THE STATE OF OBAMACARE'S CO-OP PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTEENTH CONGRESS

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CONTENTS

Page

Advisory of November 3, 2015 announcing the hearing 2

WITNESS

Mandy Cohen, Chief Operating Officer and Chief of Staff, Centers for Medicare and Medicaid Services 6

MEMBER QUESTIONS FOR THE RECORD

Adrian Smith 59

THE STATE OF OBAMACARE'S CO–OP PROGRAM

TUESDAY, NOVEMBER 3, 2015

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to notice, at 2:37 p.m., in Room 1100, Longworth House Office Building, the Honorable Kevin Brady, [chairman of the subcommittee] presiding.

[The advisory announcing the hearing follows:]

Chairman Brady Announces Hearing on the State of Obamacare's CO-OP Program

Congressman Kevin Brady (R-TX), Chairman of the Subcommittee on Health, today announced that the Subcommittee will hold a hearing on the status of the Consumer Operated and Oriented Plan (CO-OP) Program, established under the President's health care law. **The hearing will take place on Tuesday, November 3, 2015, in Room 1100 of the Longworth House Office Building, beginning at 2:00 P.M.**

Oral testimony at this hearing will be from the invited witness only. However, any individual or organization may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

Details for Submission of Written Comments:
Please Note: Any person(s) and/or organization(s) wishing to submit written comments for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, http://waysandmeans.house.gov, select "Hearings." Select the hearing for which you would like to make a submission, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Tuesday, November 17, 2015**. For questions, or if you encounter technical problems, please call (202) 225-3625 or (202) 225-2610.

Formatting Requirements:
The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.
1. All submissions and supplementary materials must be submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.
2. All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax

numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.
3. Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-226-3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available at http://www.waysandmeans.house.gov/.

Chairman BRADY. Good afternoon, everyone. First I would like to thank our witness, Dr. Mandy Cohen, of the Centers for Medicare and Medicaid Services for coming today. We appreciate your time and look forward to hearing your testimony.

We are here to discuss the Consumer Operated and Oriented Plan Program known as CO–OP. Supporters of this program argued it would increase competition in individual and small group health insurance markets. That very premise should have been cause for alarm. Only in Washington would a group of bureaucrats think they know how best to micromanage competition instead of letting consumers and markets do what they do best.

Well, what could go wrong? Well, it turns out quite a lot. First, CMS essentially allowed anyone to participate in the program regardless if he or she had any prior experience running an insurance company.

And for financing, Democrats turned predictably to the American taxpayer to provide two types of loans: start-up loans and solvency loans, both with incredibly favorable loan terms.

As our newly-elected Speaker said last week, "What matters are results." So let us look at the results of the CO–OP Program to date: $2.4 billion in taxpayer funds have gone out the door; 11 CO–OPs out of 23 have failed; and thousands of Americas—and this is where there is bipartisan concern—have found their health care security thrown out or in limbo.

I am interested to hear Dr. Cohen's position, but I suspect we are not getting this money back. What is most surprising, I think, is the Administration and everyone else knew this was coming. Their own credit estimates project massive losses for the program, and no matter the capital start-up funding or the backstops, a model that is wrong is not going to succeed as much as people want it to.

I am not interested in blame. I am interested in understanding how many of these programs are headed to failure, discussing where do we go from here, and figuring how we're going to bring some stability to those families that have been affected.

The hard-earned tax dollars collected from working Americans sitting at Treasury right now are not venture capital. You know, bureaucrats in Washington or wherever do not have the expertise to institute top-down programs in the name of competition.

We have got serious problems with provider participation in some areas. For example, Blue Cross Blue Shield of Texas just shut down a plan and narrowed the network in another, a major impact on our patients.

But artificially trying to inject competition into a market by backing what I think were shoddily designed start-ups is not a fix.

For true choice and competition, we need to empower patients. We need to eliminate the mandates that eliminate or reduce choice. We need to increase transparency so patients can be informed shoppers. On that we can all agree.

Today, we are going to learn more about this failed CO–OP Program. I look forward to a robust conversation, and I hope we can use the lessons from today to help us identify better ways to protect American tax dollars going forward and ensure greater choice, greater competition, greater quality and access for beneficiaries and their families.

Before I recognize the Ranking Member, Dr. McDermott, for an opening statement, I ask unanimous consent that all members' written statements be included in the record.

Without objection, so ordered.

Chairman BRADY. I now recognize our Ranking Member, Dr. McDermott, for the opening statement.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

The Republicans were opposed to a public option. So the CO–OPs were an alternative that was put into this bill. For the past five years Republican colleagues have systematically and deliberately sabotaged the implementation of the Affordable Care Act through phony hearings and frivolous lawsuits and meaningless repeal vote, draconian funding cuts, and in a nationwide smear campaign they have done everything in their power to undermine this landmark law.

The yearly challenges facing the CO–OPs are just the most recent consequence of this destructive Republican agenda.

The CO–OPs played an important role in providing competition. They are community based, non-profit health plans that, first and foremost, exist to serve consumers. If Congress gives them the support they need to get off the ground, they will provide the American people with more choices and help the for-profit insurers keep honest.

But my Republican colleagues have shown they have no interest in making this happen. Instead they have weakened and undermined the CO–OPs at every turn, and now they point the finger at the Administration when they struggle. In 2013, the Republican Congress slashed funding for loans and grants to CO–OPs by nearly two-thirds. These cuts have devastated CO–OPs across the country and prevented CMS from approving dozens of new applications.

Moreover, my Republican colleagues have sabotaged the risk mitigation programs designed to provide the financial stability to insurers, including CO–OPs. In the CR omnibus legislation passed at the end of last year, the Republicans inserted a rider that blocked discretionary money from being shifted into the ACA Risk Corridor Program. As a result, that program has been badly underfunded and insurers across the country have received only one-eighth of what they expected.

Many of the fledgling CO–OPs simply do not have the capital to absorb this unpredictability which contributes to the failures we have been seeing. It is not a problem with CO–OPs. It is a direct consequence of Republican sabotage.

When my colleagues continue to brazenly attack the Affordable Care Act, they refuse to put forward any constructive ideas. This is particularly ironic when it comes to risk management, risk mitigation because based on their past behavior, they should know better.

When the Congress enacted Medicare Part D, we created several risk mitigation programs that are very similar to the ones in the ACA. My Republican colleagues have strongly supported these measures for more than a decade, even longer than many experts believe was necessary to get Part D up and running. It is really a subsidy of the pharma companies.

The result has been a stable program and a stronger market for the Part D plans. In other words, Republicans enthusiastically support risk mitigation, but not when it is part of the Affordable Care Act.

Rather than play Monday morning quarterbacking and blaming everybody but the people who control the purse strings, we should be talking about things we can do to actually strengthen competition. That conversation should examine how we can make the CO–OP Program stronger, and there are some changes we need to consider.

Despite being brand new companies with no existing customer base, the CO–OPs are prohibited from using Federal start-up money on marketing. That makes it nearly impossible for them to compete against some of the most powerful corporations and advertising budgets in the world. We need to fix this and let the CO–OPs operate on a level playing field with the for-profit insurance industry.

And an honest conversation about competition must also include a discussion of creating a public option to compete with private insurers on the exchange. This would place a meaningful check on the insurance industry, give consumers more choices, and reduce the deficit by more than $100 billion.

We spent $480 billion on paperwork last year in the private industry, but do not expect to hear anything like that from my Republican colleagues this afternoon. Instead we will hear more of the same: complaints about problems they have created through their own sabotage and nothing constructive about how to make the system work better.

I yield back the balance of my time.

Chairman BRADY. Thank you, Dr. McDermott.

Just for the members' information, I know we started late today because of votes in the House. I know that Dr. Cohen does not have unlimited time.

We appreciate you being here today. So we are going to be a little tight on the timing and the questions today. Dr. Cohen, you are recognized for five minutes, and again, welcome.

STATEMENT OF DR. MANDY COHEN, CHIEF OPERATING OFFICER AND CHIEF OF STAFF, CENTERS FOR MEDICARE AND MEDICAID SERVICES

Dr. COHEN. Thank you very much for having me here today, Chairman Brady, Ranking Member McDermott, Members of the Subcommittee. I appreciate the opportunity to talk about the Consumer Operated and Oriented Plan Program, or the CO–OP Program.

CMS takes its commitment to CO–OP consumers and taxpayers very seriously. A priority is to make sure that consumers have access to quality, affordable coverage. In the year since the passage of the Affordable Care Act, we have seen increased competition and more choices for consumers.

In today's dynamic market, consumers can choose from, on average, 50 plans and five issuers for 2016 coverage. Nearly nine out of ten returning consumers will have three or more issuers to choose from, which research has shown typically intensifies price competition in the market.

New entrants to any market, especially the insurance market, can face pressures, particularly in the early stages. CO–OPs enter the health insurance market with a number of challenges, including building a new provider network, no previous claims experience on which to base pricing, and competition from large, experienced issuers, as well as uncertainty that accompanies the early years of the health insurance marketplace.

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

In addition, Congress has made a number of substantial rescissions to the initial $6 billion in funding for the CO–OPs, impacting the program's operation and available funding.

In the face of multiple pressures, it is not surprising that some new entrants have struggled to succeed. CMS plays a dual role to the CO–OP Program, providing both oversight and support. CMS works to give CO–OPs tools to succeed, including sharing best practices among CO–OPs and looking for additional regulatory flexibilities.

At the request of the CO–OPs, CMS has approved conversion of surplus notes, and we have provided and approved the infusion of outside capital and additional flexibilities that the legal and regulatory framework of the CO–OP Program allows.

CMS also plays an important oversight role. CMS along with State Departments of Insurance, which serve as a primary regulator of the insurance in States, works to ensure that CO–OPs are well run and financially sound.

CMS has implemented the CO–OP Program as required by statute and with available funds evaluating applications, monitoring financial performance, and conducting oversight. All CO–OPs are subject to standardized, ongoing program oversight activities that include calls to monitor goals and challenges, periodic on-site visits,

performance and financial auditing, reporting obligations, and a host of additional measures employed as necessary on a case specific basis such that the evaluation of CO–OPs' sustainability.

CMS increased the financial and data reporting requirements for CO–OPs, requiring them to provide quarterly statements that they are in compliance with all relevant State licensure requirements. If the CO–OPs have experienced any compliance issues with State regulators, the CO–OP is required to describe the steps being taken to resolve those issues.

Financial data collection has helped CMS to identify CO–OPs with financial issues and gives CMS the opportunity work with State insurance regulators to help correct those issues that are identified.

As part of our oversight efforts, CMS has placed some CO–OPs on enhanced oversight schedules or corrective action plans.

Despite the support and oversight, some of these new entrants to the insurance market have struggled to succeed. When States and CMS determine that a CO–OP should wind down, our first responsibility is to make sure current policy holders are able to retain coverage through the end of the year. CMS' priority is to make sure that the consumers have access to quality, affordable coverage. We are working with local officials to do everything possible to make sure consumers stay covered and retain access to high quality choices and issuers.

Like other consumers, affected CO–OP enrollees are able to shop for 2016 coverage on the marketplace right now. In 2016, nearly eight in ten returning marketplace consumers will be able to buy a plan with premiums for less than $10 a month after tax credits.

We continue to encourage those consumers already enrolled in marketplace coverage to come back to the marketplace, update their information, compare their options, and make sure they are enrolled in the plan that best meets their needs.

Since the enactment of the Affordable Care Act, CMS has worked to increase access to quality, affordable coverage through the marketplace, while being responsible stewards of taxpayer dollars.

The CO–OP Program was designed to give consumers more choice, promote competition, and improve quality of health insurance market as it has done so in a number of States. CMS will continue to work closely with the CO–OPs and State Departments of Insurance to provide the best outcome for consumers.

We appreciate the subcommittee's interest in this topic, and I am happy to answer your questions.

Chairman BRADY. Thank you, Dr. Cohen.

I think given the number of failures where we have seen it and the predictions going forward, it is pretty clear to me the history of the CO–OPs is one of the, I think, poor decision making and failed execution.

I would like to start by asking about the action CMS is taking now with the remaining CO–OPs. We all know how insurance works. Insurers have to collect enough in premiums to cover what they expect to pay out in claims. That is why having well-funded reserves are so crucial. Insurance is a delicate balance between risk and capital.

So if an insurer takes on too much risk and does not have enough capital, well, then they will quickly become insolvent. So as part of the monitoring of the insurance market regulators, as you made the point, keep a sharp eye on insurers' ratio of risk-based capital.

It is my understanding the CMS required the CO–OPs to have higher risk-based capital reserve than most States generally require of the insurers they monitor, which seems to me to be a good thing; is that correct, Dr. Cohen?

Dr. COHEN. That is correct. As you know, we have wanted to make sure that we are being good stewards——

Chairman BRADY. Sure.

Dr. COHEN [continuing]. Of taxpayer dollars and wanting to be more conservative in these first few years.

Chairman BRADY. You know, I suspect CMS sets the rate of risk-based capital standard for CO–OPs at 500 percent because they knew new entrants were riskier than the other insurers they were competing with, and they institutionalized financial discipline among the start-ups. Again, this makes sense to me. Is that a fair characterization?

Dr. COHEN. That is accurate.

Chairman BRADY. Okay. Regulators use the risk-based capital measure as an early warning sign of trouble, as a sign an insurer is in need of monitoring. It is an important test to ensure plans are appropriately capitalized for the risk they have taken on. This helps ensure the right protections are in place for those who purchase the plans from the CO–OPs and for the tax dollars backing the CO–OP experiment.

And this is why my question really is concerned about the start-up conversion process. Media reports indicate CMS is allowing CO–OPs to move their start-up loans, and let me underscore these are loans, from the liability side of the ledger where they belong to the equity side of the ledger.

So, Dr. Cohen, three fairly clear questions, I think, can be answered with a yes or no. All things being equal, without any material changes to the financial situation, a CO–OP that undergoes a start-up conversion gets a boost of capital on their books; is that right? On their books.

Dr. COHEN. So yes, and it's an accounting mechanism to create a liability into an asset, yes.

Chairman BRADY. And all things being equal, again, without any change in their financial situation, the CO–OP who gets a start-up conversion could go from failing your risk-based capital requirement to passing it; is that correct, because it increases the equity?

Dr. COHEN. The idea, again, yes, is to improve its capital position.

Chairman BRADY. And all things being equal, again, apples to apples, the CO–OP that gets a start-up conversion could go from being in a position to undergo monitoring and enhanced oversight to one not be required to do so. Again, on paper the equity looks stronger.

Dr. COHEN. Yes, that is accurate, and that is why we were careful to make sure we did this in coordination with the State Depart-

ments of Insurance. I think we share the concerns that you are articulating, and that is why we wanted to make sure the State regulators, who are the primary regulators in this space, were supportive of this conversion.

And so we would evaluate each one of these individually. They were based on the particular circumstances of that individual CO–OP. They had to request that from us, and we did not move forward unless the State Department of Insurance also thought that it was a wise move to move forward as well.

Chairman BRADY. Well, see, I would respectfully disagree. I do not understand why CMS is allowing this. Why put a test in place if you are not going to follow it?

We just came through a financial crisis where reserves on the books really did not prove to be reserves, and so when you allow CO–OPs to make changes on paper to make then appear healthier than they really are not, you are undermining your own oversight measure.

And given the number of CO–OPs that have failed and what looks like very shaky CO–OPs going forward, can you explain the logic behind this? Because they are not financially healthier or more sound. They just took the loan they got and made it appear to be capital and equity.

Dr. COHEN. Right. Chairman, I appreciate the question. There are questions we made sure to ask ourselves, some tough questions, about is this the right thing for any one of these individual CO–OPs to make sure that improving their capital position with this conversion was the right thing, to make sure, again, our primary responsibility and our primary job is to make sure that the consumers of any one of these CO–OPs are protected. That is why each one of these went under individual scrutiny before we would make that decision, and we did it in coordination with the State Departments of Insurance.

And, again, there are a number of factors that went into that, and this is only one small slice of what would be their capitalized assets, but again, that is why we looked at each individual situation to understand whether or not it made sense for that CO–OP, that in coordination with the State Department of Insurance.

Chairman BRADY. I will just say I think you need to reverse it. This does not make sense. It does not give a true picture of the CO–OPs. Those who do not have the adequate reserves ought to be getting extremely high oversight and monitoring because these are patients' lives on the line.

The destruction has already been large in States, and the Members on this dais who have had families, patients lose their care, and so going forward it seems to me we ought to always be erring on the side of accurate, honest bookkeeping for these CO–OPs.

And, again, thank you for being here today.

Dr. COHEN. Thank you, Chairman.

[The prepared statement of Dr. Cohen follows:]

STATEMENT OF

MANDY COHEN, M.D., MPH

CHIEF OPERATING OFFICER AND CHIEF OF STAFF

CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

THE CONSUMER OPERATED AND ORIENTED PLAN (CO-OP) PROGRAM

BEFORE THE

UNITED STATES HOUSE COMMITTEE ON WAYS & MEANS

SUBCOMMITTEE ON HEALTH

NOVEMBER 3, 2015

The Consumer Operated and Oriented Plan (CO-OP) Program
U.S. House Committee on Ways & Means, Subcommittee on Health
November 3, 2015

Chairman Brady, Ranking Member McDermott, 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) takes its commitment to both the CO-OP consumers and the American taxpayers seriously and we are working hard to help all Americans access high quality, affordable health insurance coverage.

CMS' priority is to make sure that Marketplace customers have access to quality, affordable coverage through the Marketplaces. In the years since the passage of the Affordable Care Act, we have seen increased competition and more choices for consumers; in 2016, nine out of ten returning customers will be able to choose from three or more issuers.[1] The CO-OPs have played an important role in that process, particularly in the early years of the Affordable Care Act. As we begin the third Marketplace Open Enrollment, CMS is eager to build on the success we have achieved in reducing the number of uninsured Americans - as several of the Affordable Care Act's coverage provisions have taken effect, an estimated 17.6 million Americans gained coverage.[2] We expect 10 million individuals to be enrolled in coverage through the Health Insurance Marketplaces and paying their premiums – so-called effectuated coverage – at the close of 2016.[3]

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 competition, and improve quality in the health insurance market. To this end, the law provided funding to eligible entities to help establish and maintain these new plans. Any start-up faces the inherent risks of building a business from the ground up. The funding provided by the law was intended to provide needed support while these non-profit insurance companies enter this difficult market for new businesses. In implementing the CO-OP program as required by statute

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[1] http://aspe.hhs.gov/sites/default/files/pdf/135461/2016%20Marketplace%20Premium%20Landscape%20Issue%20Brief%2010-30-15%20FINAL.pdf
[2] http://aspe.hhs.gov/health-insurance-coverage-and-affordable-care-act-aspe-issue-brief-september-2015
[3] http://www.hhs.gov/about/news/2015/10/15/10-million-people-expected-have-marketplace-coverage-end-2016.html

and with the funds available, CMS has been engaged in evaluating applications, monitoring financial performance, conducting oversight, and supporting state departments of insurance, which serve as the primary regulator of insurance issuers in the states.

CMS Implementation and Oversight of the CO-OP Program

The framework for implementing the CO-OP Program was based on the recommendations submitted by a Federal Advisory Committee appointed by the Government Accountability Office (GAO) under section 1322 of the Affordable Care Act to advise the Secretary of Health and Human Services (HHS) regarding the award of CO-OP loans. The Committee issued a final report in April 2011, and the major elements of how CO-OPs were selected, awarded loans, and monitored were based on the GAO-appointed Advisory Committee's report.

The CO-OP application-review process was rigorous, objective, and independent. An extensive two-tiered review process was established to review the loan applications, and Deloitte Consulting, LLP, was retained to administer the external review. In addition to verifying eligibility, Deloitte used a team of insurance experts, actuaries, business plan and financial experts, market analysts, delivery system experts, and former state insurance regulators to evaluate each element of the application. These elements included, but were not limited to, the business plan, enrollment strategy, management qualifications and health plan experience, and feasibility study in each application. The Deloitte recommendations were then sent to the internal CMS review committee, 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's oversight strategy includes frequent monitoring and early intervention to ensure that CO-OPs adhere to program requirements and goals."[4]

Twenty-four of 147 CO-OP applicants were selected to receive loan funds and ultimately entered into CO-OP loan agreements with CMS. CMS provided loan funding to the 24 CO-OPs in two forms, consistent with statute:[5] start-up loans and solvency loans. The total amount of start-up loan funding obligated and available to a particular CO-OP was based on the estimated cost of

[4] http://oig.hhs.gov/oei/reports/oei-01-12-00290.pdf
[5] Sec. 1322(b) the Affordable Care Act

specific start-up activities. Start-up loan funds were disbursed upon completion of start-up activities listed in a disbursement schedule that was incorporated into each CO-OP borrower's loan agreement.

As set forth in the statute, solvency loan funds assist loan recipients with meeting regulatory capital and surplus requirements of the state(s) in which they are licensed. CO-OPs requested additional loan funding to reflect new solvency loan needs to help CO-OPs continue to meet their state-determined solvency requirements. Each request should have included the CO-OP's estimated capital needs through the point at which the CO-OP would reach break-even and have operational cash flow or outside capital funding sufficient to allow the scheduled repayment of all CMS loans. Solvency loan award levels were set based on industry standards and state regulatory capital requirements.

In making additional award decisions, CMS reviewed applications for these subsequent loans, which included assessing new and updated business plans, conducting feasibility studies, and assessing programmatic and regulatory compliance, actuarial soundness, and pro forma financial statements. The applications included actuarially-certified analysis and financial projections, which necessarily incorporated data regarding the current and projected level of enrollment. An external panel reviewed and provided to CMS an assessment of each request for additional loan funding, consistent with processes used to make initial loan decisions set out in the CO-OP Program Funding Opportunity Announcement[6] and the CO-OP Program Final Rule.[7]

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

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

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.

New entrants to any market, especially the insurance market, can face pressures, particularly in early stages. CO-OPs entered the health insurance market with a number 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. As with any new set of business ventures, some CO-OPs have succeeded while others have encountered more challenges. There have been successful CO-OPs, which have provided consumers in their states an additional choice of health insurance and have improved competition, and there also have been CO-OPs that for a number of reasons have faced compliance, technical, operational, or financial difficulties. In the face of multiple pressures, some new entrants have struggled to succeed and some will not sell coverage on the Marketplace in 2016. In these instances, CMS is working with state DOIs, the primary regulator of insurance issuers in the states to ensure consumers have adequate coverage and when necessary a smooth transition to another plan through open enrollment.

CMS takes its oversight of taxpayer funds seriously. Since awarding both start-up and solvency loans, CMS has closely monitored and evaluated all CO-OPs to assess performance and compliance. All CO-OPs are subject to standardized, ongoing program oversight activities that include weekly, biweekly, or monthly calls to monitor goals and challenges; periodic on-site visits; performance and financial auditing; monthly, quarterly, semi-annual, and annual reporting obligations; and a host of additional measures employed as needed on a case-specific basis, such as the evaluation of CO-OP sustainability. CMS also engages regularly with state DOIs, which serve as the primary regulator of insurance issuers in the states.

CMS appreciates the work and recommendations made by the HHS OIG, which have informed and improved our oversight of the CO-OP program. CMS increased the data and financial reporting requirements for CO-OPs, requiring them to provide a quarterly statement that they are in compliance with all relevant State licensure requirements or an explanation of any deficiencies, warnings, additional oversight, or any other adverse action or determination by State insurance regulators received by the CO-OP since the last-filed quarterly report. 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. In addition, CO-OPs have monthly and quarterly reporting requirements, including financial statements (audited financial statements when available), balance sheets, income statements, and statements of cash flow as well a statement of enrollment statistics. This additional financial data collection has helped CMS to identify underperforming CO-OPs and gives CMS the opportunity to work with State insurance regulators to help correct issues that are identified. Additionally, as recommended by the OIG[8], CMS has placed some CO-OPs on enhanced oversight schedules or corrective action plans. CMS also conducts on-site forensic audits to confirm the financial conditions of the CO-OPs. These efforts, among others, have helped us identify problems early.

CMS conducts site visits to ensure that CO-OPs are meeting their obligations to the program. Since March 2015, CMS has conducted site visits of plans in 14 states. We believe these visits are a benefit to plans, consumers, and taxpayers. These visits provide CMS an opportunity to see firsthand whether and how a CO-OP meets its obligations and how they can better serve their customers and taxpayers. As such, CMS reviews management structure and staffing, financial status, business strategy, the policies and procedures of the CO-OP, a CO-OP's marketing and sales, and the CO-OP's operations, including vendor management and oversight. CMS also reviews how a CO-OP is meeting their obligations in terms of medical management and member relations. CMS also works with DOIs to leverage each other's on-site CO-OP examinations.

For CO-OPs that will not sell coverage on the Marketplaces in 2016, CMS is working collaboratively with DOIs and the CO-OPs to wind down their operations in an orderly way, while minimizing disruptions to consumers. CMS is assisting where appropriate in the development and management of wind-down plans. Like other consumers, affected CO-OP enrollees are able to shop for 2016 coverage on the Marketplace throughout open enrollment, which started Sunday.

[8] http://oig.hhs.gov/oas/reports/region5/51400055.asp

Promoting Coverage in Open Enrollment 2016

The CO-OP program is only one part of the Affordable Care Act's overall approach to encourage competition and to give consumers a variety of affordable coverage choices. Whether consumers are getting coverage from a CO-OP, another issuer, or Medicaid, millions of Americans who were previously uninsured now have access to affordable, high quality health care coverage. As several of the Affordable Care Act's coverage provisions took effect, an estimated 17.6 million Americans gained coverage. Over that period, the uninsured rate dropped from 20.3 percent to 12.6 percent – a 38-percent reduction (or 7.7 percentage points) in the uninsured rate.[9] This success benefits Americans no matter where they get their health insurance. For example, reductions in the uninsured rate generally mean that doctors and hospitals provide less uncompensated care, the costs of which are often passed along to consumers and employers who pay premiums for health coverage.[10]

With the third Open Enrollment underway, we are eager to build on this success by not only retaining current consumers, but by increasing Marketplace enrollment. We expect to have 10 million individuals enrolled in coverage through Marketplaces and paying their premiums – so-called effectuated coverage – at the close of 2016. As part of that goal, HHS believes more than one out of every four uninsured Marketplace-eligible consumers will select plans during Open Enrollment. Consumers in the Marketplace will have a range of plans to choose from. Nine out of ten returning consumers will be able to choose from three or more issuers for 2016 coverage. And on average, consumers can choose from plans sold by five issuers for 2016 coverage, just as they could for 2015 coverage. Previous research shows that price competition typically intensifies with three or more competitors in a market. In 2016, consumers can chose from an average of 50 plans in their county.[11]

Prior to the Affordable Care Act, we lived in a world where double-digit premium increases were the norm, and those plan increases often paid for inferior policies. In 2016, nearly eight in ten returning Marketplace consumers will be able to buy a plan with premiums less than $100 month

[9] http://aspe.hhs.gov/health-insurance-coverage-and-affordable-care-act-aspe-issue-brief-september-2015
[10] http://aspe.hhs.gov/sites/default/files/pdf/83961/ib_UncompensatedCare.pdf
[11] http://aspe.hhs.gov/sites/default/files/pdf/135461/2016%20Marketplace%20Premium%20Landscape%20Issue%20Brief%2010-30-15%20FINAL.pdf

after tax credits. In addition, about seven in ten returning Marketplace consumers will be able to buy a plan for $75 or less in monthly premiums after tax credits in 2016. We continue to encourage those consumers already enrolled in Marketplace coverage to come back to the Marketplaces, update their information, and compare their options to make sure they are enrolled in the plan that best meets their budget and health needs. Last year, almost 53 percent of consumers who re-enrolled in a Marketplace plan shopped around with more than half of those selecting a new plan.[12] The average consumer who switched plans saved money on his or her net premium, based on an HHS analysis of Open Enrollment in 2015.[13] Net premiums are premiums minus the amount of applicable tax credit – the amount that is paid by a consumer. Those who switched plans within the same metal tier saved an average of nearly $400 on their 2015 annualized premiums after tax credits as compared to those who stayed in their same plans.

Improved Consumer Experience

Over the last few months, our team has been hard at work, taking steps to make enrollment quicker and smoother for both returning and new customers. Ahead of Open Enrollment 2016, new features were added to HealthCare.gov based on consumer feedback about previous experiences with the site and the type of additional information they want in order to pick the right plan. We made it easier for consumers to reset their passwords and have simplified re-enrollment so when consumers come back to HealthCare.gov, they will be able to easily find their current plan and compare it with other plans available in their area.

We are also providing more consumer-specific information, tailored to whether a consumer is new or is returning so that consumers will have an experience that matches their unique situation. A new Out-of-Pocket Cost feature has been added to the website this year that will help consumers better estimate the cost of health insurance based on their own personal situation, helping them understand overall costs, in addition to premiums.

[12] http://aspe.hhs.gov/sites/default/files/pdf/83656/ib_2015mar_enrollment.pdf
[13] http://aspe.hhs.gov/sites/default/files/pdf/134556/Consumer_decisions_10282015.pdf

Conclusion

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. 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 proven to be successful, thanks to the Affordable Care Act, consumers have a variety of affordable health insurance coverage choices that meet the health care needs of their families. CMS will continue to work closely with CO-OPs and state departments of insurance to provide the best outcome for consumers. We appreciate the Subcommittee's interest and I am happy to answer your questions.

Chairman BRADY. Dr. McDermott, you are recognized.

Mr. MCDERMOTT. Dr. Cohen, in my opening statement I suggested that the Republican Congress in 2013 slashed the funding for loans and grants by nearly two-thirds; is that correct?

Dr. COHEN. That is correct. We started with, when the Affordable Care Act was passed, with around $6 billion. We have awarded about $2.5 billion, which is the remaining money which was left for the program after rescissions.

Mr. MCDERMOTT. So your chance of supporting these CO–OPs was cut by two-thirds.

Dr. COHEN. That is correct.

Mr. MCDERMOTT. And then the risk mitigation, that is, you open the doors of your CO–OP and you look out there and 50 people come in. You do not know what they have got when they come in. You charge them a premium you think is the proper one, but you may have some very sick people; is that correct?

Dr. COHEN. It is true. In the first years of the marketplace there was a lot of uncertainty about the risk pool for any one of these CO–OPs. That is correct. So they had quite a challenge in terms of setting prices because they did not know exactly who their population would be that they would be covering.

They were also building new provider networks and trying to arrange those contracts, obviously starting all of their back ends. So a lot of work to be done to start a new insurance company in this space.

Mr. MCDERMOTT. And so like the drug companies when they started on the Part D, they did not know who they were going to get either, and we set up risk mitigation programs, correct?

Dr. COHEN. That is correct.

Mr. MCDERMOTT. If it cost more than they anticipated, we would support them at least to a certain extent to get through that.

Dr. COHEN. That is right. For the marketplace we have three risk mitigation programs, a risk adjustment program which allows folks to make sure that they are not cherry-picking up the well folks, to make sure that they are actually covering folks who need coverage that are sick; a reinsurance program that helps to cover the cost of high cost enrollees; and then a risk corridor program that really gets at that uncertainty about pricing. And all of those work in tandem with each other.

Mr. MCDERMOTT. And so it would be similar to that program in Part D that we put in with the CO–OPs. We gave a pot of money to be used to mitigate any unforeseen kinds of problems that came through the door without them having any way of knowing?

Dr. COHEN. Yes. These were programs that were not just exclusively for the CO–OPs but for all of the issuers participating in the marketplace because we knew it was a transition time for all of the issuers moving into this net market for the first time, needing to cover preexisting conditions, making sure that they were covering the essential health benefits. So it was a transition for all of these issuers, and that is why those three programs were in existence, modeled as you said after the Part D, you know, very successful programs in Part D.

They are meant to be temporary. At least two of the three are temporary, again, to get us through a transition period.

Mr. MCDERMOTT. When did the CO–OPs discover that they were only going to get one-eighth, 12 percent of the money they expected? Was that the 1st of October?

Dr. COHEN. Yes, that is correct, the end of September, correct.

Mr. MCDERMOTT. So when you looked at the books and what had been appropriated by the Republicans, you only had that amount of money, and you announced to them, "You are only going to get an eighth of what you thought you were going to get"?

Dr. COHEN. So the risk corridor dollar amount was really a product of a mathematical formula based on the information submitted by the issuers themselves, based on their 2014 claims and premium experience. So whatever happened in 2014, they sent us the data on it, and that was at that point when we were able to calculate what the ins and outs of that program would be, and as you mentioned at the end of September we were able to share that information with folks.

Mr. MCDERMOTT. So what happened then is the insurance companies in all the States looked at their reserves and so forth and aid to these CO–OPs, "You are no longer able to offer insurance because you do not have the proper reserves because you have not gotten from the Federal Government what they promised you."

Dr. COHEN. I think that was one of a number of factors. I think CO–OPs had, as I have mentioned, a number of difficulties. Certainly the lower risk corridor payments certainly was one of the things that contributed to some of their challenges.

I would also mention in one of the other risk corridor programs, the reinsurance program, everyone actually got more money than they were expecting, about 25 percent more money. So one program more, so one program less.

So while I would say, on balance, those are contributing factors. As I mentioned, there were a lot of challenges for the CO–OPs, the uncertainty of pricing, the difficulty of provider networks competing against more established insurers, but certainly the reinsurance and the risk adjustment and risk corridor certainly impacted that.

Mr. MCDERMOTT. What is the longest standing CO–OP that you have? How long has it been running, two years?

Dr. COHEN. This will be their second year.

Mr. MCDERMOTT. This would be their second year. So they have been one year in operation. They lost two-thirds of their money in the loans and so forth, and then they lose the mitigation. They are in their second year.

How many years do you think it takes for them to stabilize?

Dr. COHEN. It is a good question. Certainly more than two, more than two to stabilize.

Mr. MCDERMOTT. Thank you.

Chairman BRADY. Thank you. Thank you.

Mr. Johnson is recognized for five minutes.

Mr. JOHNSON. Thank you, Mr. Chairman.

Thank you for testifying today. We appreciate that.

I am just going to be frank with you. You know, back in Collin County, Texas, people do not like Obamacare, and as a result of the law, they have seen their insurance premiums and costs increase

and their access to doctors and other providers decrease, all the while having to pay higher taxes to pay for Obamacare.

Now, we do not have a CO–OP in Texas, but the recent failing of the 11 CO–OPs is still important to my constituents. The reason why is because over $1 billion in taxpayer money has gone down the drain, and that is what happens when almost half of the Obamacare CO–OPs have failed.

Dr. Cohen, it seems with so much taxpayer funding on the line, CMS should have been more proactive to ensure the solvency of these CO–OPs. In fact, Vermont refused to allow a CO–OP to set up shop because of unrealistic assumptions on rates, enrollment and other key factors.

So these CO–OP failures ought not to have been a surprise. My question for you is: when did CMS become aware that the CO–OPs were failing, and why did you not do more to protect taxpayer dollars?

Dr. COHEN. CMS has been doing oversight of the CO–OPs from the beginning of the program. As I mentioned, we are just in the second year of the program now, and we have been doing oversight over the course of the first year of business.

Mr. JOHNSON. Yes, but when did you figure out that they were not going to make it?

Dr. COHEN. So as you mentioned, the State of Vermont was not even able to comply with State licensure and we did not even allow them to move forward in that circumstance. So all along there are guideposts and check points that we make sure to look at oversight.

If we feel like they are going beyond the guard rails that we set up, we enhance our oversight, put folks on enhanced oversight or corrective action plans. We do on-site visits to gather more information than just them sending us information. We want to go on site and see it with our own eyes, have our actuaries do on-site and make sure we are doing evaluations.

So, you know, I will say I do not think we have been easy on the CO–OPs, as you can see with some of the recent actions. We have taken our job as stewards of the taxpayer dollar very seriously. We work within the parameters of the statute and the existing funding, and you know, we will continue to do that for the life of the program.

Mr. JOHNSON. It seems like you just want more dollars. Well, I think the taxpayer just deserves more.

Thank you, Mr. Chairman.

Dr. COHEN. Thank you.

Chairman BRADY. Thank you.

Mr. Thompson, you are recognized.

Mr. THOMPSON. Thank you, Mr. Chairman.

Dr. Cohen, thank you for being here.

I cannot help but chuckle that their side of the aisle cuts two-thirds of the funding and then they blame you for not having proper oversight to make sure these CO–OPs exist. I think that is an interesting tactic, but I do not think it is particularly accurate.

Just as a bit of a refresher, can you just succinctly state the top three reasons why these CO–OPs failed?

Dr. COHEN. Why the CO–OPs failed? There were a number of reasons. It is a challenge to start an insurance company in this market. It is a challenge just to think about it without even having to start a brand new market, which is what was created here.

Whether it was building a provider network and not having the relationship with providers to get the best rates possible; I think the uncertainty as mentioned by Congressman McDermott, the uncertainty of what the consumer would look like. How sick was that population? And thus, how to set the proper pricing for that to cover their costs, and then I think obviously the lack of brand name. They are competing against big, experienced players with long relationships with their community.

So I mean, it was an uphill challenge from the beginning. Obviously some CO–OPs have risen to that challenge and have been very successful and are expanding into new markets and giving consumers new options.

Mr. THOMPSON. And had the money been there, the six billion that was in the original bill, would that have mitigated many of those problems?

Dr. COHEN. Obviously, we know that these entities in early years, that it is a challenge to maintain their solvency, and additional money would have certainly long a long way to making sure they were able to cover a lot of their claims costs, figure out some of those uncertainties, and chart a course for long-term sustainability, and ultimately paying back the loans that we give them.

Mr. THOMPSON. And I do not want to sound like an apologist for the CO–OPs. I was never a fan, but to reiterate what the Ranking Member said, this was the option that we had. What most of us wanted was the public option, and that would have provided the competition needed to really make the private insurers perform to a greater degree.

But when that option was taken away, this was kind of the fallback, and I think it is important to state that. And then when you take the money out that was put in to make the fallback work, it seems near impossible. I am surprised that any of them are still going.

In your oversight role, have you seen consumers and providers that value this CO–OP local option?

Dr. COHEN. Absolutely. Not only do we hear from individual consumers. I had the opportunity to meet with some of the CO–OPs that are expanding and are thriving and about some of the innovative and creative work that they are doing for their consumers, whether it is targeting diabetic populations and making sure they have intensive care management. You know, as a physician those are exciting and innovative ways to think about caring for a tough disease.

So, again, they were designed as a nonprofit entity that is really connected to the community with consumers on their board driving decisions about the entity and really trying to create benefits that are really tailored very closely to what the community needs, and so I think that there are a lot of great things are doing in that space.

And the ones that are succeeding are able to sort of get through this period of uncertainty. I think there is a lot of benefit they can bring.

Mr. THOMPSON. Getting back to where he said he wanted to go when he started the hearing is to figure out where the problems are and make it work, how would you suggest that we as Members of Congress support these local options and to make sure that they work and deliver to our constituents?

Dr. COHEN. So I think, as you know, on Sunday we started the next open enrollment period, and we are in it right now. So I would hope all Members are doing is educating customers and consumers that are in CO–OPs, that are not, about their options on HealthCare.gov; if they are in Federal facilitated marketplace States, make sure they know if they go and shop that they can even save even more money.

We did some analysis to show that if you can go back, you can actually save more money than they already are. We know that eight in ten consumers are benefitting from financial assistance to the tune of about $270 a month.

So there are real financial benefits for folks to go look at their options, see what is there, see what is right for their family, and so I would encourage you to make sure that your constituents know what is there for them and that there are options out there.

Mr. THOMPSON. Thank you.

Dr. COHEN. Thank you.

Chairman BRADY. Thank you.

Mr. Roskam, you are recognized.

Mr. ROSKAM. Thank you, Mr. Chairman.

Dr. Cohen, thank you for your time today.

Just to correct the record and to make sure I am clear on something, the public option has been discussed today. I am not a fan of the public option. I opposed it. Every Republican opposed it, but the Republicans were not running the show; is that not right, when the Affordable Care Act was crafted and it was passed? Is that not right, Dr. Cohen?

It was all Democratic votes. So by definition, the people that took the public option away were Democrats; is that not correct?

Dr. COHEN. That is correct.

Mr. ROSKAM. Okay. And then as we move forward, the $6 billion that could have mitigated some of these losses, the $6 billion works until when? Until the $6 billion runs out, right?

Dr. COHEN. So we had less than $6 billion to work with, about 2.5 billion, but you are right. It was a limited pool of funding, and the idea is to get folks through a time of uncertainty to a place where they had a long-term plan of, you know, having premiums to cover their costs, outside capital to fund different parts of their business.

But we knew in any start-up period that they would need both start-up and solvency loans, which is how the program was designed.

Mr. ROSKAM. But the limited amount of funds is, by definition, it is finite, and a couple of minutes ago when you were asked the question how long can the CO–OPs last by themselves, you said, and I am paraphrasing, but my understanding was, well, we know

they cannot last by themselves in the first two years; is that not right?

Dr. COHEN. Well, we see a lot of the CO–OPs are successful right now and moving forward.

Mr. ROSKAM. Right, but 11 of them, 12 if you count Vermont, they have not made it.

Dr. COHEN. That is true. We have done a lot of work in the last few months using our oversight hat to make sure that consumers know moving forward if they are shopping in open enrollment right now, we wanted to make sure that they knew that the CO–OPs that remain in the marketplace were financially viable, can make it through the entire year. Our first priority is to make sure there was not going to be a midyear failure next year for any consumers, you know, and that is how we really went about our decision making.

We played it very conservative in that way, which is why I think there has been so much activity in the last several months. We worked in partnership with the State Departments of Insurance on that oversight and will continue to do so.

Mr. ROSKAM. So sort of just the sense of restraint and reluctance and the wariness that you hear from this side of the aisle is based on the representations that were made in the past by CMS about how good things were looking, and even your language today in your testimony, things like "the CO–OP application review process was rigorous, objective and independent and since awarding both start-up and solvency loans CMS has closely monitored and evaluated all CO–OPs to assess performance and compliance."

You know, to Mr. Johnson's point, this is costing a lot of money, and it seems like at many levels it is simply a failure. It is out of balance. The risk corridors, by definition, were supposed to be budget neutral, and yet it seems like there is an admonition against a Republican Congress that you are not funding these things.

And to just follow up, to put a finer point on Mr. Johnson's interchange with you, you know, a lot of us feel like this is good money after bad.

So why in the world or what hope would you hold out that based on past CMS performance and past CO–OP performance and the fact that we are in a really limited time frame and things like, you know, quotes that come from the CMS spokesman back in a Bloomberg article of March of 2014, "While it is still early, we are encouraged by what we have seen so far and will continue to work closely with these CO–OPs to monitor their progress and assess their performance."

I mean, it just seems like it is a disaster. Let us turn the page, call it what it is, and move on. Do you not think that is a good idea?

Dr. COHEN. Well, so we have been, you know, at any given point in time there is certain information that we have in front of us. We continue to work with the State Departments of Insurance, which are the primary regulators to make sure we are understanding what is happening in the State and with those CO–OPs.

We will continue to play that oversight role. At the same time we wear another hat, which is to support the CO–OP Program, and

I think if you are thinking about a value proposition of any program, you want to understand why was it created in the first place, and when I think about that, you know, it is really, as I was mentioning earlier, is to create a program that allowed for additional competition in an era of insurer consolidation where there are not a lot of choices for consumers, you know, just looking to give folks yet one more choice of an affordable option that they can choose from.

Again, we are going to do our best to support those that are showing themselves to be successful and moving in the right direction.

Chairman BRADY. Thank you.

Mr. Kind, you are recognized for five minutes.

Mr. KIND. Thank you, Mr. Chairman.

Dr. Cohen, thank you for your testimony here today on an important topic.

But before I do, since you are a representative from CMS before the panel today, I cannot help but commend you and CMS for moving forward on advanced care planning reimbursement.

Dr. COHEN. Thank you.

Mr. KIND. It was long overdue. Many of us were actively engaged, including my absent colleague. I am not here to call him out right now, but Mr. Blumenauer and the leadership that he provided.

I hale from a part of the country in Western Wisconsin. We are very proud of the advanced directive programs that have been established at Gundersen Lutheran, Mayo Health Clinic, all over my district. I am a member at Gundersen Lutheran myself. Ninety-five percent of the patients there have an advanced directive on record. I have one. My wife has one. My teenage boys do. My parents do, and what a relief that is that they are respecting our decisions when it comes to end of life care planning.

And I always thought it was wrong that our health care providers were not being reimbursed for the education and the consultation that inevitably has to occur to help patients through this planning process.

So thank you for moving forward on that.

Now, back to the health CO–OPs. Again, I am from Wisconsin. Every time you turn around in our State you see a CO–OP. We are not afraid of CO–OPs. They are very successful business models in the private sector, whether it is farm co-ops, whether it is the health care CO–OP we have right now that is thriving in the Madison area, whether it is financial co-ops. Shoot, even the Green Bay Packers you could claim is a co-op because it is a fan-owned team, and granted, I will concede to you that they failed miserably the other night against the Broncos, but the Packer model has generally worked pretty well, and it is a matter of consumer owned, consumer driven, and that is the whole concept behind the CO–OPs.

But as you mentioned in your testimony, they were going to face some difficulties. Start-up capital any new business needs is tough to come by. Making sure you get the risk corridor, the risk management done the right way, and that is my question to you.

For any insurance company, whether it is a nonprofit CO–OP or a private or large or small, if you do not get the right blend of customers in there from older to younger and healthier, it is going to be very tough to stay in this very difficult business.

Are we doing enough in order to attract especially the younger, healthier people into the CO–OPs or into the exchanges or what have, or is there a lot more work that we need to do in order to spread that risk and have a better chance of managing it?

Dr. COHEN. I very much agree that it is very important to make sure that we are getting a risk pool that can manage the different types of risk of the different patients across it, and that is why we target most of our outreach to the 18 to 35 year old population, most of whom do not realize the financial assistance that is available. They think health care is something that is unattainable.

They also think that they are never going to get hurt, break an arm, get in a car accident, get an unfortunate disease at a younger age. So we have been doing a ton of work with the 18 to 35 year old population. All of our marketing efforts are targeted in that space, and so we continue to do that and make sure that we are——

Mr. KIND. I am sure the CO–OPs are probably experiencing the same challenge of trying to attract that risk pool——

Dr. COHEN. Absolutely.

Mr. KIND [continuing]. That can make it work and viable for them.

Another concern I want to raise with you and I am wondering if you are sharing it is obviously when you have CO–OPs failing, it means less competition in the marketplace, but we are also seeing on the other end greater mergers in the insurance market.

Is that something that we ought to be paying closer attention to, the consolidations and the mergers in the private health insurance world right now?

Dr. COHEN. So I think that is why the CO–OP Program was created in the first place, again, in that era of one or two dominant players in a market. This is, again, a locally owned, locally driven option to give consumers choices. They, you know, try to have more relationships with local providers, again, so that they can be an affordable, creative, innovative option, and I think for the entities that continue on that are expanding, they have done just that.

We are going to try to support the ongoing CO–OPs as much as possible, share best practices, have them do some shared services if they can help each other out, you know, if they share call centers or do some sort of shared services in order to help along to improve their operations.

Mr. KIND. My time is about to expire, but could you also just quickly address what is going on with the individual health insurance market right now? I am talking about those people who do not qualify for premium tax credits. Where they are seeing their premiums because I have had a couple of encounters back home of individuals who do not qualify and how expensive it is and where they are seeing their own premiums going right now.

Dr. COHEN. Yes. So we did a recent analysis of the rate increases in the individual market, about a seven percent increase of the second lowest cost over within the marketplace, and again, we

have seen historically double digit increases in the individual market. So, you know, trying to rein in the prices and I think that the competition speaks exactly to that point of being able to keep the prices under control.

Mr. KIND. Great. Thank you.

Thank you, Mr. Chairman.

Chairman BRADY. Thank you.

Dr. Price, you are recognized.

Mr. PRICE. Thank you, Mr. Chairman, and thank you for this important hearing.

And I want to thank you for your testimony, Dr. Cohen.

If you listen to the folks on the other side, the reason that the CO–OPs are failing is because there just is not enough money and it is those nasty Republicans who have removed all that money.

You mentioned that you were aware of the rescissions that occurred for the CO–OPs, and that there were bills that came forward to Congress that removed money from the CO–OPs. Do you remember what those bills were?

Dr. COHEN. I do not have them in front of me, but I am happy to follow up.

Mr. PRICE. There were three of them. One was the Department of Defense Continuing Appropriations Act of 2011. How many Democrats voted for that? Do you know?

Dr. COHEN. I do not.

Mr. PRICE. Eighty-one Democrats on that one.

A second one was the Consolidate Appropriations Act of 2012. Do you remember how many Democrats voted for that?

Dr. COHEN. Sorry, sir. I do not.

Mr. PRICE. A hundred and seventy-two.

And the third one was the 2012 Continuing Resolution. How many Democrats voted for that one? A hundred and eighty-two. How about that?

So the fact is that the CO–OPs have not failed because they have not had enough money. The CO–OPs have failed because we have got people who do not know how to run insurance company running insurance companies and not able to respond to individuals.

As a physician I can tell you that when we talk about this stuff people's eyes glaze over when you just talk about money and those kinds of things, but I want to talk about patients. Five hundred and fifty thousand patients are going to lose their coverage through a CO–OP because 11 of the CO–OPs have failed; is that correct?

Dr. COHEN. Well, we are working very hard to make sure the consumers have a——

Mr. PRICE. Five hundred and fifty thousand patients are going to lose their coverage, correct?

Dr. COHEN. That is not correct. They are going to have the opportunity to shop during this open enrollment period and can transition.

Mr. PRICE. Are they going to be able to stay in the insurance coverage in the CO–OP that they had?

Dr. COHEN. The CO–OP will end, but they will have the opportunity to——

Mr. PRICE. The CO–OP will end. That is the point. So if you like your doctor in that CO–OP, you may or may not be able to keep

that doctor, right? He or she may not be in the next plan that you are signing up for; is that correct?

Dr. COHEN. That is right. They will need to go to HealthCare.gov and look at their options and see whether or not their provider is——

Mr. PRICE. Let me talk about a couple of specific challenges that patients have. The individual mandate, which would have been complied with because of the CO–OP, does that mean that the individual does not have to become subject to the individual mandate depending on whether he or she is able to get coverage?

Dr. COHEN. So our goal has always been for coverage, and these folks are clearly, you know, saying, "I want coverage." And I think we are going to——

Mr. PRICE. But the question is whether or not they still have to comply with the individual mandate even though they have already fulfilled that.

Dr. COHEN. So they have fulfilled it, and the mandate says you need to have coverage for at least nine months of the year. So at this point they will have had coverage for at least nine months of the year, and they will not be——

Mr. PRICE. There are some CO–OPs that they are not going through nine months; is that not correct?

Dr. COHEN. There was one CO–OP earlier in the year that——

Mr. PRICE. What about deductibles? If an individual paid part of their deductible in the CO–OP and then they move to a different plan, does that deductible transfer over or does the individual have to make their new deductible?

Dr. COHEN. It would depend on the individual situation.

Mr. PRICE. The fact is that it is not likely that the deductible will be accepted by the next insurance company; is that not correct?

Dr. COHEN. So we are making sure that folks have coverage through the end of the year, which is why it is very important that we did our work now to make sure that there are no midyear closures so that——

Mr. PRICE. More money is going to come out of pocket and——

Dr. COHEN [continuing]. They can make it through the——

Mr. PRICE [continuing]. More difficult access to care.

I have got just a few minutes left. In the original final rule on CO–OPs it said, quote, "All CO–OP loans must be repaid with interest and loans will only be made to private nonprofit entities that demonstrate a high probability of becoming financially viable."

How many CO–OPs got loans?

Dr. COHEN. A total of 24.

Mr. PRICE. And how many remain in business as of the end of this year?

Dr. COHEN. At the end of this year we will have 11.

Mr. PRICE. At the end of this year we will have 11.

Dr. COHEN. That is right.

Mr. PRICE. Which means I think 11 are closing, correct?

Dr. COHEN. So there are 12 that will be closing, one that closed a while back.

Mr. PRICE. So how did you do on a high probability of becoming financially viable when 50 percent of them have closed?

Dr. COHEN. So obviously we wish we would have a better batting average here, but we wanted to make sure that overall that we kept the consumer at the center of this process. We wanted to make sure that we did our oversight role and took——

Mr. PRICE. The fact is that these are not working for patients. They simply are not working for patients from a health care standpoint or from a financial standpoint.

I want to touch very briefly in my closing seconds on this comment that you just made to Mr. Kind, and you mentioned that the amount of increase in premiums for individuals is seven percent. You were very careful to mention that it was in the Silver Plan.

What if you take all four of the plans together? What is the increase that was seen in 2015 in premiums for individuals in all four plans?

Dr. COHEN. I think it is important when you talk about rates you have to talk about——

Mr. PRICE. Twenty, point, three percent, Dr. Cohen, 20.3 percent.

What is the projection of all four plans in 2016?

Dr. COHEN. So it is important to remember that an average——

Mr. PRICE. Twenty, point, three percent, Dr. Cohen.

Dr. COHEN [continuing]. Person gets about $270.

Mr. PRICE. The fact of the matter is costs are going up. Access is going down. Quality is being limited.

Chairman BRADY. Thank you very much.

Let us ask questions; answer questions promptly. We are going to move through this on time, and, Mr. Smith, you are recognized.

Mr. SMITH. Thank you, Mr. Chairman.

And thank you, Dr. Cohen, for sharing with us your expertise and insight.

I need to express my frustration and I also though want to express my understanding that there are perhaps some frustrating points of your job as well.

Back in the summer of 2013, Pam Weldon, a constituent, approached me unprompted and presented me with her cancellation letter. That was certainly a plan that she liked, and it even covered her preexisting condition. She could afford it, and you know, fast forwarding a little bit to November 14th, she learned that the Platinum Plan she had chosen from the CO–OP in Nebraska and Iowa, CoOpportunity Health, she had chosen to replace the first plan she lost that was being discontinued. She would again have to choose a new plan.

Then she learned at the beginning of 2015, that CoOpportunity Health would be going out of business, forcing her to again find a new plan.

I have a letter here, and I would ask unanimous consent for submitting Pam Weldon's letter into the record.

Chairman BRADY. Without objection.

[The information follows:]

HEALTH CARE NEWS

How One Nebraska Woman Lost Her Health Insurance Three Times Under Obamacare

Melissa Quinn / @MelissaQuinn97 / February 17, 2015

Dec. 26, 2014, was strike three for Pamela Weldin.

The day after Christmas, Weldin, of Minatare, Neb., had logged on to Facebook to find a message from a friend of hers. Included in the note was a link to an article from the Omaha World-Herald announcing that CoOportunity Health, a nonprofit health insurance company offering plans in Nebraska and Iowa, had been taken over by state regulators.

The insurer, one of 23 Consumer Operated and Oriented Plans, or co-ops, started with the backing of the federal government and received $145 million in loans from the Centers for Medicare and Medicaid Services. But, CoOportunity's expenses and medical claims would far exceed its revenue for 2014.

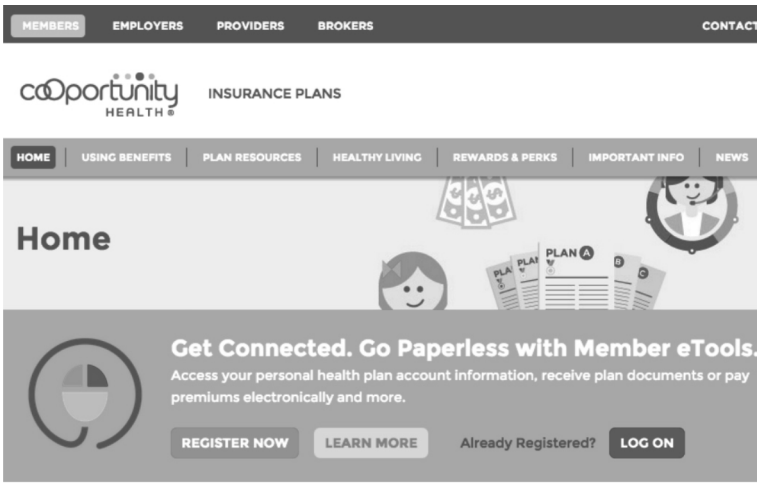
"Merry Christmas to me," Weldin, a dental hygienist turned Pampered Chef director, said in an interview with The Daily Signal of when she read the article.

A month later, Iowa Insurance Commissioner Nick Gerhart announced his intent to liquidate CoOportunity Health and encouraged those who were covered by the nonprofit to seek insurance elsewhere.

> ***"I've been pulled into the middle of all this through no fault of my own, and there's nothing fair about it. It is what it is, and you move forward," said Pamela Weldin, who lost health insurance coverage three times.***

For Weldin, 58, the insurer's liquidation marked the third time she would lose her health insurance under Obamacare, the third time she would head to HealthCare.gov to shop for coverage, and the third time she would have to purchase a brand new plan.

"I've been pulled into the middle of all this through no fault of my own," she said, "and there's nothing fair about it. It is what it is, and you move forward."



Obamacare's Co-Ops

Co-ops are no stranger to the insurance market, and lawmakers hoped the nonprofit insurance companies would help infuse competition and choice into markets where there were limited options.

However, the co-ops created under the law would be slightly different from those already in existence—to help the new insurers get off the ground and meet state reserve requirements, the federal government provided $2 billion in startup and solvency loans.

>>> One Year After Obamacare's Implementation, Taxpayer-Funded Co-Ops Struggle to Survive

Twenty-three co-ops serving 26 states were ultimately licensed and received federal loans including CoOportunity.

According to the latest quarterly filings, more than 520,000 people enrolled in insurance coverage through the co-ops through September.

An analysis conducted by The Daily Signal earlier this month, though, found that all but one of the co-ops experienced operating losses through September.

Centers for Medicare and Medicaid Services did not return The Daily Signal's request for comment.

Photo: Paul Hennessy/Polaris/Newscom

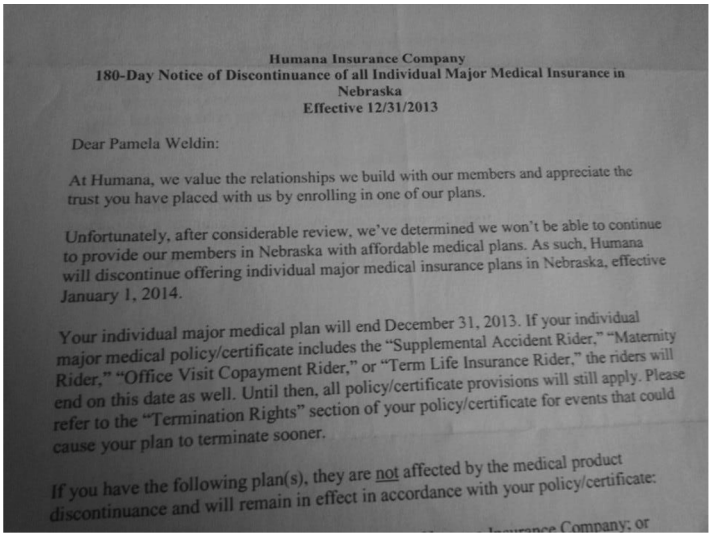
Strike One

In the months leading up to the Affordable Care Act's implementation on Oct. 1, 2013, millions of Americans began receiving notices from their health insurance companies informing them their policies had been cancelled.

Weldin was one of them.

The Nebraska woman, who was diagnosed with carpal tunnel syndrome 15 years ago, had purchased catastrophic coverage through Humana after moving from San Diego, Calif., which she kept until 2013—right before Obamacare's implementation.

That year, she received a cancellation notice from the insurance giant. The company had decided to pull out of Nebraska and wouldn't sell plans to Nebraskans through HealthCare.gov, the federal government's health insurance exchange. Eight other insurance companies followed suit.



Humana Insurance Company
180-Day Notice of Discontinuance of all Individual Major Medical Insurance in Nebraska
Effective 12/31/2013

Dear Pamela Weldin:

At Humana, we value the relationships we build with our members and appreciate the trust you have placed with us by enrolling in one of our plans.

Unfortunately, after considerable review, we've determined we won't be able to continue to provide our members in Nebraska with affordable medical plans. As such, Humana will discontinue offering individual major medical insurance plans in Nebraska, effective January 1, 2014.

Your individual major medical plan will end December 31, 2013. If your individual major medical policy/certificate includes the "Supplemental Accident Rider," "Maternity Rider," "Office Visit Copayment Rider," or "Term Life Insurance Rider," the riders will end on this date as well. Until then, all policy/certificate provisions will still apply. Please refer to the "Termination Rights" section of your policy/certificate for events that could cause your plan to terminate sooner.

If you have the following plan(s), they are not affected by the medical product discontinuance and will remain in effect in accordance with your policy/certificate:

Company; or

(Photo: Pamela Weldin)

By the start of 2014, Weldin would be left without insurance.

Like millions of other Americans who also received cancellation notices, she logged on to HealthCare.gov on Oct. 1, 2013, to browse and purchase new health insurance. But, like millions of other Americans who attempted to sign on to the site, she was a victim of its disastrous launch.

For two months, Weldin attempted to complete her application and was successful by mid-December.

Through CoOportunity, Weldin purchased a platinum level plan with premiums costing $307 a month.

>>> Obamacare Co-Ops Cost Taxpayers $17,000 Per Enrollee

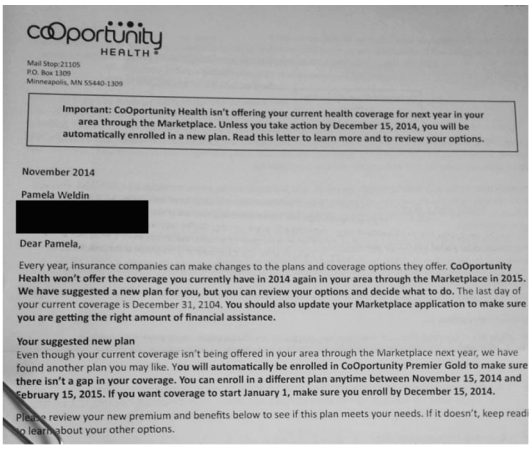
Strike Two

Weldin's insurance with CoOportunity went into effect Jan. 1, 2014, and she had the insurance for most of that year.

Like some consumers, Weldin had issues with the coverage she received through the law. Her original doctor, located seven hours away in Colorado, was no longer in network, and Weldin's plan included services she would never need. At 58 years old, the former dental hygienist had a difficult time understanding why she would need maternity coverage, but it was included in her plan.

Her new platinum plan included a $2,500 deductible, and Weldin qualified for the tax credits touted by the administration.

Then, in November 2014, CoOportunity notified Weldin that they would no longer be offering platinum plans.



coOportunity HEALTH

Mail Stop 21105
P.O. Box 1309
Minneapolis, MN 55440-1309

Important: CoOportunity Health isn't offering your current health coverage for next year in your area through the Marketplace. Unless you take action by December 15, 2014, you will be automatically enrolled in a new plan. Read this letter to learn more and to review your options.

November 2014

Pamela Weldin
[redacted]

Dear Pamela,

Every year, insurance companies can make changes to the plans and coverage options they offer. **CoOportunity Health won't offer the coverage you currently have in 2014 again in your area through the Marketplace in 2015. We have suggested a new plan for you, but you can review your options and decide what to do.** The last day of your current coverage is December 31, 2104. **You should also update your Marketplace application to make sure you are getting the right amount of financial assistance.**

Your suggested new plan

Even though your current coverage isn't being offered in your area through the Marketplace next year, we have found another plan you may like. **You will automatically be enrolled in CoOportunity Premier Gold to make sure there isn't a gap in your coverage. You can enroll in a different plan anytime between November 15, 2014 and February 15, 2015. If you want coverage to start January 1, make sure you enroll by December 15, 2014.**

Please review your new premium and benefits below to see if this plan meets your needs. If it doesn't, keep readi to learn about your other options.

(Photo: Pamela Weldin)

For the second time, Weldin "muddled through" HealthCare.gov to purchase a new health insurance plan. Again, she encountered issues with the website and had to wait until December before securing coverage with CoOportunity. Weldin ultimately selected a silver-level plan for $165 a month.

"Here you are, trying to do the right thing, trying to be responsible and have coverage and be diligent," she said. "And still, I have all these problems and glitches and everything."

Photo: Polaris/Newscom

Strike Three

It wasn't long after purchasing her new insurance with the co-op that Weldin learned CoOportunity was in financial trouble.

One day after Christmas, she read that Iowa state regulators had taken over the nonprofit insurance company, and officials warned it could go under.

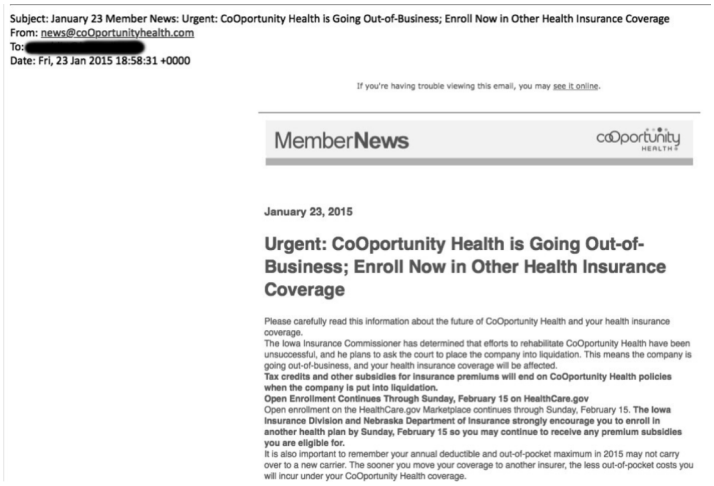
CoOportunity originally expected just 12,000 consumers to purchase coverage through the nonprofit. They ended up enrolling 120,000, many of whom were sicker and had costly health issues.

As a result, CoOportunity's expenses and medical claims exceeded their revenue from monthly premiums, which were priced too low.

The state asked the Centers for Medicare and Medicaid Services for additional money, but the agency denied its request.

"You had a perfect storm happen here," Gerhart said.

For Weldin, the new year brought grim news. She learned that CoOportunity would be liquidated. She would be out of health insurance yet again.



Subject: January 23 Member News: Urgent: CoOportunity Health is Going Out-of-Business; Enroll Now in Other Health Insurance Coverage
From: news@coOportunityhealth.com
To: [redacted]
Date: Fri, 23 Jan 2015 18:58:31 +0000

If you're having trouble viewing this email, you may see it online.

MemberNews

coOportunity HEALTH

January 23, 2015

Urgent: CoOportunity Health is Going Out-of-Business; Enroll Now in Other Health Insurance Coverage

Please carefully read this information about the future of CoOportunity Health and your health insurance coverage.
The Iowa Insurance Commissioner has determined that efforts to rehabilitate CoOportunity Health have been unsuccessful, and he plans to ask the court to place the company into liquidation. This means the company is going out-of-business, and your health insurance coverage will be affected.
Tax credits and other subsidies for insurance premiums will end on CoOportunity Health policies when the company is put into liquidation.
Open Enrollment Continues Through Sunday, February 15 on HealthCare.gov
Open enrollment on the HealthCare.gov Marketplace continues through Sunday, February 15. **The Iowa Insurance Division and Nebraska Department of Insurance strongly encourage you to enroll in another health plan by Sunday, February 15 so you may continue to receive any premium subsidies you are eligible for.**
It is also important to remember your annual deductible and out-of-pocket maximum in 2015 may not carry over to a new carrier. The sooner you move your coverage to another insurer, the less out-of-pocket costs you will incur under your CoOportunity Health coverage.

(Photo: Pamela Weldin)

“The CoOportunity people were helpful and wonderful,” Weldin said. “They answered questions. I really didn’t end up dealing with people who were adversarial or contentious. They sincerely wanted to help people and give out new information, and now they’re going to be unemployed.”

Gerhart told The Daily Signal the state acted quickly in notifying consumers about CoOportunity’s liquidation to ensure no one would have a lapse in coverage. So far, more than 80,000 have moved to other plans.

“They faced a crisis, and their claims were eating up all the surplus and reserve [money],” he said. “It was an unfortunate situation, but we had to step in.”

For the third time in less than two years, Weldin had lost her health insurance. And for the third time, she went to HealthCare.gov to select a new plan from a new company.

Now, Weldin has health insurance through Blue Cross Blue Shield. The “silver lining,” she said, is that Weldin is able to see her original doctor and nurse practitioner in Colorado. But the cost of her monthly premiums increased to $235.

“We have a president who said, If you like your plan, you can keep it. If you like your doctor, you can keep it. You will have choices,’” Weldin said. “All three things were an outright lie.”

>>> How This New Regulation Will Drive Up Your Health Care Costs

@MelissaQuinn97

Melissa Quinn
Melissa Quinn is a senior news reporter for The Daily Signal. Send an email to Melissa.

Mr. SMITH. This may be our first hearing dedicated to the topic, but certainly Nebraskans have been living with this failed CO–OP for nearly a year, and I have asked several questions of the department, of HHS. I spoke and wrote to Secretary Burwell, and actually I am awaiting more answers, certainly more solid answers.

And I would like to submit for the record the letter that I sent Secretary Burwell in January.

Mr. JOHNSON [presiding]. Without objection.

[The information follows:]

ADRIAN SMITH
THIRD DISTRICT, NEBRASKA
http://adriansmith.house.gov

COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON TRADE
SUBCOMMITTEE ON HEALTH

Congress of the United States
House of Representatives
Washington, DC 20515

January 23, 2015

The Honorable Sylvia Burwell
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Burwell:

I am writing in regards to CoOportunity Health, one of twenty-three Consumer Operated and Oriented Plan Programs (CO-OP) created through the Affordable Care Act (ACA). As you know this ACA created program has awarded $2 billion in federal loans to establish health insurance plans. Democrats included CO-OPs in the ACA as an alternative to the "public option."

One main concern raised about these CO-OPs from their inception was their financial solvency. Initial start-up funding for the CO-OPs came from low interest government loans with 5 years provided to repay. The government also provided solvency loans with fifteen year repayment periods. CoOportunity Health, which services beneficiaries in Iowa and Nebraska, received approximately $146 million in federal loans.

On December 23, 2014, the Iowa Insurance Commissioner submitted a petition for an Order of Rehabilitation of CoOportunity Health. The company was taken over by the state and now faces liquidation. Approximately 120,000 of CoOportunity Health's customers, who are mostly in Nebraska, have been strongly encouraged to switch carriers by February 15, 2015 or risk not having coverage until the next open enrollment period.

I am extremely concerned about this situation for Nebraskans needing health coverage and for the taxpayers who have seen millions of dollars lost and millions more at risk. Because of this situation, I respectfully request a response to the following questions:

1. Will the open enrollment period be extended for CoOportunity customers who have been encouraged to shop for an alternative carrier?

2. If a CoOportunity customer has not enrolled with another carrier by February 15, 2015 and the company is liquidated, what options will they have to obtain insurance?

416 VALLEY VIEW DRIVE
SUITE 600
SCOTTSBLUFF, NE 69361
(308) 633-6333
FAX: (308) 633-6335

2241 RAYBURN HOB
WASHINGTON, DC 20515
(202) 225-6435
FAX: (202) 225-0207

1811 WEST SECOND STREET
SUITE 275
GRAND ISLAND, NE 68803
(308) 384-3900
FAX: (308) 384-3902

3. Should CoOportunity be liquidated, will they be required to pay back any of their federal loans? If so, how?

4. Is the failure of CoOportunity in part due to CO-OPs having to set artificially low premiums to attract customers, risking insolvency with higher than expected enrollment numbers or claims?

5. How much funding was requested for assistance by CO-OPs in 2014? How much was available?

6. Are any other CO-OPs currently at risk of failure? Which ones, and what are you doing to monitor their financial stability and limit the risk to tax payers?

I recently learned a second CO-OP, Community Health Alliance, located in Tennessee has also suspended enrollment. This is an extremely unfortunate situation and I fear one more example of how the ACA is failing. Americans were promised they could keep the insurance they had and liked, now we are seeing they cannot even keep the insurance this law created. Because open enrollment is coming to an end, I respectfully request a response by February 2, 2015.

I appreciate your attention to this matter and look forward to working with you to ensure people have access to affordable health care.

Sincerely,

Adrian Smith
Member of Congress

AMS/mb

Mr. SMITH. And, Dr. Cohen, we have had, you know, various meetings, hearings about the overall situation with Obamacare, and I have followed up numerous times with various obviously questions and just concerns about taxpayer dollars, and actually I would like to also submit for the record, and request unanimous consent to place my questions and the Secretary's responses into the record.

Mr. JOHNSON. Without objection.

[The information follows:]

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAY 2 1 2015

The Honorable Adrian Smith
U.S. House of Representatives
Washington, DC 20515

Dear Representative Smith:

Thank you for your letter regarding your concerns about the financial solvency of CoOportunity Health, and Consumer Operated and Oriented Plan Programs (CO-OPs) more generally.

Our first priority is to make sure that existing CoOportunity consumers remain covered and receive the health care they need. Our first step was to help CoOportunity enrollees understand that they must switch to another qualified health plan offered through the Marketplace to continue to receive advance premium tax credits (APTC) and cost-sharing reductions (CSRs) to help pay for their health coverage. We conducted extensive outreach to encourage enrollees of CoOportunity to select a new plan during the open enrollment period for the 2015 plan year. Additionally, the Centers for Medicare & Medicaid Services (CMS) worked with Iowa and Nebraska Departments of Insurance (DOI) to set up a special enrollment period that ran through April 29, 2015, and allowed CoOportunity enrollees to select any non-grandfathered individual health plan offered in Iowa or Nebraska, including those outside of the Marketplace. Throughout this special enrollment period, we conducted targeted outreach to CoOportunity enrollees to make them aware of their options. Additionally, through the authority granted under the Affordable Care Act, CMS worked with the Marketplace plans to keep premiums affordable for Iowans and Nebraskans.

The vast majority of the CoOportunity enrollees have selected a qualified health plan offered through the Marketplace, which allowed them to continue to receive APTC and CSRs if they were eligible. However, a small number remain enrolled in CoOportunity with no coverage end date; their individual claims up to an aggregate of $500,000 will be paid by the state's guaranty fund.

Concerning CO-OPs more generally, section 1322 of the Affordable Care Act established the CO-OP program to foster the creation of non-profit health insurance issuers to increase consumer choice, promote competition, and improve quality in the health insurance market. To this end, section 1322 of the Affordable Care Act provided start-up and solvency loan funding to eligible entities to help establish and maintain these new plans. Since any start-up enters a market with the inherent risks of building a business from the ground up, the funding provided by the law was intended to provide needed support while these non-profit insurance companies became stable entities.

Implementation of the CO-OP program has been a collaborative effort among CMS, state DOIs, and the new CO-OP plans. As you know, states are the primary regulator of health insurance issuers and market rules. State DOIs also oversee the financial stability of issuers and protect consumers in those markets. CMS's role is to monitor CO-OPs for compliance with their loan agreements and program policies.

Due to a number of substantial Congressional rescissions to the initial funding level for the CO-OP program, CMS did not have sufficient funds to make full awards to all CO-OPs that requested additional funds. To support the new CO-OPs, while operating within the limits of reduced funding, the availability of additional loan funding was announced through guidance issued on April 30, 2014. Awards resulting from those applications were made on September 26, 2014. Additional loan funding was announced through guidance issued on August 22, 2014, and awarded on December 15, 2014.

The applications included actuarially certified analysis and financial projections, which necessarily incorporated data regarding current and projected levels of enrollment. On September 26, 2014, CMS granted CoOportunity Health an additional $32,700,000 based on a request of $32,700,000. This amount was included among the five loan requests granted by CMS, totaling $267,895,000 in additional loan funding to existing CO-OPs to support solvency and to expand coverage into additional states. The awards included:

- The Maine Community Health Options CO-OP received $67,630,000;
- Common Ground Healthcare Cooperative in Wisconsin received $28,450,000;
- CoOportunity Health in Iowa and Nebraska received $32,700,000;
- Health Republic Insurance in New York received $90,688,000; and
- HealthyCT in Connecticut received $48,427,000.

Pursuant to the August 22, 2014 funding announcement, CMS received a request from CoOportunity Health for an additional $55,000,000 in federal loan funding. While the total funding requests received in response to the August 22, 2014 announcement exceeded the amount of funding available to make loan awards, CMS was able to award $65,000,000 to Kentucky Health Cooperative and $22,667,899 to Common Ground Healthcare Cooperative in Wisconsin.

CMS therefore considered a number of additional factors in making loan awards, including: the reasonableness and viability of the business plan, contingency plans, market impact, and CMS's evaluation of the CO-OP experience and performance to date.

When using these criteria to review CoOportunity's request leading up to the December award announcement, based on the financial analyses discussed above, CMS and the external review panel concluded that the capitalization needs of CoOportunity Health were well in excess of additional funds available, and decided not to fund this request.

With respect to your question regarding Community Health Alliance of Tennessee, this CO-OP achieved its enrollment target for 2015 much earlier during open enrollment than it anticipated, and therefore requested that its state regulator permit the CO-OP to suspend writing new business in accordance with the financial capacity exception to the federal guaranteed availability requirements. Consumers who have already purchased Community Health Alliance plans for the 2015 plan year remain enrolled and will continue to receive coverage. CMS is working closely with state officials and the CO-OP on a plan to resume new enrollment for the 2016 open enrollment period later this year.

CMS is committed to safeguarding the interests of CO-OP beneficiaries and taxpayers in our management of the CO-OP program. CMS has worked with the Nebraska and Iowa Departments of Insurance and the CO-OP to assist with the smoothest possible transition for the current members of CoOportunity. CMS continues to conduct oversight of CO-OPs in their operational phase. CO-OPs are required to provide monthly data on enrollment, quarterly financial statements, including cash flow data, and semi-annual reporting. CMS evaluates the data to assess performance and compliance. CO-OPs also undergo site visits by CMS and submit to regular external audits. While the day-to-day oversight of insurance companies, and review and approval of their products and rates is performed by state regulators, CMS will continue to monitor each CO-OP's progress. CMS communicates weekly or more frequently with all CO-OPs regarding performance and challenges, and engages in regular communications with state regulators.

Again, thank you for your interest in this matter. I hope that you find this information helpful, and I look forward to working with you to provide accessible, affordable, and high quality health insurance options to all Americans.

Sincerely,

Sylvia M. Burwell

Mr. SMITH. Thank you.

Now, finally, on September 30th, I joined Chairman Brady and my colleague, Mr. Roskam, in sending a letter to the Acting CMS Administrator seeking further information on CO–OP solvency and oversight. We requested a response by October 14th, but have not yet received a response.

In the meantime, actually in the meantime, seven additional CO–OPs have collapsed. I am sure you are well aware of that, and I would like to request unanimous consent to submit that letter for the record as well.

Mr. JOHNSON. Without objection.

[The information follows:]

Congress of the United States
U.S. House of Representatives
COMMITTEE ON WAYS AND MEANS
1102 LONGWORTH HOUSE OFFICE BUILDING
(202) 225-3625
Washington, DC 20515-6348
http://waysandmeans.house.gov

September 30, 2015

Mr. Andrew Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Mr. Slavitt:

On July 30, 2015, the Department of Health and Human Services Office of the Inspector General (OIG) raised concerns over the oversight of the Consumer Operated and Oriented Plans (CO-OPs) by the Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS).[1] In its report, the OIG made several recommendations to improve the program and protect taxpayer dollars. We write today seeking additional information regarding CO-OPs, the OIG report, and the actions CMS is taking to ensure taxpayer funds are protected.

We have long been concerned about the financial solvency of CO-OPs. Federal spending, consisting of both start-up and solvency loans, totals $2.4 billion to date.[2] As you are aware, earlier this year, CoOportunity Health, the CO-OP serving Nebraska and Iowa, went bankrupt and was liquidated by the state of Iowa after only one year of offering health coverage.[3] In July, Louisiana Health Cooperative announced it would be closing.[4] In August, Nevada Health CO-OP announced to their 14,000 subscribers that it too would close by the end of 2015.[5] And in September, New York State told Health Republic Insurance of New York to stop writing new policies and to shut down

[1] Department of Health and Human Services Office of Inspector General, Actual Enrollment And Profitability Was Lower Than Projections Made By The Consumer Operated And Oriented Plans And Might Affect Their Ability To Repay Loans Provided Under The Affordable Care Act (July 30, 2015).
[2] *Id.*
[3] Anna Wilde Mathews, *State Regulators to Shut Down Insurer CoOportunity Health*, WALL ST.J (Jan. 23, 2015).
[4] Timothy Boone, *Louisiana Health Cooperative discontinuing insurance operations after being created with federal funds under Obamacare*, NEW ORLEANS ADVOCATE (July 26, 2015).
[5] Jackie Valley, *Nevada Health Co-Op to close, leaving thousands to find new insurance*, LAS VEGAS SUN (Aug. 26, 2015).

operations.[6] These four CO-OPs received approximately $146 million, $66 million, $65.9 million, and $265 million respectively in taxpayer funds.[7] It is highly unlikely these loans will ever be fully repaid, and taxpayers will be forced to pay for the losses of these failed programs.

Furthermore, according to the OIG report, more CO-OPs remain in serious financial trouble.[8] The report found that from January 1 through December 31, 2014, 21 of the 23 CO-OPs incurred net losses and more than half of the 23 CO-OPs had net losses of at least $15 million.[9] One CO-OP, Kentucky Health Cooperative, had a net loss of more than $50 million in 2014 alone.[10]

The credit ratings firm Standard and Poor's (S&P), found the medical loss ratios were more than 100 percent for several CO-OPs, which suggests that these CO-OPs spent more in healthcare claims than they received in premiums.[11] S&P noted that, as of September 2014, 11 CO-OPs had worse loss ratios than CoOportunity Health, which closed earlier this year.[12]

While the OIG report was helpful in providing much-needed information on the CO-OPs, including enrollment numbers and income data, it unfortunately confirmed many of the concerns we have long expressed about the CO-OPs ability to repay federal loans. We look forward to working with you to improve oversight, accountability, and transparency of the CO-OPs, and most importantly, to protect taxpayers who stand to lose when they fail. To assist the Committee, please provide the following no later than October 14, 2015:

1. According to the OIG report, CMS has recently placed four CO-OPs on enhanced oversight or corrective action plans, and two CO-OPs on low enrollment warning notifications. Which plans have received these warnings or have been placed on corrective plans? Describe the criteria used to determine CO-OPs subject to increased oversight. Also, please provide all corrective action plans.

2. What criteria does CMS use to determine the financial solvency of CO-OPs? Since the publication of the OIG report, has CMS instituted any additional

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[6] Rick Karlin, *Health Republic Insurance of New York co-op is closing*, ALBANY TIMES-UNION (Sept. 25, 2015).
[7] Kaiser Family Foundation, Consumer Oriented and Operated Plan (CO-OP) Loans Awarded.
[8] Department of Health and Human Services Office of Inspector General, Actual Enrollment And Profitability Was Lower Than Projections Made By The Consumer Operated And Oriented Plans And Might Affect Their Ability To Repay Loans Provided Under The Affordable Care Act (July 30, 2015).
[9] *Id.*
[10] *Id.*
[11] Bob Herman, Co-op insurance plan finances should be watched closely, Modern Healthcare (Feb. 14, 2015).
[12] *Id.*

requirements? Please provide the Committee with all relevant guidance issued.

3. The OIG recommended CMS work with state insurance regulators to identify and correct underperforming CO-OPs. What steps has CMS taken to work with state insurance regulators to identify underperforming CO-OPs? Has this coordination resulted in identifying any CO-OPs for additional oversight? If so, which CO-OPs? What additional oversight measures are planned?

4. What criteria were used to determine whether CO-OPs received additional funds after their initial start-up financing?

5. In the event that a CO-OP appears unlikely to repay its loans, what steps will CMS take to protect taxpayer dollars? How does CMS plan to recoup these losses?

6. Please provide the terms and conditions for all CO-OP recipients, including any modifications. Additionally, are there any conditions limiting compensation to CO-OP agents, including employees, contractors, executives and directors? If so, what are these conditions and how does CMS ensure compliance?

We thank you for your attention to this matter and look forward to a timely response to our questions. If you have any questions, please contact Oversight Subcommittee staff at (202) 225-5522.

Sincerely,

PETER J. ROSKAM
Chairman
Subcommittee on Oversight
Committee on Ways & Means

KEVIN BRADY
Chairman
Subcommittee on Health
Committee on Ways & Means

ADRIAN SMITH
Member
Subcommittee on Health
Committee on Ways & Means

Mr. SMITH. And I have a question. What did HHS or why did HHS deny in our case, Nebraska-Iowa CoOpportunity Health's request to suspend enrollment?

Dr. COHEN. Why did we deny their request to suspend enrollment?

Mr. SMITH. Correct.

Dr. COHEN. I am not actually familiar with that request and that denial. I know that I would say any of those decisions we do in coordination with the State Department of Insurance, who are the primary regulators of the insurance companies. They obviously have additional information about the state of play of any one of the insurance companies, the state of the risk pool.

I am happy to take back and look further to understand sort of the sequence of events there for you.

Mr. SMITH. Right. I would really appreciate that because it appeared then that Tennessee then requested a suspension of enrollment and that was granted. So any background that you could give to us on that scenario of perhaps what the standards are for either granting or denying the requested suspensions in enrollment.

I actually asked the Tennessee Insurance Commissioner about her interactions with HHS, and she told us that HHS, quote, "certainly had a differing opinion about the financial stability of the company," end quote, and referring certainly to the Community Health Alliance there in Tennessee.

Now, in Nebraska and Iowa, the Life and Health Insurance Guaranty Associations have begun paying out $80 million to cover outstanding claims on CoOpportunity Health policies. Will providers in other States where CO–OPs have shut down be made whole?

Dr. COHEN. I am sorry. Can you repeat that?

Mr. SMITH. Will providers in other States where CO–OPs have shut down be made whole?

Dr. COHEN. So the reason we have been doing the work we have and the oversight place is to make sure that CO–OPs could make sure to pay out the remaining claims over the course of this year and have an orderly wind-down process, and we do that in coordination with the State Departments of Insurance.

Obviously like in the case of Nebraska, there is a guaranty fund that is a backstop for consumers there to make sure that claims are paid.

Mr. SMITH. I have further questions, but my time has expired so I will submit those in writing. I request your assistance in getting those answered.

Dr. COHEN. Absolutely, Congressman.

Chairman BRADY [presiding]. Thank you.

Mr. Pascrell, you are recognized.

Mr. PASCRELL. Yes, thank you, Mr. Chairman.

Mr. Chairman, I have heard a lot of crocodile tears. Let us get down to the nitty gritty.

You are attempting to do to the ACA what you did to the IRS. You are trying to choke the funding. Let us put it all on the table. That is the bottom line. That is where you are heading.

I have listened very carefully to our astute folks on the other side of the aisle. The health insurance marketplace is rooted in competi-

tion. I think you are for competition. That is all you talk about, or do you believe in it?

When the ACA was being crafted some advocated strongly for the public option because I believed, as many others, that would truly drive competition and consumer choice in the marketplace. The public option was not part of the final bill.

It is imperative that local nonprofit insurers continue to be part of the marketplace. In the State of New Jersey our CO–OP, Health Republic of New Jersey, the name of the CO–OP, offers 17 plans on the marketplace in 2016. The CO–OP offered the lowest priced Silver Plan on the marketplace and enrolled over 60,000 residents last year.

New Jersey was unique in that our State has an unusually small number of insurers offering plans. No competition. In fact, when you look through all of the 50 States before the ACA, there was very little competition going on in those States, and we know what the results of it were in premiums and everything else.

Since the marketplace opened for business, new insurers have come into the marketplace, into New Jersey. Five insurers are now offering a total of 59 plans for 2016, and premium increases have been much lower than the average.

So I have got some questions, Dr. Cohen. I am not the grand inquisitor. So I come as a friend. Can you discuss what we have seen on a national scale with respect to competition and choice in the health insurance marketplaces?

Dr. COHEN. Yes. Thank you.

We for the coming 2016 year, we recently released information about what consumers can experience now if they go to HealthCare.gov in the federally facilitated marketplace States, and the average consumer can choose amongst 50 plans and five issuers, and 90 percent of folks are looking at three or more issuers to choose from.

So, you know, that is great progress in terms of the competition that is available to them in the marketplace, and again, I want to make sure that folks know that in addition, what is so unique about the marketplace is the financial assistance. We know that eight in ten are taking advantage of that financial assistance.

Mr. PASCRELL. Thank you.

The Affordable Care Act has been successful, I think, in arming consumers with the tools that they need in order to make these judgments. We want people to go on there, want people to study these different plans because my needs are different than your needs, et cetera.

The designation of the plans by metal and the user friendly interfaces on HealthCare.gov help consumers compare apples to apples when shopping for health insurance.

Dr. Cohen, during the open enrollment period which just started, consumers will be able to do more than compare coverage and premiums between different plans. HealthCare.gov now has a feature that helps people understand out-of-pocket costs.

Dr. COHEN. Right.

Mr. PASCRELL. Very concerned about out-of-pocket costs. Can you tell us a little bit about how that works and how you think it is going to improve the situation?

Dr. COHEN. Yes, absolutely. We share your concern your concern about out-of-pocket cost because it is not just the premium per month that people are paying, but it is that total out-of-pocket cost.

Mr. PASCRELL. Do you think most people understand that when they go to compare?

Dr. COHEN. We know that it is a challenge.

Mr. PASCRELL. Well, why are we not telling people? Why are we not educating people?

Dr. COHEN. Actually when you go to the HealthCare.gov site, it actually walks you through the definitions.

Mr. PASCRELL. Right.

Dr. COHEN. Premium, deductive, out-of-pocket cost, and now for the first time in this open enrollment season we have an out-of-pocket cost calculator. It tries to ask you a few simple questions about you, your family. Are you a high utilizer of health care? Do you have a chronic illness? Do you take prescription drugs ongoing, or if something bad happens, do you use the doctor?

And it helps you understand what type of product might be the best fit for your family.

Mr. PASCRELL. Every State had the ability to get money from the Federal Government to educate the public about these changes that have been going on over the past several years.

Our State of New Jersey chose the governor—may I finish my sentence, Mr. Chairman?

Chairman BRADY. Yes, sir.

Mr. PASCRELL. Thank you.

My State of New Jersey, the governor of that State chose not to take the $7.5 million, which is what it was in New Jersey, to help educate the public. On every turn my friends on the other side of the aisle and their counterparts in State governments have tried to close down the ACA, for the record.

Thank you, Mr. Chairman.

Chairman BRADY. The gentleman's time has expired. Thank you.

Ms. Jenkins, you are recognized.

Ms. JENKINS. Thank you, Mr. Chairman.

And thank you, Dr. Cohen, for being here with us today.

Dr. COHEN. Thank you.

Ms. JENKINS. The recent developments and failings of Obamacare's CO–OP Program are extremely disconcerting to me and should be for all Americans. Hard earned taxpayer money has once again been wasted with now almost half of all the CO–OPs resulting in failure.

And according to the Office of Inspector General, many more CO–OPs remain at risk of shutting down. This is not only a disaster for all of Americans who have lost their health insurance plan, but also for the American taxpayer. Billions of dollars of taxpayer funding has been wasted; hard earned taxpayer dollars were wasted on a program that was improperly designed at the most fundamental level.

This is exactly the sort of thing that I and so many others warned about during the debate on Obamacare. When the government gets so deeply entangled in the private sector, things go badly.

Now we must seek to understand what led to the massive failure and what, if anything, we can do moving forward to avoid the situation in the future.

Dr. Cohen, CMS joined by State regulators allowed certain CO–OPs to reclassify their start-up loans as surplus notes, as the chairman noted. This means that CO–OPs would be able to categorize these loans as equity rather than liability on their balance sheet, essentially allowing some CO–OPs to appear to satisfy CMS' 500 percent risk-based capital requirement.

Of course, the truth is the underlying economic substance of the CO–OP has not been changed. This is basically an accounting trick. Can you tell us and give us any idea how popular this shell game is with the remaining CO–OPs?

So how many States applied for a start-up conversion?

Dr. COHEN. So I want to make sure to let you know that we share your concern about being good stewards of taxpayer dollars. We are going to use every tool at our disposal to make sure that any funds that can be recovered back for the taxpayer will be for this program.

On this question in particular about the conversion that we were talking about, we look at those on an individual case-by-case basis, as I was mentioning. We do that in coordination with the State Departments of Insurance and then make a decision about whether or not that is the appropriate thing to move forward in that position.

I believe we have done that for seven of the CO–OPs.

Ms. JENKINS. Do you know which States?

Dr. COHEN. I have that I am sure in my many—I am happy to search through and give you the list now or I am happy to follow up if that is helpful.

Ms. JENKINS. Okay. If you can put your finger on it relatively quickly. If not, if you can get that to the committee.

Dr. COHEN. The seven that have gotten the conversion, I have it: Arizona, Michigan, Oregon, Colorado, New Mexico, Connecticut, and Wisconsin.

Ms. JENKINS. Okay. How many States were granted a start-up conversion?

Dr. COHEN. Those are the seven that were granted the conversion.

Ms. JENKINS. So all seven of those States were granted.

Dr. COHEN. That is right.

Ms. JENKINS. How many States have applications for a start-up conversion pending?

Dr. COHEN. We have a number pending. I do not know the exact number that are pending.

Ms. JENKINS. Can you get those to us and which States are pending?

Dr. COHEN. I will see what I can do in follow-up. I know that there is market sensitivity about sharing. Once it is done, I am able to share that information, which is why I can share who has already been approved. While it is in consideration, there are market sensitivities, but I will be happy for our staff to work with yours to see what we can provide.

Ms. JENKINS. Okay. How many were rejected for a start-up conversion?

Dr. COHEN. The same thing. I know there are some market sensitivities around it, but I will see what we can do in terms of providing that information.

I know I am allowed to, which I have in front of me, I am allowed to share those that we have approved, but I will get back to you about the ones——

Ms. JENKINS. Okay. Do you know how many of the remaining CO–OPs would have failed the risk-based capital test but for their participation in the start-up conversion process?

Dr. COHEN. I do not know the answer to that question.

Ms. JENKINS. Okay. Can you try to get us that?

What specific monitoring and oversight activities has CMS conducted for those specific CO–OPs that would not have met the risk-based capital test without the start-up conversion process?

Dr. COHEN. So we obviously do a number of oversight activities, as I was reading off a litany before, whether it is on-site visits and the increased reporting, but what I would say is that we do that in partnership with the State DOIs. They are the folks that day to day are managing the health of these insurance companies and making sure they are operating within the parameters of the State.

And so we work very closely for that ongoing oversight, and we will continue to do that for the CO–OPs that continue to be in existence.

Ms. JENKINS. Okay. Thank you, Dr. Cohen.

I yield back the balance of my time.

Dr. COHEN. Thank you.

Chairman BRADY. Thank you, Ms. Jenkins.

Mr. Marchant, you are recognized.

Mr. MARCHANT. Thank you, Mr. Chairman.

I thank you for being here, Dr. Cohen.

Dr. COHEN. Thank you.

Mr. MARCHANT. This last week I read four articles about the CO–OPs. The first one was in the New York Times. The headline was "Health Care CO–OP Closings Narrow Consumer Choices," not exactly a right-wing institution.

Bloomberg Business, "Your Health Plan Will Now Destruct was the headline.

Newsweek, "The Calamitous Collapse of the Obamacare CO–OPs," again, not a right-wing organization.

And the Washington Post, "Financial Health Shaky at Many Obamacare Insurance CO–OPs."

So do these articles make a fair representation of the status of what is going on with the CO–OP Program?

Dr. COHEN. Well, the facts on the ground know that 12 of the CO–OPs will not be continuing to 2016 of the 24, and obviously our job is to protect consumers, make sure that we are being good stewards of taxpayer dollars, but also supporting what we think is a very important program adding additional competition into the marketplace.

I think it is important to also remember that CO–OPs are only one piece of the larger Affordable Care Act which we have been

talking about and, you know, make up a larger piece of what consumers are experiencing when they go to HealthCare.gov.

So, again, we had some work to do on the oversight front, which we have done, in order to make sure that consumers knew that if they went to the marketplace now, that they can put their faith in the products that are there. They know that they are financially viable and will be there to provide them coverage for next year.

Mr. MARCHANT. Is your agency looking to use the surplus in the transitional reinsurance program to support the CO–OPs that remain open?

Dr. COHEN. Are we looking at using the reinsurance dollars to support the CO–OPs? No. That appropriation is for the reinsurance program for the entire market. That will be used for the three years that the program——

Mr. MARCHANT. No, use the surplus.

Dr. COHEN. No, the surplus carries over to the next year of the reinsurance program and will be used with the reinsurance program itself, which applies well beyond the CO–OPs to all of the issuers participating in the marketplace.

Mr. MARCHANT. So if you took the amount of money that was lost, would you agree that the $1,072,000,000 number is correct about the amount that was lost last year?

Dr. COHEN. That is the number of dollars that were loaned to these CO–OPs. As I mentioned to the Congresswoman, we are going to be using every tool available to recover taxpayer dollars here. Obviously that money went to provide coverage to Americans over the past two years. So we know all dollars will not come back to us, but we will be using all tools available to recover any unspent taxpayer dollars.

Mr. MARCHANT. That money will go back into the fund?

Dr. COHEN. To the Treasury.

Mr. MARCHANT. To the Treasury or will it go back to into——

Dr. COHEN. To the Treasury.

Mr. MARCHANT [continuing]. A revolving fund that goes out to the other CO–OPs?

Dr. COHEN. No. I do not want to give you inaccurate information. So let me follow up on when we recover money where that money goes exactly, whether it comes back to the CO–OP Program or back to the Treasury.

Mr. MARCHANT. Is 400,000 a correct number to use? Is that participants who have lost or is that the number of policies that have been lost?

Dr. COHEN. That is a good question. I will have to follow up whether it is participants or policies. What I would say is that that represents folks not just in the marketplace. It represents folks potentially inside and outside the marketplace in the individual market and in the small group market, and depending on the CO–OP and what book of business they picked up, some even picked up some Medicaid managed care business as well. So those numbers can represent a mix of different types of policies.

Mr. MARCHANT. Well, if you took that number and divided using 400,000 into the amount of money lost, it is about $2,700.

Dr. COHEN. So again, not money lost. We still have tools at our disposal to recover that fund, as well as that money went to pay claims and coverage for Americans over the last several years.

Mr. MARCHANT. And my last question is: using the business metaphor, when you inject this loan in there, you have to have some repayment scheme in mind. The insurance companies have to have some eventual repayment of this money that they presented you or did you make them in their business plan tell you when and under what circumstances they would pay the money back?

Dr. COHEN. Yes, absolutely. All of the companies that applied for this, and I will say almost 150 entities applied to be CO–OPs and we only chose the best 24. Obviously they presented business plans—sorry, Chairman—business plans and strategies. Obviously though when the rubber hits the road and reality hits, business plans are just that, plans, and then we have to evaluate them as they move along.

Chairman BRADY. Thank you. The time has expired.

Mr. Davis, you are recognized.

Mr. DAVIS. Thank you very much, Mr. Chairman.

And thank you, Dr. Cohen, for being here.

I have always been a big fan of co-ops ever since I have understood what they were, and I view them as a great business model because they actually spanned opportunity and create opportunity for more people to be engaged and involved in the process of commerce in our society and in our country.

I come from Illinois where our experiences with the Affordable Care Act have been great, quite good. I mean it has generated tremendous returns for our citizens in terms of health care and other kinds of benefits that we have experienced as well.

It has also been my experience that with start-up businesses, if they do not have enough capital or if they do not have the capital resources that are needed, it increases the likelihood that they are going to have some difficulty and in many instances they actually fail.

And so we have had CO–OPs that have been successful. We have had some that were not so successful, but the one thing that we do know is that many important Affordable Care Act protections have made dramatic improvements to American lives. These include a prohibition on health insurers denying coverage for children with preexisting conditions.

The Administration estimates that 17.6 million children are no longer denied coverage by insurers because of an illness. Additionally, 105 million Americans have had lifetime coverage limits eliminated.

You obviously travel throughout the country, and I suspect that you have met a lot of people from all political parties who have benefitted from these protections. What do people tell you about the Affordable Care Act and how it has helped them?

And what would happen to these people if my Republican colleagues got their way and were able to actually dismantle this law and these programs?

Dr. COHEN. So it is interesting. Once we get outside of our world here at CMS and are able to interact with folks who are benefitting from the new options of coverage and taking advantage of

the tax credits, it is not about politics for them. It is really about what is right for their family, and that for the first time they are able to compare choices and find something that is affordable for them.

I think poignant in my mind were some particular parents who were able to start their own new business. They had wanted to for a long time, had been thinking about it, but because one of their young children had a severe illness, they worried about what coverage would look like for them on the individual market and so stayed with the job they had, which they were lucky enough to have, but what the Affordable Care Act gave them was that freedom and flexibility to start the new business and find coverage that worked for them and for their children.

And that is what we hear about every day, whether it is coverage for someone who has a preexisting condition or just thought it was out of reach for them; a young person who goes and gets one of their preventative care visits and realizes they had high blood pressure, and as a physician I am like, "Great. Get on your ACE inhibitor now so that they prevent problems well into the future."

So those are the kinds of success stories, small, but each build up to something really great.

Mr. DAVIS. Well, thank you very much, and I think that they would say the risk that we take is worth it even if there are some instances where we are not exactly successful, but they are in much better shape than they were before the ACA was passed.

Thank you, Mr. Chairman. I yield back.

Chairman BRADY. Thank you.

Mrs. Black, you are always good about joining the Health Subcommittee. You are recognized for five minutes.

Mrs. BLACK. Thank you, Mr. Chairman. It is great to be a part of this Committee.

And, Dr. Cohen, thank you for being here to testify today.

Dr. COHEN. Thank you.

Mrs. BLACK. Dr. Cohen, my friends on the other side of the aisle would suggest that Congress is at fault for this failure. We have heard it several times, and because we stopped good taxpayer money following after bad, and I suspect that we could have pumped billions of dollars more into this program and still not overcome what I think are the fundamental problems of this program.

So let us talk about the program that the Democrats actually designed. This is not a Republican design. Let us talk about that. Let me ask you a couple of questions.

In this program could a health insurer applying for a loan under the CO–OP Program be a for-profit entity?

Dr. COHEN. So there are restrictions in terms of the types of dollars that the CO–OPs could get. They could get a bank loan and other types of outside loans. There are restrictions about whether or not that outside capital would influence the governance structure, which is pretty prescriptive in statute.

And, again, I think as you have heard, that governance structure is really consumer driven, and that was why the nature of the program was put in there.

So it does limit their options. It also prohibits them from merging or getting dollars from another for-profit insurer.

Mrs. BLACK. The answer really is no on that.

So let me ask you this. Could a health insurer applying for a loan under the CO–OP Program use the funding for marketing?

Dr. COHEN. They are not allowed to use their dollars for marketing. What I would say is that one of the things the Affordable Care Act does and HealthCare.gov in particular, it allows for CO–OPs to be listed side by side of some of the much more established plans and so they can compete on price and benefits, which is what the CO–OPs——

Mrs. BLACK. In fact, what happened in the State of Tennessee is we had our CO–OP could not market. So what they were doing is giving free cell phones, and they were stopped by our Commissioner as a result of that.

Could a health insurer applying for the loan under the CO–OP Program be one that actually operated as a health insurer prior to the law's passage?

Dr. COHEN. There are some restrictions about getting funding from current insurers. I would have to look back if there is a statute of limitations of how long ago they were an insurer, et cetera, about getting funding.

Mrs. BLACK. Essentially the answer is no.

So here is the situation. The American taxpayer has invested $2.4 billion, and this is taxpayer money, into a group of folks who never operated an insurance company before, never made any money at it, and in your testimony you also answered a question to say they had no previous claims experience, which was a problem, and they could not advertise their product to potential customers.

It seems like it is awfully difficult given those circumstances, that there are some really fundamental problems with the program to begin with.

You are an internist; is that correct?

Dr. COHEN. That is right, ma'am.

Mrs. BLACK. Have you practiced in private practice?

Dr. COHEN. I have not practiced in private practices.

Mrs. BLACK. Oh, you have not. Okay. Well, I would just set forward this scenario in real life because I have worked with physicians who have practice in private practice, and I know how important it is to have a business manager operating their particular office. So let us just say they hired someone that said, "Oh, by the way, I have never operated a physician's office and I have never made any money at it. I have no experience in previous claims, and I am not going to advertise."

Do you think that office could be successful with that business manager being in charge?

Dr. COHEN. What I think it is important to step back and recognize about the CO–OP Program is that they were designed specifically to have a governance board that was consumer driven. I think that was the heart of it. I think you had some of your other colleagues mention that this is not unique to the health care space.

Mrs. BLACK. Just real quickly because I am going to run out of time here, I do want to ask a question about what you expect to recover. Do you all have a number that you expect to recover?

Dr. COHEN. We are doing the work right now with the CO–OPs. As you know, the recent announcements they are still winding down over the course of this year. As I mentioned, we take taxpayer dollars very seriously but——

Mrs. BLACK. But you do not have a number that you anticipate?

Dr. COHEN. No, not right now.

Mrs. BLACK. And I just may close by saying the reason why co-ops work in other situations, and I like them; we have farmers co-ops. We have an electric co-op. We have other utility co-ops, and the reason why they work is because everybody in it has skin in the game. It is not taxpayer dollars. It does not come from some dropping of dollars out of the sky. It works because everybody that is in it has something in the skin of the game.

Here we have taxpayer dollars to the point of $2.4 billion, and that is a real concern.

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

Chairman BRADY. Thank you, Mrs. Black.

I would like to thank you, Dr. Cohen, for your testimony today. I appreciate your continued assistance. A number of questions were raised, and if you would follow up with them.

As well, as a reminder, any Member who wishes to submit questions for the record will have 14 days to do so. If any of them do, please respond in writing in a timely manner.

Again, thank you very much for being here today.

With that, the committee is adjourned.

[Whereupon, at 3:59 p.m., the subcommittee was adjourned.]

[Member Questions for the Record follows:]

Secretary Burwell's Hearing
"FY 2016 Budget" Before
House Ways & Means Committee
June 10, 2015

Questions from Representative Adrian Smith from Nebraska:

The ACA created 23 Consumer Operated and Oriented Plan Programs, or CO-OPs, which were an alternative to the public option and are low cost, government subsidized health care plans. As I mentioned in the hearing, Nebraska was served by one such CO-OP, CoOportunity Health, which has since been seized by the State of Iowa and liquidated. I have been frustrated by the lack of information HHS has provided surrounding this situation, including at the June 10, 2015 hearing, and respectfully ask for a response to the following questions.

1. **CO-OPs are funded by two different loan programs, low interest government loans with 5 years to repay and solvency loans with 15 years to repay. How much money has HHS provided to the CO-OPs through each of these loan programs? How much to each individual CO-OP, including CoOportunity?**

Answer: HHS is committed to working with you and your staff. Section 1322 of the Affordable Care Act provided start-up and solvency loan funding to eligible entities to help establish and maintain new CO-OP plans. The total amount of start-up loan funding obligated and available to a particular CO-OP was based on the estimated cost of specific start-up activities. Solvency loan award levels were set based on industry standards and state regulatory capital requirements. Approximately $2.4 billion has been awarded to CO-OPs as of December 16, 2014, when the final awards were made. Of this amount, CoOportunity was awarded a total of about $14.7 million in start-up loan funds and about $130.6 million in solvency loan funds.

Information on loan awards made to CO-OPs in other states may be found here: https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html.

2. **What safeguards are in place to ensure the CO-OPs repay these loans within the 5 year and 15 year windows respectively? Will CoOportunity be required to repay any of the approximately $150 million they are reported to have received**

in taxpayer dollars? Are there any penalties in place if a CO-OP does not make a loan payment on time?

Answer: HHS is committed to safeguarding the interests of CO-OP beneficiaries and taxpayers in our management of the CO-OP program. The Centers for Medicare & Medicaid Services (CMS) continues to conduct oversight of CO-OPs in their operational phase. CO-OPs are required to provide monthly data on enrollment, quarterly financial statements, including cash flow data, and semi-annual reporting. In tandem with state Divisions of Insurance and other state oversight, CMS evaluates the data to assess performance and compliance. CO-OPs also undergo site visits by CMS and submit to regular external audits. While the day-to-day oversight of insurance companies, and review and approval of their products and rates is performed by state regulators, CMS continues to monitor each CO-OP's progress. CMS communicates weekly or more frequently with all CO-OPs regarding performance and challenges, and engages in regular communications with state regulators.

Under the terms of the loan agreements between CO-OPs and CMS, in the event that any payment due under the agreement is more than 60 calendar days late, CMS has the right to exercise any right or remedy specified in the loan agreement or available under applicable law, including the right to discontinue further loan disbursements or terminate the agreement. In the event that any payment due under the agreement is delinquent for more than 180 days after the due date, CMS shall refer the matter to the Department of Justice for processing and other federal action, in accordance with the terms of applicable federal law. If a CO-OP is unable to make a payment as a result of a state solvency payment restriction, state reserve requirements, other state solvency regulations or requisite surplus note arrangements, and a notice is provided to CMS with sufficient documentation to verify the claim, CMS will provide the CO-OP with a 60-day grace period to remedy the deficiency.

HHS is focused on maximizing the recovery of government funds from CO-OPs, including CoOportunity Health,within the Affordable Care Act's multi-faceted framework for stabilizing insurance markets nationwide. CMS is working with the liquidators responsible for CoOpportunity Health to quantify the scope of CMS's interests based on the required run-out of remaining policies as well as claims and obligations arising under the risk-adjustment, risk corridor, and transitional reinsurance programs for FY 2014. The liquidator has established December 15, 2015 as the last day to file claims in the liquidation proceeding, after which the amount recovered will be determined.

3. **CMS is supposed to be carefully monitoring the CO-OPs financial stability through, among other measures, audits and semi-annual program reports, yet provided CoOportunity with $32.7 million in taxpayer dollars on September 26, 2014. What did CMS know regarding CoOportunity's finances according to the most recent audit and program report CMS had at that time?**

Answer: In making loan award decisions for additional rounds of funding in 2014 (made in September and December), CMS reviewed applications, including assessing updated business plans, conducting feasibility studies, and assessing programmatic and regulatory compliance, actuarial soundness, and pro forma financial statements. The applications included actuarially-certified analysis and financial projections, which necessarily incorporated data regarding the current, and projected, level of enrollment. In accordance with guidance issued on April 30, 2014, an external panel reviewed and provided to CMS an assessment of each funding request, consistent with the CO-OP Program Funding Opportunity Announcement and the CO-OP Program Final Rule. In addition to the information provided by the external review panel, and CMS's analysis, the number of awardees and the total amount awarded were limited by the availability of resources. CMS made the final loan award decisions based on the information provided in the application and these analyses.

On September 26, 2014, CMS mademade a loan award to CoOpportunity Health of $32,700,000, which was the full amount requested by the CO-OP in response to the funding opportunity announcement released by CMS on April 30, 2014.

Additional loan funding availability for existing CO-OPs OPswas also announced through guidance issued on August 22, 2014 and, CMS received a request from CoOportunity Health for an additional $55,000,000 in federal loan funding. When using these criteria to review CoOportunity's request leading up to the December 2014 award announcement, based on the financial analyses discussed above, CMS and the external review panel believed the capitalization needs of CoOportunity Health to be well in excess of additional funds available and ultimately decided not to fund this request. In late December, the state of Iowa brought to our attention their immediate concerns over the rapidly deteriorating financial viability of the CoOportunity insurance company.

4. My understanding is Iowa and Nebraska were told they could not suspend enrollment on CoOportunity and have it remain a Qualified Health Plan, yet Tennessee was later allowed to do so. How and why was that policy changed?

Answer: CMS did not prevent CoOportunity from freezing enrollment. Section 2702 of the Public Health Service Act and regulations at 45 CFR 147.104 generally require issuers to guarantee the availability of coverage. However, the law permits issuers to close enrollment where the issuer demonstrates to the applicable state authority that it does not have the financial reserves necessary to underwrite additional coverage. The Tennessee CO-OP froze enrollment during 2015 open enrollment based on a demonstration to state regulators that further enrollment would exceed current financial capacity, as permitted by the state statute and regulation.

5. Recent reports claim only one CO-OP did not have an operating loss in 2014. Is that true? Do you project any others are in danger of liquidation?

Answer: CMS regularly monitors each CO-OP's operational performance, financial performance, and compliance. This monitoring is concurrent with on-going financial and operational monitoring by state insurance regulators. If, based on this monitoring, there are concerns regarding a CO-OP's performance or compliance, CMS may solicit additional information from the CO-OP or provide technical assistance. In cases where more serious concerns are identified, and in coordination with state regulators, CMS may put the CO-OP on a corrective action plan (CAP) or enhanced oversight plan (EOP). Additionally, CMS may terminate the CO-OP's Loan Agreement.