohen. Eight.

Mr. JORDAN. Eight. So your position is that certain information can't get out because it could somehow jeopardize the ability of CO-OPs to survive. I just fail to see that. Twenty-three started, 12 have already collapsed. Of the 12 remaining, eight are under some corrective action plan, and somehow, if we get information about enrollment projections and profitability, that is going to ruin their reputation? I mean really?

Dr. COHEN. Well, again, I'm happy to share that information

with you, Chairman

Mr. JORDAN. Well, no, let me ask -Dr. COHEN.—out of a public setting.

Mr. JORDAN.—somehow if consumers get that information, that is somehow going to hurt them?

Dr. COHEN. Well

Mr. JORDAN. It seems to me that is the kind of information they would need to know so they will say, look, this thing is going down. I need to run as far away from this-I need to get insured somewhere else.

Dr. Cohen. And that's really the job of the State Department of Insurance to be the ones to certify whether or not the insurer has

the ability to sell a product on the Mr. JORDAN. What are these CAPs? What is in this corrective action plan? What is that? Is that a letter to them saying, hey, things

don't look so good, you got to change some things? What is that? Dr. COHEN. Yes, it's a pretty detailed plan saying we've identified these particular

Mr. JORDAN. Detailed in what area? Give me some examples of things you require these CO-OPs to do to change -

Dr. COHEN. Sure.

Mr. JORDAN.—to correct the ——

Dr. Cohen. We identify operational issues that they had whether it's in their management team, how they're doing vendor oversight, what they're doing with their provider networks, how they're pricing their product, their business strategy. It could be a range of issues.

Mr. JORDAN. So it is our understanding that the very things you just outlined that you put in this corrective action plan for the eight of the 12 who are still out there, the 12 who collapsed had the exact same plan sent to them.

Dr. COHEN. No, that's—they were all tailored individually to their situation. Some of them, we couldn't—we realized that we didn't—couldn't identify a correctible issue and that, frankly, we

went straight to a wind-down process with some of them.

Mr. JORDAN. Is it your opinion that—and then I am going to yield to the chairman for the remainder of my time. Is it your opinion that the three who are currently still operating and not—or, excuse me, it would be the four that are still operating who are not under a corrective action plan, are they going to be around at the end of the year?

Dr. Cohen. So again, too early to tell in the year. We're just

looking at their Q4 data from the end of last year —

Mr. JORDAN. Can you guarantee us that those four who aren't under a corrective action plan, so of the 12 surviving, the ——

Dr. Cohen. Yes.

Mr. JORDAN.—four who aren't under a CAP or enhanced oversight, can you guarantee us that they are going to be around?

Dr. COHEN. So we will continue to do our oversight of them in a very strict way, and as new information comes up, if we need to, we will put more folks on corrective action plans —

Mr. JORDAN. So it is likely that those four may go on a corrective action plan, too?

Dr. COHEN. It's too early for me to know. I think that's the work ahead of us.

Mr. JORDAN. I yield to the chairman.

Mr. MULVANEY. Dr. Cohen, are you making any contingency plans for any of the currently operating CO–OPs to shut down during 2016?

Dr. Cohen. I think a lot of our oversight work is in and of itself the planning that we're doing, trying to identify issues with them

Mr. MULVANEY. Does it bother you that I think several—I think it is at least four, maybe as many as seven of the CO–OPs that have already gone out of business or are winding down never went on a CAP to begin with?

Dr. COHEN. Again, if we identify something we think is correctible, reversible, addressable, we put them on a CAP. Others, we recognize that that wouldn't ——

Mr. MULVANEY. Are you taking any specific actions to prepare for the possible shutdown of any of the currently operating CO–OPs?

Dr. COHEN. I don't know exactly what you're referring to, but I think the work that we're doing on the oversight work is that contingency planning.

 $Mr.\ Mulvaney.$  Have you ever corrected, reversed, or fixed anything under any of the CAPs?

Dr. Cohen. So these are things that are structural to the program. As I was mentioning, some of the things, whether it's ——

Mr. MULVANEY. I understand what they are. I am asking you if you have fixed them.

Dr. Cohen. So it—they don't fix overnight. These are things that take many months—

Mr. MULVANEY. And you have had many months ——

Dr. Cohen.—to see those corrected ——

Mr. Mulvaney.—you have had some of them under CAPs for many months. Have you made any improvements that we ——

Dr. Cohen. Yes, I think some of them have certainly made some improvements in their vendor management and their—in the way that they're looking at their operations and the way that they're looking at their provider networks, yes.

Mr. Mulvaney. Several times today you have mentioned that you take a seriously hard look at the CO-OPs, that you aggressively work on oversight, you have strict oversight. Do you believe that you are entitled to see anything from the CO-OPs that this committee and this Congress is not entitled to see?

Dr. Cohen. Again, we are happy to share with you any of the information —

Mr. MULVANEY. I understand that, and I appreciate that. Do you believe that you are entitled to see anything that we are not?

Dr. Cohen. I—no, again, we're happy to share with you the information that we can —

Mr. Mulvaney. Mr. Redmer, the last question.

Mr. REDMER. Sure.

Mr. Mulvaney. I understand the concern about going public with the information. Evergreen chose to go public in November of 2015 to a committee of this Congress that it was under a CAP, didn't it?

Mr. Redmer. They went to go public—I'm sorry, say again.

Mr. MULVANEY. They made public statements in Congress to one of the committee—of this body that they were under a CAP?

Mr. REDMER. I don't know whether they did or not but —

Mr. MULVANEY. I can assure they did.

Mr. Redmer. But I can tell you discussing the CAP is not a concern for me as a regulator. What's of concern to me is disclosing confidential proprietary information that could be used against them in the marketplace by just passing out nuggets that might be out of context.

Mr. MULVANEY. Fair enough. I thank both of you very much.

Mr. REDMER. Thank you.

Mr. MULVANEY. And I am sorry to wrap this up very quickly, but as you can see, we have got 7 minutes to run across the street. We are going to hold the record open for 5 days for any member who wants to submit a written statement. We thank the witnesses.

There being no further business and without objection, we will

stand adjourned. Thank you very much.

Mr. REDMER. Thank you.

Dr. COHEN. Thank you.

[Whereupon, at 3:24 p.m., the subcommittee was adjourned.]

## **APPENDIX**

MATERIAL SUBMITTED FOR THE HEARING RECORD



February 24, 2016

The Honorable Jason Chaffetz Chair Oversight & Government Reform Committee U.S. House of Representatives Washington, DC 20515 The Honorable Elijah Cummings Ranking Member Oversight & Government Reform Committee U.S. House of Representatives Washington, DC 20515

Dear Mr. Chair and Mr. Ranking Member:

We write to you on behalf of the National Association of Insurance Commissioners (NAIC), which represents the insurance regulators in the fifty states, Washington, DC, and the five U.S. territories. As the committee prepares for its hearing on the Consumer Oriented and Operated Plans (CO-OPs) created under the Affordable Care Act (ACA), we would like to add the following insights.

Each CO-OP is unique and each faces different challenges in its market. The specific factors that led to the failure of a CO-OP vary. Some of the contributing causes state regulators have identified are: they were new companies taking on unknown risk pools and operating in a very competitive marketplace; their enrollment was higher or lower than expected in some states; and, some had operational challenges. Another key factor was the management of the programs intended to help them: the risk corridor and risk adjustment programs.

The risk corridor program was, and continues to be, of particular concern to CO-OPs and state regulators. First, Congress decided to significantly change the rules of the program after CO-OPs and other carriers had already set their rates, requiring it to be budget neutral each year. This cut funding for carriers by \$2.5 billion in 2014 alone. In addition, actions by the Centers for Medicare and Medicald Services (CMS) to downplay the shortfall and delay the final announcement further damaged the financial health of some CO-OPs.

The risk adjustment formula is also of great concern to state regulators. The current formula used by the federal government has proven to place newer carriers at a distinct disadvantage. The NAIC has urged CMS to review the formula and work with carriers and state regulators to make adjustments for 2015 and 2016 to ensure it is providing appropriate protection for all carriers, and not wait until 2017 or 2018 to enact reforms.

State regulators have also requested flexibility to set enrollment caps for Qualified Health Plans – both CO-OPs and non-CO-OPs – prior to open enrollment when they determine that the plan would be significantly impacted if it took on enrollment beyond its financial capabilities. To date, the federal Exchange has rebuffed these requests, blaming technical issues. Controlling enrollment can be an important tool in preserving the solvency of carriers and this tool should not be taken away due to technical issues.

The Honorable Jason Chaffetz The Honorable Elijah Cummings February 24, 2016 Page Two

Finally, for the sake of the eleven CO-OPs that continue to operate in our states, we encourage all congressional members and their staff to heed the confidential nature of some of the financial information that may come to your attention. Divulging information on state actions or the financial status of any plan that is not public could threaten the long-term success of these plans.

Thank you for your consideration. We are available to answer any questions you or other members of the Committee may have about these or other issues impacting CO-OPs or the health insurance market as a whole.

Sincerely,

John M. Huff NAIC President

Director

Missouri Department of Insurance,

Financial Institutions and Professional Registration

Ted Nickel NAIC President-Elect

Commissioner
Wisconsin Office of the
Insurance Commissioner

Juli Mi, M. Peak

Julie Mix McPeak NAIC Vice President

Commissioner

Tennessee Department of Commerce & Insurance

Eric A. Cioppa

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Maine Bureau of Insurance

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