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## ObamaCare Co-ops: Cause Célèbre or Costly Conundrum?

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### Overview

The Affordable Care Act created a new kind of “cooperative” health insurance arrangement heralded by supporters of health reform. The co-ops were founded on the idealistic belief that community members could band together to create health insurance companies that would be member-driven, service-oriented, and would not have to answer to shareholders or turn a profit.

But the 23 co-ops that were created had significant start-up costs, no experiential data upon which to set premiums, generally had to pay extra to lease physician and hospital networks, and had few people in the companies and none on their boards with insurance experience.

The idealism has quickly faded. After receiving hundreds of millions of dollars in government start-up loans, most co-ops are surviving now on what remains of more than \$2 billion in federal “solvency loans” and on the promise of future “shared risk” payments that are likely to produce only a fraction of the revenue co-ops have booked.

Standard & Poor’s observed that becoming a co-op “can be like learning to ride a bike without training wheels.” Some co-ops launched with premium prices far below their competitors, gaining a significant market share, but they quickly saw their medical costs far outpace their premium revenue and reserves.

Others started more slowly with little enrollment, only to try to jump ahead of competitors with lower premiums in the second year. The average premiums for co-op plans were lower than those for other issuers in more than half of the rating areas for states in which they participated in 2014, according to the Government Accountability Office.<sup>1</sup>

The lower premiums did attract new customers, but the co-ops now are burning through inadequate premium revenue and dwindling amounts of unspent loan funds to pay medical claims.

**This paper will take a deeper look** at co-ops in Iowa, Kentucky, Tennessee, and other states that reveal their precarious financial condition.

Iowa's CoOpportunity Health shows the peril. The co-op set off alarm bells when it was liquidated in January 2015, forcing 120,000 people to find new sources for health insurance. But this is not an isolated example of serious problems with this experiment. Co-ops in 10 other states had even worse loss ratios in the third quarter of 2014 than Iowa did, regulatory filings show.

The Kentucky Health Cooperative deserves special attention because it has the second highest enrollment of any of the remaining co-ops. Until recently, Kentucky had been considered one of the more successful co-ops, capturing 75% of enrollees in state-run health insurance exchange enrollment. But there are disturbing similarities between its numbers and the failed Iowa co-op.

Kentucky has been awarded \$146.5 million in taxpayer loans, including \$65 million in solvency funding in November of 2014. Most of these funds have been exhausted, and now the co-op is banking on risk corridor payments.

It would be considered insolvent if not for an additional receivable of \$76 million in risk-corridor payments it expects this summer to maintain a semblance of solvency. The availability of further solvency loan funding has all but disappeared, and the risk corridor program payments are expected to shrink for

2015 and then disappear after the 2016 exchange plan year.

Kentucky's co-op posted a "medical loss" ratio of 158 percent for 2014 – for every premium dollar it collected, it spent that dollar and an additional 58 cents on the cost of claims. The co-op now has even less of a margin for error after exhausting its existing federal loan allocations. This sort of performance will not be sustainable for Kentucky or for other co-ops that are similarly challenged.

In Tennessee, the Community Health Alliance co-op went through a boom-bust cycle. Its enrollment rapidly expanded in the latest enrollment cycle after it offered the lowest premiums in many areas of the state. But it suddenly had to freeze enrollment in January 2015 after its enrollment surged from just 1% of the market in 2014 to 25% mid-way through 2015 enrollment period.

Regulators grew concerned that the co-op was gaining a larger market share than it could support. The Tennessee co-op learned that lowering premium prices substantially to expand enrollment only produced larger losses. Its latest move was to ask regulators to approve an average 23% premium increase for 2016.

As this paper will show, the co-ops are trying different tactics to outrun their losses, but the tactics resemble a family in financial trouble taking out additional credit cards to pay daily bills. The idealistic co-op experiment is not turning out as supporters had hoped.

## Starting with hope and promise

Throughout much of the debate over what became the Patient Protection and Affordable Care Act, advocates pushed for a "public option" that would have put a government-run health insurance entity in competition with private insurers. The public option was itself a compromise for health reform advocates who preferred a single-payer, government-run health system. The public option was the most they could hope to get.

But even that proved to be too difficult to get the 60 votes needed to pass the United States Senate. Instead, the ACA contained a provision allowing creation of a Consumer Operated and Oriented Plan (co-op) program. The co-ops would be non-profit health insurers, governed and operated by consumer members and chartered and regulated by the states, competing with established insurers.

Not even all of those who voted for the ACA were supportive. For example, Senator John D. Rockefeller (D-WV) criticized the co-op program design in a letter to the Chairman and the Ranking Member of the Senate Finance Committee in 2009. Senator Rockefeller wrote: "I believe it is irresponsible to invest over \$6 billion in a concept that has not proven to provide quality, affordable health care."<sup>2</sup>

In practice, the public is finding that the co-ops do present options to the public, but neither is attractive: They have the choice of not enrolling in co-op coverage because the premiums are so high compared to competing plans. Alternatively, they can prepare to help finance large bailouts for those co-ops that offered low premiums to gain a larger market share but which are accumulating losses at a rapid rate.

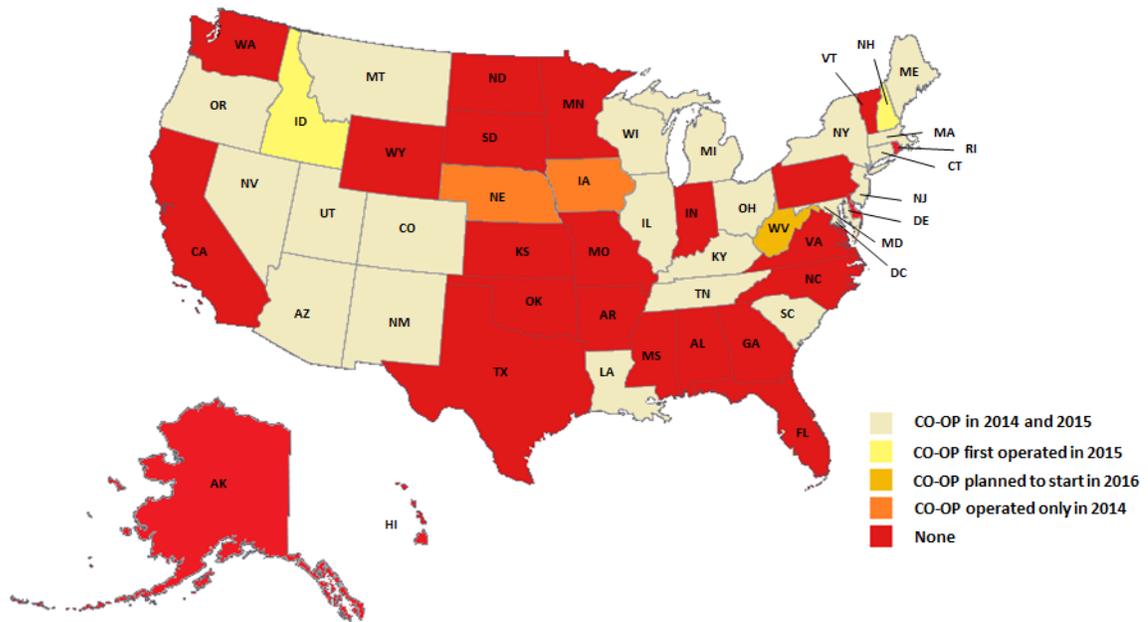
**The ACA provided some special advantages** to help co-ops get established and start operating, beginning with \$6 billion in federal government loans. The law required the Department of Health and Human Services (HHS) to distribute funds to at least one co-op in each state and the District of Columbia. The co-ops could offer health coverage on and off the health insurance exchanges in the

individual and small-group markets. Co-ops would be required to meet the same regulatory requirements imposed on private insurance companies at the federal and state levels, including solvency and licensure, network adequacy, provider payments, rate and form filing, and state premium assessments. Any surplus revenues were to be devoted to reducing premiums, or to improving benefits or the quality of care for its members. No representative of a government agency, insurance company, or insurance industry association could serve on a co-op board.

Consumer groups, community organizations, medical provider organizations, unions, business coalitions, and others could qualify as "persons applying to become qualified nonprofit health insurance issuers," as described in the law. Regulations further clarified that sponsors needed to provide 40% or more of total co-op funding, not including federal loans. A co-op also cannot receive more than 40% of its funding from state and local governments or more than 25% from an insurance company that existed before the date the co-op provision was incorporated into the Senate bill on July 16, 2009.

The ACA says the co-ops are to "foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans" that would provide better benefits and lower prices and compete with established health insurers. The co-ops expected to keep costs down because they did not need to accumulate profits and because they expected to have lower administrative costs. They would rely on preferred vendors, grassroots marketing efforts, wellness promotion, as well as creative payment models and benefit design to inject both innovation and competition into states' health insurance markets.

In all, 23 state-based co-ops have been established. A handful of them operated in more than one state in 2014 (Iowa – Nebraska) and 2015 (Montana/Idaho, Massachusetts/New Hampshire, Maine/New Hampshire) or plan to expand in 2016 (Kentucky/West Virginia).<sup>3</sup>



Adapted from Scott Harrington, “The financial condition and performance of CO-OP plans,” University of Pennsylvania Leonard Davis Institute of Health Economics and Robert Wood Johnson Foundation, February 2015.

As of December 2014, more than 478,000 members had enrolled in coverage through the co-ops, about 347,000 in individual policies and 131,000 in group coverage. This March, the National Alliance of State Health Co-ops reported a new figure of one million “effectuated” co-op members in the 2015 enrollment period, with little further explanation or documentation of this apparent doubling of co-op enrollment in less than three months.<sup>4</sup>

Enrollment in 2014 varied widely in the numbers of enrollees the co-ops attracted. Some gained dominant market share and others had very little enrollment. Enrollment ranged from 869 in Arizona’s Meritus Mutual Health Partners and 1,582 in

Oregon’s Health CO-OP to 155,402 in New York’s Health Republic. Iowa’s CoOpportunity Health was the second-largest co-op with an estimated 120,000 members before being liquidated this year. Only one other co-op exceeded 50,000 members in 2014 – the Kentucky Health Cooperative with 56,680 members.

A Government Accountability Report showed that co-op enrollment got off to a slow start. During the first open enrollment period (October 1, 2013, through March 31, 2014), more than half of the 23 co-ops had lower enrollment than expected, and eight had enrollment greater than projected.<sup>5</sup> The lower-than-expected enrollment was a harbinger of problems to come.

## Early warning signs

There were many hopes for the success of the co-ops, and they had the significant advantage of access to extremely generous federal loans at very low interest rates and attractive payment terms which their competitors did not have. Nonetheless, some of these new, untested, citizen-run health insurance plans began having problems before they sold their first policy. It quickly became clear to Congress that taxpayer dollars were at risk. Three times, Congress has cut funding for co-ops – cuts all signed into law by President Obama – reducing total appropriations from the initial \$6 billion to \$2.4 billion.<sup>6</sup>

But the congressional actions were not fast enough to protect taxpayers.

For example, in 2013, Vermont’s insurance commissioner denied a license to the co-op to even get started. “The CO-OP has not shown sufficient evidence that it will be able to sustain solvency, repay its federal loans and gain enrollment,” Insurance Commissioner Susan Donegan said.<sup>7</sup> She also stated the co-op would likely attract few customers because its policies were priced 17% higher than the same policies offered by competitors. In addition, there were other allegations reported of a kickback scheme to a company owned by the co-op’s president.<sup>8</sup> At least \$33 million in federal loans had been awarded to the Vermont Health CO-OP. HHS is calling for repayment, but no information is available about how much, if any, of the money has been or will be returned to the federal treasury.

**The failure of Iowa’s co-op** offers the most disturbing “mine canary.”

On September 26, 2014, the Center for Consumer Information & Insurance Oversight at the Centers for Medicare and Medicaid Services awarded Iowa’s CoOpportunity Health \$32.7 million in solvency funds, bringing its

total in federal loans to more than \$145 million.<sup>9</sup> But just three months later, the Iowa state health insurance regulator reported that the co-op, which operated in both Iowa and Nebraska, was in a “financially hazardous situation.” The co-op had an operating loss of \$163 million for 2014 and another \$4.6 million as of January 2015, for a total loss of nearly \$168 million.<sup>10</sup>

It was liquidated on January 23, 2015, after the state insurance commissioner indicated the co-op had insufficient funds to pay medical claims over the next six months. At least 120,000 CoOpportunity Health members in Iowa and Nebraska were quickly forced to find coverage elsewhere. The Iowa Insurance Division had this helpful advice for them: “Your coverage with CoOpportunity Health will stop, and claims will not be paid after cancellation. If you do not purchase replacement insurance, you may be penalized by the federal government.”<sup>11</sup>

**Shock waves reverberated through the co-op community** with the failure of CoOpportunity Health, but it should not have been a complete surprise. Its leading indicators included:

- rapid customer growth
- inadequate premium pricing
- adverse claims experience
- low levels of risk-based capital
- heavy reliance on federal solvency loans
- problems associated with delayed risk-corridor payments

Iowa’s co-op was not alone in facing challenges, and comparable problems are raising red flags with other co-ops.

Iowa’s business model was extremely flawed. It underpriced its products, offered very rich benefits, and paid much larger broker commissions than its competitors. It priced its richest benefit Platinum plan 7% lower than

the average Silver plan, 24% lower than the average Gold plan, and 41% lower than the only other Platinum plan in the market. It's not surprising that it attracted enrollment that was 10 times greater than expected. In most businesses, that is not considered a problem but rather a success because that means receiving 10 times the revenue.

Iowa's CoOpportunity and others blame their problems on having sicker-than-normal patients enrolled. Jesse Patton, an independent insurance agent in Des Moines, said it appeared that CoOpportunity made its benefits too generous. By doing that, he said, "what they ended up doing was attracting a lot of sick people."

News reports would indicate Patton was correct. The *Des Moines Register*<sup>12</sup> reported that "Customer Lori Kauzlarich of Des Moines said she was disappointed by the collapse of CoOpportunity." Kauzlarich had "previously bought health insurance from a high-risk plan run by the state, because she has a serious bone-marrow condition. The high-risk plan cost about \$700 per month, and it had higher deductibles than the \$520-per-month plan she obtained from CoOpportunity last January.

"Kauzlarich said CoOpportunity's coverage and service were 'fabulous.' At one point, she had \$30,000 worth of tests in one day but only had to pay \$400 toward them. She spoke Friday at the John Stoddard Cancer Center, where she had just had a monthly transfusion of a pricey bone-strengthening drug, which CoOpportunity covered with 'no questions asked,'" the *Register* reported.

In October 2014, CoOpportunity Health announced that it was withdrawing from Iowa's alternative program for Medicaid expansion because high medical costs were outpacing the premiums it received for providing private Medicaid coverage.

To cover higher-than-expected medical claims payments, CoOpportunity applied to raise its premiums by an average of 19% for 2015, compared to only 9% for competing private insurer, Coventry. After pricing its premiums significantly lower than competitors in 2014, premium increases in Iowa's CoOpportunity were higher than competitors for 2015. These premium increases were expected to have led to a loss of enrollment in the co-op before it was liquidated.

**The threat of losing some of the risk corridor subsidies** (see page 9) allowed under the ACA further undermined future prospects for its solvency. According to the petition for liquidation, Iowa's CoOpportunity was counting on \$81 million in risk corridor reimbursement in 2015 – despite new congressional restrictions on such funding – a number that grew from \$60 million, demonstrating the desperate circumstances of the co-op.

Even generous government start-up funding, bailout money, and expected risk reimbursements could not overcome Iowa's flawed business model. It had reported a net loss of \$39.8 million through September 30, 2014. A final report for 2014 has not yet been released to determine its total losses.

The Iowa insurance commissioner officially placed CoOpportunity Health under regulatory supervision in December 2014 soon after the Centers for Medicare and Medicaid Services (CMS) indicated it would not provide additional solvency loan funding. But the commissioner's order also emphasized the co-op's rapidly deteriorating cash position. CoOpportunity Health was losing \$14.5 per \$100 of premiums collected for the first nine months of calendar year 2014.<sup>13</sup> It was ordered to be liquidated effective February 28, 2015.

Nick Gephart, Iowa's insurance commissioner, asked, "If the second largest (co-op) can't

make it, how viable are the other ones? I don't know. But at the end of the day, they didn't have enough capital to support 120,000 members.”

One motivation for pulling the plug may have been to stem the losses paid by the insurance guaranty funds that provide up to \$500,000 in financial protection per covered person to customers and providers if the insurer is unable to meet its obligations. Surviving companies – or actually their policy holders – will pay for the co-ops’ losses, ultimately in the form of higher premiums.

After the liquidation of CoOpportunity Health, the Nebraska and Iowa Life and Health Guaranty Associations assumed responsibility for paying all outstanding claims for CoOpportunity Health. The associations are funded by assessments against member health insurers. For 2015, the Nebraska Guaranty Association assessed commercial carriers the highest amount allowed by law to pay outstanding claims for CoOpportunity members. “Under each state’s guaranty fund association laws, \$170 million of CoOpportunity Health’s policyholder health claims are, in part, now funded and paid out of proportional assessments levied on each of the insurance company members of the respective guaranty associations,” health law attorney William Schiffbauer writes.<sup>14</sup> “The size of the unpaid claims necessitated the association to secure a line of credit from a commercial bank with additional guarantees.”

### **Independent analyses show others likely to follow Iowa**

Aaron Albright, CMS communications director, said in response to the Iowa co-op liquidation, “we do not believe that any other co-ops are facing immediate solvency problems.” But independent analyses suggest otherwise. Many observers are wondering which co-op will be next to fail.

A Standard & Poor’s Rating Services report issued on February 10, 2015, concludes that co-ops across the country have weak operating performance as “a result of high medical claims trend and not enough scale to offset administrative costs.” It warned that “The solvency problems experienced by [Iowa’s] CoOpportunity Health introduce questions about co-ops’ finances in general.” S&P reported that 10 co-ops had worse loss ratios in the third quarter than Iowa did.<sup>15</sup>

Co-ops also made optimistic projections of medical cost trends, expecting they would be well under 5% when established carriers were more accurately predicting a 6% trend. Therefore, it is not surprising that these politically-conceived entities would be facing significant problems. In fact, S&P reports that all but one of the co-ops it studied had “negative net income.” Only Maine, with a whopping 83% share of the exchange market in the state, was in positive financial territory with its 39,000 members.

The co-ops had significant start-up costs, no experiential data upon which to set premiums, generally have to pay to lease physician and hospital networks, and have few people in the companies and none on their boards with insurance experience. S&P’s observation that becoming a co-op “can be like learning to ride a bike without training wheels” is being proven by the co-ops’ experience.

### **More truths and unpleasant consequences**

A separate analysis by A.M. Best found that losses escalated throughout 2014, the first year the co-ops were operating. Aggregate losses in all of the co-ops totaled nearly \$244 million by the third quarter, compared to \$72 million in the first quarter of 2014. “A.M. Best is concerned about the financial viability of several of these plans,” it said in its report.<sup>16</sup>

Other estimates based upon National Association of Insurance Commissioners annual financial statements indicate that the

co-ops combined had net underwriting losses of \$389 million in calendar year 2014. The number would have been higher were it not for expected receivables of \$225 million from risk corridor payments that the co-ops booked as “income.” Without the risk corridor payments, the co-ops would have had aggregate losses of \$614 million in 2014.

According to an analysis by Scott E. Harrington of the University of Pennsylvania’s Leonard David Institute of Health Economics:<sup>17</sup> “The ratios to premiums of medical claims, claim adjustment expenses, and general expenses for CO-Ops combined for the first three quarters of 2014 [produced] ... a total ratio of costs to premiums of 116.8%.” That means the co-ops on average were losing nearly \$17 for every \$100 of premiums they collected, including estimated risk adjustment and risk corridor recoveries they expect to receive this summer. These loss ratios are another warning sign: Iowa CoOpportunity Health was losing \$15 per \$100 of premiums before it was liquidated. Second was Kentucky’s Health Cooperative which lost \$13 per \$100 in premiums last year.

These losses put the insurance coverage for hundreds of thousands of people at risk. Many physicians and hospitals are in jeopardy of not getting paid for services rendered by co-ops that are treading water – or are underwater.

### **Taxpayers to the rescue, or just on a deeper hook?**

Even the Obama administration’s Office of Management and Budget projected<sup>18</sup> in 2012 that taxpayers would lose more than 40% of the value of the co-op loans, about half from defaults and about half from the artificially

low interest rate loans the co-ops receive from taxpayers. Co-ops are on track to meet and exceed those expectations. However, the Obama administration still appears to be trying desperately to bail them out, reports by the U.S. House of Representatives Committee on Oversight and Government Reform demonstrate.<sup>19 20</sup>

In addition to the \$2.1 billion allocated to launch the co-ops and keep them afloat, CMS released a list in December 2014 of an additional \$300 million it had allocated in “solvency funds” to co-ops last year.<sup>21</sup> There is no explanation of the criteria used to determine why some co-ops received the added federal funding and others didn’t and why some received very generous awards and others much smaller amounts – or nothing. Nor is there any explanation about who decides which co-ops fail and which get additional infusions of federal funds.

A branch of CMS in charge of overseeing the co-op program, the Center for Consumer Information & Insurance Oversight (CCIIO), is supposed to allow the various co-ops to draw down the funds in increments, as they meet or exceed developmental milestones – but those milestones remain confidential contractual agreements that have not been disclosed to the public that is financing the loans through tax dollars. CMS also is silent on whether it is planning additional solvency loans and where the money would come from if they are granted.

There is little correlation between the amount of solvency loans awarded and a co-op’s total enrollment. The only consistent marker is that almost all are suffering net underwriting losses, as the table on the next page demonstrates.

ACA Co-ops: Does Size Matter?				
Entity Name	State	December 2014 Total Enrollment	Federal Loan Awards: Total Solvency Loans (\$)	2014 Year Underwriting Gain/(Loss) Excl. Risk Corridor Receivable (\$)
Health Republic Insurance of New York, Corp.	NY	155,402	241,366,000	(93,660,000)
Kentucky Health Cooperative, Inc.	KY	56,680	124,498,000	(126,644,000)
Consumers' Choice Health Insurance Company	SC	45,668	68,868,000	(10,301,000)
Maine Community Health Options	ME	39,742	119,810,000	5,293,000
Common Ground Healthcare Cooperative	WI	26,034	100,104,000	(61,921,000)
Arches Mutual Insurance Company	UT	22,962	79,544,000	(31,466,000)
Nevada Health CO-OP	NV	16,523	48,820,000	(19,632,000)
Colorado Health Insurance Cooperative, Inc.	CO	14,657	57,130,000	(33,519,000)
New Mexico Health Connections	NM	14,297	64,268,000	(9,184,000)
Montana Health Cooperative	MT	13,160	78,301,000	(12,087,000)
Evergreen Health Cooperative Inc.	MD	11,694	52,109,000	(14,910,000)
Consumers Mutual Insurance of Michigan	MI	11,122	52,847,000	(17,886,000)
Louisiana Health Cooperative Inc.	LA	9,980	52,613,000	(23,404,000)
Freelancers Co-op Program of Oregon, Inc.	OR	8,813	50,397,000	(21,701,000)
HealthyCT, Inc.	CT	7,966	106,969,000	(28,081,000)
Coordinated Health Mutual, Inc.	OH	6,677	113,248,000	(6,404,000)
Freelancers Co-op Program of New Jersey, Inc.	NJ	4,254	94,317,000	(13,866,000)
Land of Lincoln Mutual Health Insurance Company	IL	3,461	144,214,000	(20,597,000)
Meritus Health Partners*	AZ	2,622	72,423,000	(13,449,000)
Community Health Alliance Mutual Insurance Company	TN	2,287	54,802,000	(22,371,000)
Minuteman Health, Inc.*	MA	1,700	131,351,000	(20,584,000)
Oregon's Health CO-OP	OR	1,582	49,500,000	(7,478,000)
Meritus Mutual Health Partners*	AZ	869		(10,052,000)
CoOpportunity Health**	IA		130,612,000	
<b>Total Co-ops</b>		<b>478,152</b>	<b>2,088,111,000</b>	<b>(613,904,000)</b>

Data is sourced from NAIC annual financial statements available from SNL Financial and the CMS website.  
\*Enrollment and financial information for the Arizona and Massachusetts co-ops were not available due to Arizona having an April 1 annual statement filing date and the Massachusetts co-op not filing timely. Third quarter data were used for these two co-ops.

## The 3Rs

Because of other potentially-destabilizing provisions of the ACA that govern insurers, the law included protections from high losses in the early years, partly to encourage insurers to participate in the exchanges and to stabilize year-to-year premiums. Most of the co-ops are relying heavily in their financial statements on three provisions designed to smooth out losses, often referred to as the “3 Rs” – permanent risk adjustment, temporary reinsurance, and temporary risk corridor payments. For example, Iowa CoOpportunity was expecting \$60 million in risk corridor reimbursement but wouldn’t have been able to receive the money until this summer. (Now that it has been liquidated, other carriers are paying assessments to cover its outstanding claims and other bills.)

A *Health Affairs* policy brief<sup>22</sup> explains the three premium stabilization programs

authorized under the ACA:

*Risk adjustment* is a way of paying insurers based on their enrollees' predicted medical costs, which are estimated using various risk factors known to be associated with medical claims. Insurers that enroll a disproportionate share of high-risk people receive payment transfers from insurers with relatively low-risk people.

*Reinsurance* partially compensates insurers when enrollees experience high medical costs due to a catastrophic illness or accident.

Under *risk corridors*, the government reduces insurers' risk by partially offsetting high losses and sharing in large profits. Risk

corridors are based on how allowable costs compare with a target amount. Insurers whose ratio of allowable costs relative to the target amount is too high, meaning their premiums did not cover all their claims, will receive partial reimbursement for those losses. Insurers whose ratios are too low, meaning their premiums were much more than was needed to cover their expenses, will be charged an amount to partially offset their profits. By eliminating some of the pricing uncertainty associated with a new program and new population, risk corridors are intended to encourage insurers' participation in the new market.

The University of Pennsylvania's Scott E. Harrington took a preliminary look through the third quarter of 2014 at the role complex risk formula calculations play in setting premiums and determining co-op income.<sup>23</sup> Harrington writes:

About a third of the CO-OPs reported estimated recoveries from risk adjustment; another third reported estimated recoveries from the risk corridor program. No CO-OP reported any estimated net payments to those programs. In total, the CO-OPs reported \$164 million of estimated risk corridor recoveries, representing 11.8% of the \$1,387 million in reported premiums including risk sharing recoveries, and \$90 million of risk adjustment recoveries (6.5% of reported premiums including risk sharing recoveries). CoOpportunity Health (IA & NE) and Common Ground Healthcare (WI) accounted for over half of the reported estimates for risk

corridors and risk sharing.

State regulators authorized insurers to include estimated risk-sharing revenues (and any payments) in reported income, assets, and liabilities for 2014 financial reports. The efficacy of that treatment for risk adjustment and risk corridors was debated extensively by regulators in 2014 in view of uncertainty in the amounts ultimately to be received or paid and the lags in receiving or making payments under the programs. The decision was made in December to continue allowing insurers to recognize estimated amounts in their financial statements going forward prior to their final determination and payment, provided that there existed a reasonable basis for estimation.

Harrington points out that there is substantial variation in underwriting results among the co-ops:<sup>24</sup>

Given start-up related expenses with a large fixed component, the general expense ratios are often very high for CO-OPs with little enrollment. The ratios to premiums of medical claims, claim adjustment expenses, and general expenses for CO-OPs combined for the first three quarters of 2014 were 91.7%, 3.8%, and 21.3%, respectively, producing a total ratio of costs to premiums of 116.8% (known as the "combined ratio" in insurance circles). That ratio corresponds to an underwriting loss (which does not consider a very modest amount of investment income) of about \$17 per \$100 of premiums (with premiums including estimated risk adjustment and risk

corridor recoveries). Among the five CO-OPs with the largest enrollments, the combined ratio ranged from a high of 114.5% for CoOpportunity Health (medical claims ratio of 100%), with Kentucky Health Cooperative a close second (combined ratio of 112.8%, medical claims ratio of 100%), to a low of 90.8% for Maine Community Health Options (medical claims ratio of 70.5%).

A recent announcement from CMS indicates it plans to boost payments for the reinsurance program because not as many health plans filed claims as expected during the first year of exchange operation. Companies whose customers' medical claims exceeded \$45,000 in 2014 were eligible for the reinsurance program up to the allowed \$250,000 cutoff, and CMS says it plans to pay 100%, rather than just 80%, of these claims.<sup>25</sup>

But the co-ops' challenges with the temporary reinsurance and risk corridor programs remain. Some co-ops are blaming the Consolidated and Further Continuing Appropriations Act of 2015 for their problems. The law provides that CMS may not transfer funds from other accounts to pay for the risk corridor program, and it blocks CMS from making multi-year loss calculations.<sup>26</sup>

Harrington and actuary Kurt Wrobel explain the interaction between the 3 Rs and premium increases. "While the temporary reinsurance and risk corridor programs have thus far mitigated insurers' risk (even with uncertainty concerning risk corridor funding), the cessation of those programs in 2017 will put additional upward pressure on rates, which could destabilize enrollment," they write.<sup>27</sup>

Another S&P report entitled "The Unfunded ACA Risk Corridor May Make The U.S. Insurance Market Less Stable, Not More" shows that risk corridor funding is unlikely to produce the revenues most of the co-ops are anticipating. The rating service expects there will be enough money to pay only 10% of claims: "Standard & Poor's Ratings Services expects the ACA risk-corridor pool to be significantly underfunded if the government enforces budget neutrality. Budget neutrality requires the pool to be funded by payments insurers make into the pool. No external funding can be allocated to it. Our study of risk-corridor receivables and payables recorded in U.S. health insurance companies' 2014 annual financial statements found that receivables insurers booked for the ACA corridor far outweigh the payables."<sup>28</sup>

Under the law, issuers that earn 3% more than estimated must pay into the risk corridor, while those that lost more than 3% get payments. Slightly more than half of the issuers S&P analyzed did not record anything for the program. Thirty percent logged receivables, and 14% reported payables. S&P says some companies could have recorded receivables but did not because they don't expect the money to come through.

Co-ops are expected to bear the brunt of the financial blow. S&P estimates that if the risk corridors come up short, it could eliminate more than half of the recorded capital of small insurers. Large regional carriers might see a 20% drop.<sup>29</sup> Some industry experts are speculating that CMS may decide to give co-ops priority in receiving money from the diminished pool of risk-corridor payments.

**A rude awakening is in store** for some insurers, especially the co-ops that believed they would be able to make up their losses

on policies already written with the anticipation of risk payments. The typical response of insurers who lose money is to raise premiums in future years, and there is evidence in filings for 2016 that this is happening.<sup>30</sup>

A co-op's low premium prices create a ripple effect in which other insurers are forced to take additional risks with their own premium pricing in order to avoid losing premium-sensitive customers. In addition, profitable insurers that priced more responsibly will be required to make payments to the co-ops – co-ops that underpriced premiums to gain market share.

### **What's ahead in other states?**

**In Tennessee**, the Community Health Alliance (CHA) co-op started slowly in 2014, participating in five of the state's eight rating areas. It enrolled about 2,000 Tennesseans, well short of its 25,000 goal. For the entire year of 2014, Tennessee's CHA co-op posted a net loss of more than \$22 million, excluding risk corridor receivables.

The co-op has received more than \$73 million in federal loans as of the end of last year. All of the federal loan funds originally awarded to the co-op now have been exhausted.

For 2015, the co-op expanded to all rating areas and offered the lowest premiums in many areas of the state, with premiums 10% to 25% below those of commercial competitors. But alarms began ringing midway through this year's enrollment period when CHA enrollment soared to 53,000 (although final open-enrollment membership was lower because some enrollees didn't pay their premiums or

switched to other carriers). On January 15, 2015, enrollment was frozen, and CHA stopped signing up new members on and off the exchange.

HHS reports<sup>31</sup> that 231,440 people in Tennessee enrolled in private plans through the exchange during the 2015 open enrollment (November 15 to February 22, including the week-long extension). CHA co-op enrollment had surged from just 1% of the market in the first year to 23% for 2015.

CHA told state regulators that enrollment had "grown exponentially from 2014 to 2015 and had significantly outpaced expectations," explained Julie Mix McPeak, Tennessee Department of Commerce and Insurance Commissioner.<sup>32</sup>

CHA is not in "some type of trouble in its operations," the organization explained to members. "Be assured you are enrolled in a health plan that is managing growth the way any prudent organization would." Commissioner Mix McPeak said freezing enrollment was a "preventative measure to support the long-term viability of CHA and the protection of Tennessee consumers."<sup>33</sup>

"Freezing enrollment in CHA was a decision we made after lengthy discussions with CHA leadership, the Department of Health and Human Services and an analysis of CHA's financial conditions and projections," Mix McPeak said.

The decision to halt enrollment was the first such move for an exchange as regulators grew concerned the co-op was gaining a larger market share than it could support. The co-op expects to participate in exchange enrollment in 2016 once – or if – the freeze is lifted.

But the co-op is asking Tennessee insurance regulators to approve an average 32.6% premium increase for 2016. “You can expect price increases for this fall. Our increase is double digit, it’s pretty large,” said Jerry Burgess, CEO of CHA. “Everybody is getting more accurate in predicting their cost, and all payers are getting more accurate in pricing their product.”<sup>34</sup>

While many enrollees are eligible for subsidies to offset some of their cost of the premium hikes, the Tennessee market is likely to be whipsawed again in 2016 by premium and enrollment fluctuations.

Tennessee demonstrates another failed strategy of lowering premium prices substantially to expand enrollment. Trying to make up losses based upon expanding volume is not a sustainable business model for the co-ops.

**Colorado’s** HealthOp co-op also started slowly, enrolling about 15,000 people in 2014 out of total exchange enrollment in the state of 137,000, or about a 9% market share. It lost \$23 million that year.<sup>35</sup>

In 2015, the co-op rocked Colorado’s insurance market by offering the lowest-priced plans in nearly every region of the state. By the close of the 2015 enrollment period, the co-op had 40% of Colorado’s health insurance exchange market with 55,000 signups and a total of nearly 75,000 members on and off the exchange. Total enrollment in Colorado’s exchange from all companies for 2015 is more than 140,000.<sup>36</sup>

Colorado HealthOp’s premium rates dropped so significantly that it pushed down federal subsidies available to all plans on the Colorado exchange.<sup>37</sup>

The co-op has received a total of \$72 million in federal start up and solvency loans. Executive director Julia Hutchins is lobbying Washington for additional relief, admitting that “all is not hunky-dory in CO-OP land. We are start-ups. That means we have growing pains. Capital is not always easy to come by.”<sup>38</sup>

Hutchins wants to be allowed to convert start-up loan financing to solvency loans in order to meet state and federal financial reserve requirements. In addition, she wants the administration to allow the co-op to “bank” future receivables under the federal reinsurance program “to ease our access to private, third party sources of capital.” That’s because, she writes, “Paradoxically, perhaps, our initial reliance on federal dollars has substantially restricted our ability to become self-sufficient by finding new partners and funding sources.”<sup>39</sup>

The Colorado strategy is not to earn more money or operate more efficiently but simply to change its accounting of past transactions. Nothing actually would change, but the co-op could claim that its liabilities are actually assets. Skeptical analysts also expect the losses they experienced in 2014 to accelerate along with the much larger enrollment in 2015.

Colorado Insurance Commissioner Marguerite Salazar has required the state’s co-op to set up a multi-million dollar fund after posting a nearly \$23 million loss for 2014. She told a legislative oversight committee in June 2015 that she has had her financial experts reviewing HealthOP’s finances and is continuing to do so on a monthly basis.<sup>40</sup>

## More money

Other states are coming back to Washington directly asking for more money. New York's Health Republic Insurance, the co-op with the largest enrollment, engaged Washington lobbyists to try to secure \$90 million in federal solvency funds, a request that was approved by CMS in September, 2014. Federal law forbids a recipient of federal funds "to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any federal action."<sup>41</sup>

New York's Health Republic Insurance received \$265 million in federal loans and had the largest enrollment, with 155,000 members in 2014. Its premiums are significantly lower than established carriers in virtually every region of the state. But the co-op has applied for premium increases in 2016 of more than 14%, with some regions of the state as high as 30%. Yet industry actuaries believe that those raises will not be enough to offset high claims costs and the exhaustion of federal loan dollars.

## Case study: Kentucky

Until recently, the Kentucky Health Cooperative had been considered one of the more successful co-ops, with 75% of enrollees in the state's health exchange. It deserves special attention because the Kentucky co-op has the second highest enrollment of the remaining co-ops with 57,000 members in 2014.

There are disturbing similarities between the Kentucky cooperative and Iowa's failed co-op. Kentucky's co-op has been awarded \$146.5 million in taxpayer loans, including \$65 million in solvency funding as recently as November of 2014. Most of these funds have been exhausted, and now the co-op is banking on risk corridor payments, expected this summer. It is applying for a big premium increase of 25% for next year and is banking on so-called risk-protection payments from other insurers to maintain a semblance of solvency.

How did Kentucky Health Cooperative gain such a large share of the new state exchange market? Primarily by offering significantly lower premiums and running the risk of future insolvency.

The most revealing way to view a co-op's performance is without the artificial boost to be provided by other more efficient competitors through risk corridor payments.

The true operating record for the Kentucky co-op for 2014 was as follows: Its premium per-member per-month in the first quarter of 2014 was \$316.45, and it subsequently dropped to \$264.86 in the fourth quarter. Those premiums were more than 25% lower than the co-op's closest competitor in the Kentucky exchange market. Yet at the same time, the Kentucky Health Cooperative's actual claims cost for all of 2014 was \$450.18, which ran about 33 percent higher than the same competitor, over the entire year! Not surprisingly, the Kentucky Health Coop posted a medical loss ratio of 158 percent for 2014 – i.e., for every premium dollar it collected, it spent that dollar and an additional 58 cents.

**Kentucky Co-op - Statutory Blank as of Dec 31, 2014**

**2014 Financial Results Update:**

*Dollars in millions*

	Q1	Q2	Q3	Q4	YTD
<i>Metrics excluding \$76M Risk Corridor in premium:</i>					
Net Loss	(\$1.7)	(\$21.8)	(\$45.5)	(\$57.4)	(\$126.4)
Loss Ratio	90.4%	136.3%	170.3%	200.3%	158.0%
Prem PMPM	\$316.45	\$297.81	\$280.30	\$264.86	\$284.86
Claims PMPM	\$285.94	\$405.98	\$477.24	\$530.53	\$450.18
<i>Metrics including \$76M Risk Corridor in premium:</i>					
Net Loss	(\$1.7)	(\$21.8)	(\$0.5)	(\$26.4)	(\$50.4)
Loss Ratio	90.4%	136.3%	90.7%	120.6%	108.7%
Prem PMPM	\$316.45	\$297.81	\$526.31	\$440.09	\$413.99
Claims PMPM	\$285.94	\$405.98	\$477.24	\$530.53	\$450.18

This sort of performance is unsustainable. The availability of further solvency loan funding has all but disappeared, and the risk corridor payment program will shrink in 2015 (due to federal budget neutrality funding constraints) and then disappear after the 2016 exchange plan year.

The Kentucky co-op had expected to enroll about 30,000 customers. Instead, nearly twice as many people signed up in 2014. CEO Janie Miller explained, “We almost doubled our enrollment. Therefore we needed additional capital sitting there from which we would, of course, pay claims.” Like Iowa, the Kentucky co-op is claiming to be a victim of its own “success,” or perhaps “excess,” in offering attractive, but unsustainably low, premiums to its customers. Was it hoping to make up future losses with more volume?

Like Iowa’s co-op, larger volume for the Kentucky Cooperative has not translated into financial success. The Kentucky co-op lost about \$126 million on its claims for the entire year, before booking in advance “receivable” risk corridor payments of \$76 million to offset some of that loss.

In the near term, Kentucky is relying on low interest loans from the federal government (so-called solvency loans), along with expected payments later this year from its competitors (risk corridor payments) and other insurers (reinsurance) to prop up its underpriced coverage.

The state’s co-op already has drawn down almost \$144 million in federal loans (including \$124.5 million in solvency loans) – all but exhausting its full allocation of \$146.5 million. Those amounts include the decision of CMS to unexpectedly inject \$65 million in solvency funds to the Kentucky Health Coop on November 10, 2014, purportedly to allow it to expand into neighboring West Virginia. However, those proposed plans for expansion to the neighboring state have been delayed at least until 2016. The funds appear to be used primarily to support its business in Kentucky.

In addition, the Kentucky co-op expects \$42 million in reinsurance settlements and \$76 million in risk corridor payments in 2015 from other insurers in the state for its losses in 2014 and anticipates \$32 million and \$107 million respectively for 2015

operations. Its loss ratios – even with the risk corridor payments – are nearly 109%.

“If Obamacare were really such a success story in Kentucky, why did this co-op need a taxpayer bailout?” Senate Majority Leader Mitch McConnell (R-KY) asked. “Even more disconcerting, why was that bailout kept a secret from the very people who were about to enroll in it?”<sup>42</sup> Consumers have received little or no notice about the financial problems of the Kentucky or other co-ops.

**Kentucky fell into the trap of pricing** its premiums unrealistically low. “When they were setting their rates for 2014, they were just shooting in the dark,” according to Timothy Jost, a health law professor at Washington and Lee University in Virginia who is a major supporter of the ACA.

As state regulators examined the 2014 quarterly reports, they clearly saw trouble and required the co-ops to increase premiums for 2015. The initial teaser rates – aimed at gaining a large market share – were clearly unsustainable, much like the sub-prime mortgage rates of a decade ago.

Rate increases show another parallel between Iowa and Kentucky. The Kentucky Health Cooperative first applied with state regulators in May 2014 for a 9.9% premium increase for its 2015 offerings. That request was subsequently withdrawn, and a 15% increase was approved on September 2. Then on October 31, a 20% price increase was approved for 2015, clearly in hopes the higher premium would provide enough income to allow it to pay claims and stay afloat. But the higher rate impacts enrollment.

The Kentucky Cooperative’s initial business model seems to be at least partially

responsible for its later problems. Kentucky did not have its own network of physicians, hospitals and other providers so it leased networks from established insurers that had contracts with providers in the state. The added cost of leasing networks added to the Kentucky co-op’s overhead – extra administrative costs that its commercial competitors did not have. That leaves the co-op less revenue to pay for administrative overhead and compromises its ability to pay for medical services provided to customers. The co-ops are further handicapped by not being able to have board members with experience in running or operating an insurance company – or properly pricing insurance.

So that means that to keep operating, the co-ops are underpricing their products, paying extra to rent networks of providers, and drawing on payments from other insurers through the 3Rs – payments that are likely to disappoint – and on taxpayer bailout funds. This is neither a competitive nor a sustainable business model!

Providers are in jeopardy of not getting paid by these new co-op entities that find much more money is going out than is coming in, even with an influx of federal and 3R funding.

### **Impact on rates**

Most co-ops aspired to keep prices low, and like Iowa and Kentucky, consequently gained a significant market share. But the co-ops’ below-market pricing has a ripple effect throughout the market.

By underpricing premiums, co-ops pushed down the price of the Silver plan baseline which meant lower subsidies for all of the insurers in the state. This, in turn, forced other companies to either underprice their

policies or lose market share. In addition, the co-ops that were underpricing their products and therefore accumulating losses would have qualified for a greater share of the risk corridor payments paid by their competitors.

According to Standards & Poor's: "Keeping pricing low may help co-ops gain scale and perhaps even disrupt the market in the near term, but in the longer term after two of the 3Rs (permanent risk adjustment, temporary risk corridor, and temporary reinsurance) are no longer available to subsidize performance, the market will likely transition to rational pricing," its February 10, 2015, report concluded.<sup>43</sup>

That's certainly an optimistic view.

### **Protecting taxpayers with oversight and investigation**

Whatever the claims were when co-ops were conceived, there is nothing unique or magic about the co-op model that allows them to meet their original hope and promise.

Co-ops were required to meet the same regulatory requirements imposed at the federal and state levels on private insurance companies, including solvency and licensure, network adequacy, provider payments, rate and form filing, and state premium assessments. The federal government was placing public trust in the states as regulators to exercise due diligence in assuring taxpayer dollars were being invested in organizations that could meet these tests. Some responsibility for the failure and precarious state of the co-ops therefore rests with the states.

Whether out of enthusiasm for the new form of non-profit, community run insurance carriers, a desire for the health law to

succeed, or other motivations, states that allowed the co-ops to price premiums significantly below expected costs share some blame. "Approving premiums that are too low introduces unreasonable competitive pressure, disruption in the marketplace, and shifting hundreds of millions of dollars in claims to be paid by taxpayers and others," attorney William Schiffbauer writes.<sup>44</sup>

The American Academy of Actuaries wrote in comments to HHS on the proposed co-op rule that co-ops should be required to cover "average" expected costs and warned "it is difficult to recover from underpricing." Co-ops in Kentucky, Tennessee, Colorado, Iowa/Nebraska, and a number of other states received approval for health insurance premium rates that were far below those of competing carriers, even though their costs were often higher and their medical loss exposure was unknown at best. Their market share quickly shot up among premium-sensitive consumers, but regulatory filings show the added revenue was not enough to cover medical claims.

Only Vermont's regulator's anticipated the problems its co-op would have faced, denying approval of its application. Iowa's implosion after a little over a year of operations is a harbinger of other failures likely to follow. So far, only Maine's Community Health Options is operating in the black. All others are quickly burning through taxpayer dollars invested in the ACA's untested cooperative health insurance concept. Receiving less than anticipated from risk corridor payments will put further pressure on balance sheets.

**The co-ops were created to address a political agenda** by liberals who disparaged commercial health insurance carriers and their profit motive. Even with an influx of \$2.4 billion in federal funds loaned at

extremely attractive terms – advantages private carriers do not have – has not been enough to help them succeed.

Many of the larger established carriers also are struggling in the exchange market. Many other carriers of all sizes had similar experiences in other states.<sup>45</sup> This shows the difficulty any insurance company has in staying solvent while answering to federal overseers who often make rules based upon political imperatives rather than the realities of market forces.

Taxpayers should not be forced to throw good money after bad. Co-ops should not be propped up further by giving them additional federal money. They need to survive based upon how they perform in competition with other insurers in the market. In the real world, businesses that lose money do not stay in business. Losing money every year is not a plan for success.

In 2013, Congress shut down the Community Living Assistance Services and Supports (CLASS) Act for long-term care insurance after HHS concluded it could not meet the test of self-sustainability required by the ACA. Congress also has shut off any additional funding for co-ops, but it must remain vigilant in overseeing the Obama administration, which is likely to look for other piggy banks for money to keep co-ops temporarily afloat.

Some co-ops may be able to succeed going forward, but the trajectory does not look promising. Taxpayers are paying many times over for the co-op experiment. Congress would be well advised to exercise its oversight function to 1) make sure no additional federal dollars are wasted on this program, 2) investigate how \$2.4 billion in taxpayer loans have been spent, and 3) determine who will be responsible for paying back the loans.

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