**STATEMENT OF**

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**ON**

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

**BEFORE THE**

**UNITED STATES HOUSE COMMITTEE ON WAYS & MEANS**

**SUBCOMMITTEE ON HEALTH**

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**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.