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Rob Portman, Chairman

Failure of the Affordable Care Act Health Insurance CO-OPs

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I. EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act (ACA) created the Consumer Operated and Oriented Plan Program—known as the CO-OP Program. Under the CO-OP Program, the Department of Health and Human Services (HHS) distributed loans to consumer-governed, nonprofit health insurance issuers. HHS ultimately received $2.4 billion of taxpayer money to fund 23 CO-OPs that participated in the program. Twelve of those 23 CO-OPs have now failed, leaving 740,000 people in 14 states searching for new coverage and leaving the taxpayer little hope of recovering the $1.2 billion in loans HHS disbursed to those failed insurance businesses.

The Senate Permanent Subcommittee on Investigations (PSI) has completed an investigation of that failure—and whether HHS exercised good stewardship of public money when it poured billions of dollars into these insurance startups. Our investigation revealed that it did not. HHS was alerted to weaknesses in the failed CO-OPs' business plans and financial forecasts before it approved their initial loans; failed to use major accountability and oversight tools available to it throughout 2014 even though it knew of the CO-OPs' severe financial distress; continued to disburse loans to failing CO-OPs despite warning signs; and allowed CO-OPs to continue to book risk corridor payments as assets despite credible warnings that those payments would not materialize. We summarize some of our key findings below.

First, HHS approved the failed CO-OPs despite receiving specific warnings from a third-party analyst about weaknesses in their business plans. Before it approved the now-failed CO-OPs, HHS retained Deloitte Consulting LLP to evaluate the CO-OPs' loan applications and business plans. Deloitte's analysis, reviewed by the Subcommittee, notified HHS of several significant weaknesses in the CO-OPs' business proposals. Those weaknesses included:

- **Defective Enrollment Strategies**. Deloitte identified serious problems in the enrollment strategy of seven of the 12 failed CO-OPs. Those problems ranged from inadequate actuarial analysis, to unsupported assumptions about sustainable premiums, to a lack of demonstrated understanding of the health demographics of the CO-OP's target population.

- **Budgetary and Financial Planning Problems**. Deloitte's reports reveal that the proposed budgets of 10 of the 12 failed CO-OPs were incomplete, and Deloitte thought that many were unreasonable, not cost-effective, or not aligned with the CO-OP's own financial projections. Deloitte also expressed skepticism about the risk-taking and unreasonable assumptions reflected in some of the CO-OPs' financial projections. The firm warned that Colorado, Utah, and Louisiana all relied on unreasonable projections of their own growth.

It cautioned that it could not trace the assumptions underlying the budgets of the Nevada, Tennessee, and Kentucky CO-OPs to their actual business plans. And, perhaps tongue-in-cheek, it observed that Iowa and Nebraska's CO-OP, CoOpportunity, had a target profit "much lower than the industry benchmark" of 4.8%: CoOportunity's stated target profit margin was *zero*.

- **Management Weaknesses**. HHS required the CO-OP applicants to identify their management teams, including the qualifications and experience of its leadership. In Deloitte's reports to HHS, the firm identified some leadership concerns for all of the 12 failed CO-OPs. Several prospective CO-OPs had not even identified their senior leadership team, and others had executives for whom background checks turned up red flags.

Despite these identified weaknesses, Deloitte gave each CO-OP a "passing" score based on a grading scale set by HHS, and HHS approved the loans in spite of the warning signs.

Second, even though HHS was aware of serious financial distress suffered by the CO-OPs in 2014, it failed to take any corrective action or enhance oversight for more than a year. The CO-OP loan agreements armed HHS with significant accountability tools for borrowers who were missing the mark, but here HHS took a pass. Inexplicably, for over a year, the agency took *no* corrective action, nor did it put any CO-OP on enhanced oversight. Five of the 12 failed CO-OPs were *never* subject to corrective action by HHS, and HHS waited until September 2015 to put five others on corrective action or enhanced oversight. Two months later, all twelve CO-OPs had failed.

That failure to take action is difficult to understand. Throughout 2014 and 2015, HHS regularly received key financial information from the CO-OPs, including monthly reports on enrollment and financial data sufficient to calculate net income, along with audited quarterly financial statements. Those reports showed that the failed CO-OPs experienced severe financial losses that quickly exceeded even the *worst-case* loss projections they had provided to HHS as part of the business plans in their loan applications. Cumulatively, by the end of 2014, the failed CO-OPs exceeded their projected worst-case-scenario losses by at least $263.7 million—— four times greater than the expected amount. The CO-OPs' enrollment numbers were similarly alarming. According to the 2014 reports they submitted to HHS, five of the failed CO-OPs dramatically underperformed enrollment expectations (leading to insufficient income for premiums), while five others *overshot* their enrollment projections (which also causes losses due to underpriced premiums). HHS was aware of these problems in *early* 2014, but took no corrective action and continued to disburse loans to the distressed CO-OPs.

Third, despite serious financial warning signs, HHS did not withhold any loan disbursements from the now-failed CO-OPs—and in many cases accelerated planned disbursements. Instead, over the course of 2014–2015, HHS disbursed $848 million in taxpayer dollars to the failed CO-OPs, even as those entities lost more than $1.4 billion. For every dollar that HHS sent them over this period, the failed CO-OPs lost about $1.65.

Fourth, HHS approved *additional* solvency loans for three of the failed CO-OPs in danger of being shut down by state regulators, despite obvious warning signs that those CO-OPs will not be able to repay the taxpayer. State regulators require health insurers to maintain a certain amount of capital reserve—called the "risk based capital" requirement. HHS made solvency loans available to the CO-OPs at risk of failing to meet these requirements, and to date has issued additional solvency loans to six CO-OPs, for a total of $352 million. As with CO-OPs' initial loan applications, Deloitte completed the external assessment for these additional solvency loans. But according to Deloitte, HHS required a truncated analysis of the applications; for example, Deloitte did not even evaluate the "the likelihood that each CO-OP would achieve sustainable operations based on the revised business plan."

Three of the CO-OPs that received additional solvency funds from HHS have since failed. The Subcommittee's investigation revealed that HHS issued those additional loans despite clear warnings that the CO-OPs were in financial trouble.

- **Kentucky CO-OP**. HHS approved a $65 million additional solvency loan to the Kentucky CO-OP. It did so even though Deloitte's review of the CO-OP's application revealed several problems, including failure to provide any detail for its plans to remedy enrollment difficulties; an unsupported explanation of its plans to raise premiums by 15%; an unexplained projection that the CO-OP would reduce its medical loss ratio by 74% in the coming year; and questionable income projections.
    - **Result:** The Kentucky CO-OP eventually collapsed after suffering losses of $50.4 million in 2014 and another $114.8 million in 2015.
- **New York CO-OP**. The New York CO-OP received $90.7 million in additional solvency funding despite severe financial difficulties brought on largely by too-high enrollment in 2014, after the CO-OP dramatically underpriced its premiums. In its application for additional solvency funds, the CO-OP proposed to solve this problem by raising premiums by 10%, but Deloitte told HHS that the CO-OP had failed to analyze the effect that would have on enrollment and failed provide any concrete data supporting the effectiveness of its proposed plan. Deloitte noted the option that the CO-OP could forego

additional loans and "scale down its operation." But rather than scale down, in September 2014, HHS granted the New York CO-OP a $90.7 million additional solvency loan that would allow it to *scale up*—in every respect but profits.

  - **Result**: The New York CO-OP's losses reached a staggering $544 million by the end of 2015. It was shut down by the New York Department of Financial Services near the end of 2015, leaving more than 215,000 policyholders to search for new insurance policies.

- **Iowa and Nebraska CO-OP (CoOpportunity).** CoOpportunity, the CO-OP serving Iowa and Nebraska, received $32.7 million in additional solvency loan funding. But given the unsupported assumptions underlying the CO-OP's proposed solutions to its financial woes, Deloitte warned HHS that the loan may not be enough to permit the CO-OP to maintain its solvency. In addition, Deloitte cautioned that CoOportunity's financial projections depended heavily—to the tune of $94.6 million—on the availability of so-called 3R funds from ACA risk sharing measures.

  - **Result:** Less than three months after HHS approved CoOportunity's additional solvency loan, the Iowa Insurance Division suspended and later liquidated it. CoOportunity's operating losses exceeded $163 million, and its liabilities exceeded its assets by $50 million. The CO-OP's closure left 120,000 policyholders scrambling to find a new insurance plan mid-year.

Fifth, HHS looked on as the CO-OPs booked, as assets, massive uncertain payments from the ACA's risk corridor program. That program requires profitable insurers to pay into a government fund to compensate insurers suffering a loss; but because it is intended to be budget-neutral, if there are not enough payments *into* the fund, insurers with losses have no source of risk corridor income. By October 2014, a research arm of Citibank had publicly warned that HHS would not collect "nearly enough" from profitable insurers to cover risk corridor payments to the unprofitable. And Deloitte specifically cautioned HHS that the struggling CO-OPs were relying heavily on uncertain risk corridor payments to prop up their financial forecasts. But HHS continued to predict, as recently as July 2015, that "risk corridor collections will be sufficient to pay for all risk corridor payments." In reality, HHS was able to pay only 12.6 cents on the dollar. That shortfall further destabilized the CO-OPs.

Sixth, the heavy costs of failed CO-OPs will be borne by taxpayers, doctors, patients, and other insurers. None of the failed CO-OPs have repaid a single dollar,

principal or interest, of the $1.2 billion in federal solvency and start-up loans they received. Our investigation suggests no significant share of those loans ever will be repaid based on the latest balance sheets we obtained. In the aggregate, the failed CO-OPs' *non-loan* liabilities exceed $1.13 billion—which is 93% greater than their reported assets. All 12 failed CO-OPs told PSI they had no "planned payments" on any of their CO-OP loans. And when the Subcommittee asked HHS for its projections or assessment of the prospects for repayment, the Department could not provide any.

The American taxpayer is not the only creditor that stands to suffer large losses due to the failure of the CO-OP program. The closed CO-OPs currently owe a substantial amount of money in medical claims to doctors and hospitals. At least six failed CO-OPs currently owe more in medical claims than they hold in assets. Three of those (Colorado, South Carolina, and CoOpportunity) will be able to access funds from statewide insurance guaranty associations—meaning *other* insurance companies must cover the CO-OPs losses, ultimately through increased premiums to their policyholders. But the other three—New York, Louisiana, and Kentucky—have no recourse to guaranty funds, so the burden of unpaid medical claims may be borne by doctors, hospitals, and enrolled individuals. The New York CO-OP, for example, reported that it had approximately $380 million in unpaid medical claims and $158 million in assets as of December 31, 2015—a shortfall of *$222 million*.

* * *

After detailing these findings, this report briefly addresses two misconceptions about the CO-OP program. First, HHS officials and others have sometimes suggested that the CO-OPs' financial difficulty was caused by "adverse selection"—by attracting enrollees with above-average health risks. But the agency's own data from the ACA's risk adjustment program indicates otherwise. That program redistributes money from insurers with healthier enrollees to those with less healthy enrollees. Our analysis of the data shows that the failed CO-OPs were net *payors* of risk corridor charges (by $116 million), which indicates that as a class they enrolled healthier—not sicker—policyholders than others in their states.

Second, HHS officials have suggested publicly that a series of budget cuts to the CO-OP program contributed to the collapse of the 12 failed CO-OPs. There is no evidence to support that claim. The failed CO-OPs received $350 million *more* than they requested in their loan applications, and HHS was aware of the first two of three budget cuts before it made any awards. The primary consequence of CO-OP budget cuts was to prevent HHS from launching *additional* CO-OPs—one for each state, as the law directed—and thus limit future losses to the taxpayer.

II. BACKGROUND

The Patient Protection and Affordable Care Act (ACA) created the Consumer Operated and Oriented Plan program—known as the CO-OP program.[1] Under the CO-OP program, the Department of Health and Human Services (HHS) distributed loans to consumer-governed, nonprofit health insurance issuers. Congress initially allocated $6 billion for the CO-OP Program,[2] with the goal of establishing CO-OPs in all 50 states and the District of Columbia.[3] Subsequent legislation reduced funding for the program, and HHS ultimately awarded $2.4 billion to fund 23 CO-OPs that participated in the program.[4]

In early 2015, CoOportunity Health, the CO-OP established in Iowa and Nebraska, failed.[5] Since then, an additional 11 CO-OPs have failed.[6] In total, the failed CO-OPs received $1.2 billion in federal loans, and their collapse left 740,000 people in 14 states searching for new coverage.[7]

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[1] *See* 42 U.S.C. § 18042(a)(1) ("The Secretary shall establish a program to carry out the purposes of this section to be known as the Consumer Operated and Oriented Plan (CO-OP) program."). HHS's Centers for Medicare & Medicaid Services (CMS) administered the program, but for simplicity we refer to HHS throughout this report.

[2] *See id*. § 18042(g) ("There are hereby appropriated, out of any funds in the Treasury not otherwise appropriated, $6,000,000,000 to carry out this section.").

[3] *See id.* § 18042(b)(2)(B) ("If no health insurance issuer applies to be a qualified nonprofit health insurance issuer within a State, the Secretary may use amounts appropriated under this section for the awarding of grants to encourage the establishment of a qualified nonprofit health insurance issuer within the State or the expansion of a qualified nonprofit health insurance issuer from another State to the State.").

[4] Robert Pear, *Most Health Insurance Co-ops Are Losing Money, Federal Audit Finds*, NY TIMES (Aug. 14, 2015) (explaining that the 23 CO-OPs "have received $2.4 billion in federal loans to help pay start-up costs and to meet state solvency requirements"), http://www.nytimes.com/2015/08/15/us/most-health-insurance-co-ops-are-losing-money-federal-audit-finds.html?mtrref=www.google.com&gwh=BB95458959A76808E77C498EB0AD76B9&gwt=pay&_r=0.

[5] *See* Anna Wilde Mathews, *State Regulator to Shut Down Insurer CoOportunity Health*, WALL ST. J. (Jan. 23, 2015) ("Iowa's insurance regulatory plans to shut down insurer CoOportunity Health, making it the first failure of one of the nonprofit cooperatives created under the Affordable Care Act."), http://www.wsj.com/articles/state-regulator-to-shut-down-insurer-cooportunity-health-1422052829.

[6] The list of failed CO-OPs is as follows: CoOportunity Health (Iowa and Nebraska); Louisiana Health Cooperative, Inc.; Nevada Health Cooperative, Inc.; Health Republic Insurance of New York; Kentucky Health Care Cooperative (Kentucky and West Virginia); Community Health Alliance Mutual Insurance Company (Tennessee); Colorado HealthOp; Health Republic Insurance of Oregon; Consumers' Choice Health Insurance Company (South Carolina); Arches Mutual Insurance Company (Utah); Meritus Health Partners (Arizona); Michigan Consumer's Healthcare CO-OP.

[7] Amy Goldstein, *More Than Half of ACA Co-ops Now Out Of Insurance Marketplaces*, WASH. POST (Nov. 3, 2015), https://www.washingtonpost.com/national/health-science/more-than-half-of-aca-co-

A. HHS's Loan Decisions.

HHS received loan applications between July 2011 and December 2012.[8] Among other things, an organization was eligible to become a CO-OP if it was owned and operated by its customers, was a nonprofit organization, and could demonstrate to HHS a high probability of financial viability.[9] As part of the application to become a CO-OP, HHS required applicants to describe the proposed CO-OP's governance structure, including its plans to conform with regulations established in 45 C.F.R. §§ 156.500-520; describe its operational, financial, and administrative strategies; and disclose its bylaws.[10] HHS also required applicants to submit a feasibility study and a business plan. The feasibility study included an actuarial analysis examining the likelihood of success for the CO-OP.[11] The business plan included information about the applicant's management team; the markets to be served; the plans the CO-OP would offer; a description of why plans would be appropriate for the target market; a description of the CO-OP's strategy for enrolling members; and information about the CO-OP's budget and plans to repay HHS-provided loans.[12]

HHS reviewed these applications with the assistance of outside consultants and, based on its own review, decided whether to make a loan. HHS also decided how large a loan to make, and in doing so, considered four factors: (1) the results of the external review; (2) the size of the loan request and the CO-OP's anticipated results; (3) the CO-OP's ability to repay the loan; and (4) the likelihood that the CO-OP would meet program objectives.[13]

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ops-now-out-of-insurance-marketplaces/2015/11/03/5ba95b86-824b-11e5-9afb-0c971f713d0c_story.html.

[8] *See generally* Dep't of Health & Human Servs., Centers for Medicare & Medicaid Servs., *Loan Funding Opportunity Number: OO-COO-11-001* (July 28, 2011, rev. Dec. 9, 2011), http://apply07.grants.gov/apply/opportunities/instructions/oppOO-COO-11-001-cfda93.545-instructions.pdf.

[9] *Id.* at 43.

[10] *Id.* at 32-33.

[11] *Id.* at 33.

[12] *Id.* at 33-36.

[13] Dep't of Health & Human Servs., Office of Inspector Gen., *The Centers for Medicare & Medicaid Services Awarded Consumer Operated and Oriented Plan Program Loans in Accordance With Federal Requirements, and Continued Oversight Is Needed*, at 2 (July 30, 2013), http://oig.hhs.gov/oas/reports/region5/51200043.pdf.

There were two types of available loans, both distributed pursuant to a Loan Agreement between HHS and the CO-OP: start-up loans and solvency loans.[14] Start-up loans covered certain specified costs of establishing a CO-OP, including employee salaries and benefits, consultant costs, and equipment.[15] Solvency loans were used to cover capital reserve requirements and other solvency requirements established and monitored by state insurance regulators.[16] Under the CO-OP loan agreements, solvency loans were disbursed as needed to meet those risk-based capital requirements as well as HHS's own risk-based capital standard.[17] But HHS retained discretion to withhold any disbursement if, *inter alia*, the CO-OP failed to meet performance levels set by a corrective action plan; it could also terminate the agreement.[18]

The process for receiving loans was as follows: CO-OPs applied for both start-up loans and solvency loans at the same time. HHS then decided whether and how much to award the CO-OP. Once it did so, HHS distributed a portion of the start-up loan; additional disbursements of funds were contingent on the CO-OP meeting milestones established by the Loan Agreement.[19] With respect to solvency loans, HHS first distributed a portion of the funds and then distributed additional funds as needed to meet risk-based capital requirements.[20] Start-up loans were due to be repaid within five years; solvency loans were due within 15 years.[21]

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[14] 45 C.F.R. § 156.520(a) ("Applicants may apply for the following loans under this section: Start-up Loans and Solvency Loans.").

[15] *See* Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., *Loan Funding Opportunity Number: OO-COO-11-001*, at 10, 35 (July 28, 2011, rev. Dec. 9, 2011) ("Start-up Loans are intended to assist applicants with approved start-up costs associated with establishing a new health insurance issuer."), http://apply07.grants.gov/apply/opportunities/instructions/oppOO-COO-11-001-cfda93.545-instructions.pdf.

[16] 45 C.F.R. § 156.520(a)(2)("Solvency Loans awarded under this section will be structured in a manner that ensures that the loan amount is recognized by State insurance regulators as contributing to the State-determined reserve requirements or other solvency requirements (other than debt) consistent with the insurance regulations for the States in which the loan recipient will offer a CO-OP qualified health plan.").

[17] *See, e.g.*, Loan Agreement Between Michigan CO-OP and HHS § 5 (executed Aug. 29, 2012).

[18] *See id.* §§ 5.3, 12.1, 16.2.

[19] *See* Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., *Loan Funding Opportunity Number: OO-COO-11-001*, at 10 (July 28, 2011, rev. Dec. 9, 2011) ("After the first drawdown of Start-up Loan funds, subsequent drawdowns will be conditioned on the submission of evidence of the loan recipient's successful completion of milestones described in loan recipients' Business Plan and Loan Agreement.").
http://apply07.grants.gov/apply/opportunities/instructions/oppOO-COO-11-001-cfda93.545-instructions.pdf; *id.* at 12 (same for Solvency Loans).

[20] 45 C.F.R. § 156.520(b)(1), (c)(1).

[21] *Id.* § 156.520(b)(2), (c)(2).

By January 1, 2014—the date the program took effect—HHS awarded $2.4 billion to 23 CO-OPs operating in 26 states. The following table summarizes loan award amounts allotted to each of the 23 CO-OPs.[22]

CO-OP States	Start-up Loan Award	Solvency Loan Award	Total Award Amount
Health Republic Insurance of New York (New York)	$23,767,000	$241,366,000	$265,133,000
Minutemen Health, Inc. (Massachusetts/New Hampshire)	$25,091,995	$131,351,000	$156,442,995
Kentucky Health Care Cooperative (Kentucky/West Virginia)	$21,996,872	$124,497,900	$146,494,772
CoOportunity Health (Iowa/Nebraska)	$14,700,000	$130,612,100	$145,312,100
Maine Community Health Options (Maine)	$12,506,124	$119,810,000	$132,316,124
InHealth Mutual Ohio (Ohio)	$15,977,304	$113,248,300	$129,225,604
HealthyCT (Connecticut)	$21,011,768	$106,969,000	$127,980,768
Health Republic Insurance of New Jersey (New Jersey)	$14,757,250	$94,317,300	$109,074,550
Common Ground Healthcare Cooperative (Wisconsin)	$7,635,155	$100,104,199	$107,739,354
Land of Lincoln Health (Illinois)	$15,940,412	$144,214,400	$160,154,812
Meritus Health Partners (Arizona)	$20,890,333	$72,422,900	$93,313,233
Arches Mutual Insurance Company (Utah)	$10,106,003	$79,544,300	$89,650,303
Consumers' Choice Health Insurance Co. (South Carolina)	$18,709,800	$68,868,408	$87,578,208
Montana Health Cooperative (Montana/Idaho)	$8,556,488	$76,463,200	$85,019,688
New Mexico Health Connections (New Mexico)	$13,050,282	$64,267,500	$77,317,782
Community Health Alliance Mutual Insurance Co. (Tennessee)	$18,504,700	$54,802,000	$73,306,700
Colorado HealthOp (Colorado)	$15,205,529	$57,129,600	$72,335,129

[22] U.S. Gov't Accountability Off., GAO-15-304, *Private Health Insurance: Premiums and Enrollment for New Nonprofit Health Insurance Issuers Varied Significantly in 2014,* at 24 (Apr. 2015), http://www.gao.gov/assets/670/669945.pdf.

Consumer's Mutual Insurance of Michigan (Michigan)	$18,687,000	$52,847,300	$71,534,300
Louisiana Health Cooperative, Inc. (Louisiana)	$13,176,560	$52,614,100	$65,790,660
Nevada Health Cooperative, Inc. (Nevada)	$17,105,047	$48,820,349	$65,925,396
Evergreen Health Cooperative, Inc. (Maryland)	$13,341,700	$52,109,200	$65,450,900
Health Republic Insurance of Oregon (Oregon)	$10,252,005	$50,396,500	$60,648,505
Oregon's Health CO-OP (Oregon)	$7,156,900	$49,500,000	$56,656,900
TOTAL award amounts:	**$358,126,227**	**$2,086,275,556**	**$2,444,455,783**

B. CO-OPs Begin to Fail.

Of the 23 CO-OPs, 12 have already failed.[23] In this section, we provide brief summaries of each of the failed CO-OPs. Throughout this report, for simplicity, we generally refer to the failed CO-OPs below by their state (*e.g.*, The Louisiana CO-OP) rather than their formal names.

- **CoOportunity Health (Iowa and Nebraska).** CoOportunity Health was awarded an initial $112 million HHS loan in February 2012,[24] followed by an additional $32 million solvency loan award in September 2014.[25] Less than three months later, on December 16, 2014, it was placed under supervision by the Iowa Insurance Division.[26] It was liquidated on February 28, 2015.[27] According to the Insurance Division, liquidation was necessary because "rehabilitation of CoOportunity [was] not possible . . . and medical claims

[23] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., Ctr. for Consumer Information & Insurance Oversight, *Loan Program Helps Support Customer-Driven Non-Profit Health Insurers* (Dec. 16, 2014), https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html.
[24] *Id.*
[25] *Id.*
[26] Pet. for Order of Liquidation, *Iowa v. Gerhart,* Equity Case No. EQCE077579, ¶ 14, http://www.iid.state.ia.us/sites/default/files/press_release/2015/01/29/petition_pdf_11438.pdf.
[27] *Insurers Should Learn From CoOportunity Health Collapse*, LAW360 (Mar. 18, 2015) (noting that "CoOportunity Health was ordered into liquidation on March 2, 2015"), http://www.law360.com/articles/631678/insurers-should-learn-from-cooportunity-health-collapse.

currently exceed cash on hand."[28] At the time, CoOportunity had operating losses over $163 million and $50 million more in liabilities than in assets.[29]

- **Louisiana Health Cooperative, Inc.** The Louisiana CO-OP was awarded a $65 million HHS loan in September 2012 and an additional $750,000 loan in December 2013.[30] On July 7, 2015, the CO-OP's Board of Directors agreed to wind down its activities.[31] As the Louisiana Insurance Commission explained, "the continued operation and further transaction of business by [Louisiana Health Cooperative] would be hazardous to policy holders, subscribers, members, enrollees, creditors, and/or the public."[32]
- **Nevada Health Cooperative, Inc.** The Nevada CO-OP was awarded a $66 million HHS loan in May 2012.[33] On August 21, 2015, the Nevada Division of Insurance suspended the CO-OP's operations.[34] According to the Division of Insurance, in the previous six months, the CO-OP's "operating loss . . . [wa]s greater than 50 percent of [its] surplus" and the CO-OP likely could not satisfy the state's capital and reserve requirements.[35]
- **Health Republic Insurance of New York.** HHS awarded the New York CO-OP an initial $175 million loan in February 2012[36] and an additional $91

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[28] Press Release, Iowa Insurance Division, http://www.iid.state.ia.us/node/10074702.
[29] Final Order of Liquidation, *Iowa ex rel. Gerhart, Comm. of Ins. v. CoOportunity Health, Inc.*, Equity No. EQCE077579, at 4 (Mar. 2, 2015), http://www.doi.nebraska.gov/legal/cooportunity/FINAL%20ORDER%20OF%20LIQUIDATION.pdf.
[30] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., Ctr. for Consumer Information & Insurance Oversight, *Loan Program Helps Support Customer-Driven Non-Profit Health Insurers* (Dec. 16, 2014), https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html.
[31] Pet. for Rehabilitation, Injunctive Relief, and Rule to Show Cause of Louisiana Health Cooperative, Inc., *Donelon v. Louisiana Health Cooperative, Inc.*, No. 641928, ¶ 11 (Sept. 1, 2015), https://www.ldi.la.gov/docs/default-source/documents/financialsolvency/receivership/Louisiana-Health-Cooperative/petition-for-rehabilitation.pdf?sfvrsn=0.
[32] *Id.* ¶¶4, 5.
[33] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., Ctr. for Consumer Information & Insurance Oversight, *Loan Program Helps Support Customer-Driven Non-Profit Health Insurers* (Dec. 16, 2014), https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html.
[34] Pet. for Appointment of Commissioner as Receiver and Other Permanent Relief, Case No. A-15-725244-C, at 5 (Sept. 25, 2015) ("On August 21, 2015, the Commissioner issued an Order of Voluntary Suspension."), http://doi.nv.gov/uploadedFiles/doinvgov/_public-documents/News-Notes/2015-09-25%20File%20Stamped%20Appointment%20Petition%20re%20CO-OP%20Receivership.pdf.
[35] *Id.* at 7.
[36] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., Ctr. for Consumer Information & Insurance Oversight, *Loan Program Helps Support Customer-Driven Non-Profit*

million loan in September 2014.[37] On September 25, 2015, the New York Department of Financial Services (NYDFS) directed the CO-OP to cease writing new health insurance policies and announced that the CO-OP would commence an orderly wind down after the expiration of its existing policies.[38] When the CO-OP began its wind down, the NYDFS had an ongoing investigation "specifically focused on the New York CO-OP's inaccurate financial reporting"—with particular focus on "collecting and reviewing evidence related to the New York CO-OP's substantial underreporting to [the NYDFS] of its financial obligations."[39]

- **Kentucky Health Care Cooperative (Kentucky and West Virginia).** HHS awarded the Kentucky CO-OP an initial $58.5 million loan on June 19, 2012.[40] In 2013 and 2014, it received an additional $85 million in loans, including a $65 million solvency loan in late 2014.[41] The CO-OP announced on October 9, 2015 that it would stop offering health plans on the ACA marketplace.[42] A court order liquidating the CO-OP concluded that "the further transaction of business would be hazardous, financially or otherwise, to its policy holders and to the public."[43]

Health Insurers (Dec. 16, 2014), https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html.

[37] Press Release, House Energy & Commerce Committee (Nov. 25, 2015), https://energycommerce.house.gov/news-center/press-releases/committee-leaders-press-administration-status-remaining-1-billion.

[38] Press Release, New York Dep't of Fin. Servs. (Oct. 30, 2015), http://www.dfs.ny.gov/about/press/pr1510301.htm.

[39] Press Release, New York Dep't of Fin. Servs. (Nov. 13, 2015), http://www.dfs.ny.gov/about/press/pr1511131.htm.

[40] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., Ctr. for Consumer Information & Insurance Oversight, *Loan Program Helps Support Customer-Driven Non-Profit Health Insurers* (Dec. 16, 2014), https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html.

[41] *Id.; see* Adam Beam, *Health Insurer Receives $65 Million Federal Loan*, WASH. TIMES (Dec. 18, 2014) ("A Kentucky nonprofit that is one of the largest insurance providers on the state's health exchange received a $65 million federal loan last month to keep it afloat just days before the second open enrollment period began."), http://www.washingtontimes.com/news/2014/dec/18/health-insurer-receives-65-million-federal-loan/.

[42] Press Release, Kentucky Health Cooperative, Inc. (Oct. 9, 2015), http://www.prnewswire.com/news-releases/kentucky-health-cooperative-not-offering-plans-in-2016-300157384.html.

[43] Order of Liquidation, *Maynard v. Kentucky Health Cooperative, Inc.*, at 3.

- **Community Health Alliance Mutual Insurance Company (Tennessee).** HHS awarded a $73 million loan to the Tennessee CO-OP in August 2012.[44] On October 14, 2015, it announced its plans to wind down and not sell health plans in 2016.[45] The Tennessee Department of Insurance stated that "the risk of the [Tennessee CO-OP's] potential failure in 2016 was too great" to allow it to continue operations.[46]
- **Colorado HealthOp**. HHS awarded the Colorado CO-OP a $69 million loan in July 2012 and an additional $3 million loan in October 2013.[47] On October 16, 2015, the Colorado Division of Insurance announced that it would bar the Colorado CO-OP from selling health plans in 2016.[48] In approving a liquidation plan, a court concluded that "the CO-OP is in such condition that the further transaction of business would be hazardous, financially or otherwise, to the CO-OP's policy holders, its creditors, or the public."[49]
- **Health Republic Insurance of Oregon.** HHS awarded a $59 million loan to the Oregon CO-OP in February 2012 and an additional $1 million loan in November 2013.[50] On October 16, 2015, the CO-OP announced it was no longer offering new health insurance policies and would not be participating in open enrollment for 2016.[51] The CO-OP explained that "[i]n 2014 and 2015 [it] had medical expenses that exceeded the amount of money [it]

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[44] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., Ctr. for Consumer Information & Insurance Oversight, *Loan Program Helps Support Customer-Driven Non-Profit Health Insurers* (Dec. 16, 2014), https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html.

[45] Tennessee Dep't of Commerce and Insurance, *Tennessee CO-OP Community Health Alliance Voluntarily Enters Runoff* (Oct. 14, 2015), https://tn.gov/commerce/news/18562.

[46] *Id.*

[47] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., Ctr. for Consumer Information & Insurance Oversight, *Loan Program Helps Support Customer-Driven Non-Profit Health Insurers* (Dec. 16, 2014), https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html.

[48] Colorado Dep't of Regulatory Agencies, *Division of Insurance Moves to Protect Colorado Consumers, Takes Action Against HealthOp* (Oct. 16, 2015), https://www.colorado.gov/pacific/dora/Division-of-Insurance-action-HealthOP.

[49] Order of Liquidation and Finding of Insolvency, *Salazar v. Colorado HealthOp*, Case No. 2015-CV-33680 (Jan. 4, 2016), at 2 ¶6, http://cohealthop.org/wp-content/uploads/2016/01/Certified-Copy-of-Order-of-Liquidation-and-Finding-of-Insolvency.pdf.

[50] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., Ctr. for Consumer Information & Insurance Oversight, *Loan Program Helps Support Customer-Driven Non-Profit Health Insurers* (Dec. 16, 2014), https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html.

[51] Statement, Oregon Dep't of Consumer and Business Services, http://www.oregon.gov/DCBS/Insurance/news/Pages/2015/oct162015.aspx.

received in premiums."[52] Moreover, it explained that the only way it would be able to continue operations was if HHS guaranteed to pay for some of its losses.[53]

- **Consumers' Choice Health Insurance Company (South Carolina).** The South Carolina CO-OP was awarded an $87 million HHS loan in March 2012.[54] On October 21, 2015, it was placed under supervision of the South Carolina Insurance Department.[55] The next day, the CO-OP agreed to wind down its operations and announced that it would not offer health insurance coverage in 2016.[56] The Insurance Department determined that the CO-OP was "in hazardous financial condition rendering its continued operation hazardous to the public and/or its insureds, warranting supervision."[57]
- **Arches Mutual Insurance Company (Utah).** The Utah CO-OP was awarded an $85 million HHS loan in July 2012 and an additional $4 million loan in September 2013.[58] It announced it was withdrawing from the 2016 marketplace on October 27, 2015,[59] and was placed into receivership on November 2, 2015.[60] In a press release announcing the decision to close the CO-OP, the Utah Insurance Commission cited low capital resulting from a failure of federal payments as the reason for its closure."[61]

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[52] Health Republic Insurance, *Goodbye and Good Luck Oregon: Closure Announcement FAQ*, http://healthrepublicinsurance.org/.
[53] *Id.*
[54] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., Ctr. for Consumer Information & Insurance Oversight, *Loan Program Helps Support Customer-Driven Non-Profit Health Insurers* (Dec. 16, 2014), https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html.
[55] Consent Order Commencing Rehabilitation Proceedings & Granting an Injunction & Automatic Stay of Proceedings, *Farmer v. Consumers' Choice Health Insurance Company*, Civil Action No. 2016-CP-40-00034, at 4 (Jan. 6, 2016), http://www.cchpsc.org/wp-content/uploads/2016/01/CCHP_receivershipdetails.pdf.
[56] *Id.*
[57] *Id.*
[58] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., Ctr. for Consumer Information & Insurance Oversight, *Loan Program Helps Support Customer-Driven Non-Profit Health Insurers* (Dec. 16, 2014), https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html.
[59] Kristen Moulton, *Utah Shuts Down Arches, The State's Nonprofit Insurance CO-OP*, THE SALT LAKE TRIBUNE (Oct. 28, 2015), http://www.sltrib.com/home/3108049-155/utah-shuts-down-arches-utahs-nonprofit.
[60] Rehabilitation Order, *In re Arches Mutual Insurance Co.*, Civil No. 150907803, ¶¶ 1-2 (Nov. 2, 2015), https://archeshealth.org/media/pdf/Arches%20Rehabilitation%20Order.pdf.
[61] Utah Insurance Dep't, *Arches Health Plan to Cease Operation* (Oct. 27, 2015), https://insurance.utah.gov/news/documents/PR-ArchesCeasesOperation10-27-2015.pdf.

- **Meritus Health Partners (Arizona).** The Arizona CO-OP was awarded a $93 million HHS loan on June 7, 2012.[62] On October 30, 2015, it was placed under the supervision of the Arizona Insurance Commission.[63] According to the Insurance Commission, the Arizona CO-OP had "yet to make a profit and [has] lost over $78 million since [its] inception."[64]
- **Michigan Consumer's Healthcare CO-OP.** The Michigan CO-OP was awarded a $71 million HHS loan in May 2012.[65] It was placed on rehabilitation on November 3, 2015[66]—two days after the start of Open Enrollment for 2016. A court granted the Michigan state insurance regulator's petition for liquidation and a declaration of insolvency on February 10, 2016.[67]

C. Previous Reports Concerning the CO-OP Program.

HHS's Office of Inspector General and the Government Accountability Office (GAO) have released several studies reviewing HHS's application and selection process, examining HHS's early implementation of the program, and conducting performance reviews of CO-OPs. In July 2013—five months before any CO-OPs began operating—the Inspector General released two reports on the CO-OP Program.

In the first report, the Inspector General found that "11 of the 16 CO-OPs reported estimated startup expenditures . . . that exceeded the total startup funding provided by CMS."[68] The Inspector General found that, despite this funding

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[62] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., Ctr. for Consumer Information & Insurance Oversight, *Loan Program Helps Support Customer-Driven Non-Profit Health Insurers* (Dec. 16, 2014), https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html.
[63] Press Release, Arizona Dep't of Insurance, *Meritus Health Placed Under Supervision* (Oct. 30, 2015), https://insurance.az.gov/press-release-meritus-health-placed-under-supervision.
[64] *Id*.
[65] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., Ctr. for Consumer Information & Insurance Oversight, *Loan Program Helps Support Customer-Driven Non-Profit Health Insurers* (Dec. 16, 2014), https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html.
[66] *Michigan Places Consumers Mutual Insurance in Rehabilitation,* INSURANCE JOURNAL. (Nov. 25, 2015), http://www.insurancejournal.com/news/midwest/2015/11/25/390170.htm.
[67] *See generally* Order of Liquidation and Declaration of Insolvency, Case No. 15-948 CR (Feb. 10, 2016), http://www.michigan.gov/documents/difs/Liquidation_Order_2.10.16_514365_7.pdf.
[68] *See* Dep't of Health & Human Servs., Office of Inspector Gen., *The Centers for Medicare & Medicaid Services Awarded Consumer Operated and Oriented Plan Program Loans in Accordance With Federal Requirements, and Continued Oversight Is Needed*, at 5 (July 30, 2013), http://oig.hhs.gov/oas/reports/region5/51200043.pdf.

shortfall, the CO-OPs had received limited private funding.[69] To solve this issue, the Inspector General recommended that HHS ensure that CO-OPs do not exhaust their startup funds before becoming fully operational and that HHS monitor efforts to obtain private funding.[70] In the second report, the Inspector General found that, while CO-OPs were making significant progress in meeting milestones, CO-OPs were struggling to "hire staff, obtain[] licensure, and build[] necessary infrastructure such as provider network arrangements and technology systems."[71] The Inspector General also concluded that, ultimately, success in meeting program goals depended on "a number of unpredictable factors," including the "State's Exchange operations, the number of people who enroll in the CO-OP and their medical costs, and the way in which competing plans will affect the CO-OP's market share."[72]

The Inspector General issued a third report in July 2015.[73] The Inspector General found that, "[a]lthough CMS awarded CO-OP loans to applicants on the basis of their ability to become financially viable," "many CO-OPs have lower-than-expected enrollment numbers and significant net losses,"[74] with more than half of the CO-OPs suffering net losses of *at least* $15 million.[75] The Inspector General noted that these low enrollment numbers and high losses limited the ability of the CO-OPs to repay loans and remain viable.[76]

GAO published a review of CO-OP enrollment and premium costs in 2014.[77] GAO's review found that the 22 CO-OPs operating in 2014 failed to meet their enrollment projections by 559,000 and 14 of the 22 CO-OPs failed to meet their enrollment projections.[78] Moreover, GAO found that the average premium costs for

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[69] *Id.* at 3.
[70] *Id.* at 6.
[71] Dep't of Health & Human Servs., Office of Inspector Gen., *Early Implementation of the Consumer Operated and Oriented Plan Loan Program*, at 13 (July 30, 2013), http://oig.hhs.gov/oei/reports/oei-01-12-00290.pdf.
[72] *Id.*
[73] Dep't of Health & Human Servs., 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*, at 5-6 (July 2015), http://oig.hhs.gov/oas/reports/region5/51400055.pdf.
[74] *Id.* at 11.
[75] *Id.* at 8.
[76] *Id.* at 5.
[77] *See* U.S. Gov't Accountability Off., GAO-15-304, *Private Health Insurance: Premiums and Enrollment for New Nonprofit Health Insurance Issuers Varied Significantly in 2014,* at 24 (Apr. 2015), http://www.gao.gov/assets/670/669945.pdf.
[78] *Id.* at 18.

CO-OP plans varied relative to health insurance plans offered on the private market[79]—perhaps suggesting that CO-OPs struggled to accurately price plans.

D. A Note on Terminology.

Throughout this report, we refer to three risk-spreading mechanisms utilized by the ACA: "reinsurance," "risk corridors," and "risk adjustment." We briefly explain those concepts here, which we sometimes refer to as the "3Rs." The ACA established "reinsurance" as a temporary measure, in place between 2014–2016, in order to safeguard insurers against claim payments to "high risk" people who have purchased health insurance on the individual market.[80] It works in the following way: Once an insurance policyholder has incurred a certain amount of medical costs, the government begins to reimburse the insurer some of the costs up to a specified threshold.[81] Although each state is permitted to establish and administer its own reinsurance plan, in practice the federal government has the job of administering reinsurance in most states.[82] In 2014, for example, only two states had their own reinsurance plans.[83] Funds for reinsurance payments are collected through fees levied on all health insurance plans.[84]

"Risk corridors"—another temporary mechanism in place between 2014-2016—limit insurers' allowable losses from qualified health plans in the individual and small group markets.[85] The program requires insurers calculate a "risk corridor ratio" using an established formula.[86] If the ratio is below a certain amount, it means that the insurer has likely made a profit and must share some of the profit with HHS; by contrast, if the ratio is above a certain amount, it means that the insurer has likely suffered a loss, and HHS must cover a portion of that loss.[87]

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[79] *See id.* at 15 ("The percentage of rating areas where the average premium for CO-OP health plans was lower than the average premium for other issuers varied significantly by each state and tier.").
[80] Angela Booth & Brittany La Couture, *The ACA's Risk Spreading Mechanisms: A Primer on Reinsurance, Risk Corridors and Risk Adjustment*, AMERICAN ACTION FORUM (Jan. 9, 2015), http://americanactionforum.org/research/the-acas-risk-spreading-mechanisms-a-primer-on-reinsurance-risk-corridors-a.
[81] *Id.*
[82] *Id.*
[83] *Id.*
[84] *Id.*
[85] *Id.*
[86] *Id.*
[87] *Id.*

Unlike reinsurance and risk corridors, the ACA's "risk adjustment" provision is permanent.[88] During the "risk adjustment" process, either the state or the federal government compares the actuarial risk of the insurance pool within each qualified health plan purchased on the individual and small group markets with the average actuarial risk in the state for all qualified plans.[89] Insurance pools with lower than average actuarial risk must make payments to insurance pools with higher than average actuarial risk.[90]

III. FINDINGS AND ANALYSIS

The Subcommittee's investigation focused on HHS's decision to approve the failed CO-OPs and HHS's management and monitoring of its multibillion-dollar CO-OP loan portfolio. The investigation reveals that HHS approved the failed CO-OPs notwithstanding flaws in their business plans. Once the CO-OPs began losing money at rates far worse than their worst-case projections, HHS barely used the corrective action or enhanced oversight tools available to it. HHS eventually approved additional solvency loans in an attempt to save failing CO-OPs, but again did so despite obvious warning signs. The end result was to exacerbate losses that will now be shouldered by taxpayers, doctors, and others — even as more than 700,000 consumers were forced to find new health insurance plans.

The financial toll of this failed experiment is much steeper than has been previously reported. The twelve closed CO-OPs ran up more than $1.4 billion in losses over just the two years they sold plans. Based on the latest balance sheets obtained by the Subcommittee, the failed CO-OPs' currently estimated *non-loan* liabilities (including unpaid medical bills) exceed $1.13 billion—which is 93% greater than their $585 million in reported assets. In addition, the CO-OPs' debt to the U.S. government stands at over $1.2 billion. Prospects for repayment are dim.

A. HHS Approved The Failed CO-OPs Despite Problems Identified By Deloitte In The CO-OPs' Business Plans.

HHS retained Deloitte Consulting LLP to evaluate loan applications and business plans submitted by health insurance CO-OPs seeking a federal award. Deloitte reviewed each Grant Application for compliance with the "essential CO-OP Program [Funding Opportunity Announcement] criteria established by CMS for funding." [91] According to the funding announcement, CMS "relied on the ACA, the CO-OP final rule, the proposed rule for exchanges on standards for qualified health

[88] *Id.*
[89] *Id.*
[90] *Id.*
[91] Deloitte Review – Utah 3.

plans, and the final report of the CO-OP Advisory Board to establish the review criteria" discussed in detail below.[92]

To conduct these reviews, Deloitte conducted in-person interviews with CO-OP applicants and "worked with CMS to specify procedures and acceptance criteria to be used in the review of the CO-OP applications."[93] As established by HHS, Deloitte evaluated the applicant CO-OPs based on the following 13 criteria:

Deloitte CO-OP Evaluation Criteria[94]	
Project Narrative	Feasibility
Qualifications of Management & Key Personnel	Provider Arrangements, Target Market, & Products
Pro Forma Financials	Operations
Budget	Governance & Licensure
Enrollment Strategy & Regulatory Capital Requirements	Loan Funding & Repayment Schedule
Integrated Care Plan	Statewide Basis
Evidence of Private Support	

Deloitte analyzed the strengths and weaknesses of the loan applications using these criteria. HHS provided Deloitte with a detailed breakdown of what Deloitte should consider when evaluating each criterion and provided scores for each category. [95] Each criteria carried a maximum point value, and under HHS's instructions, 70 points (out of a possible 100) was enough to "pass" Deloitte's review.[96] HHS and Deloitte told the Subcommittee that a "pass" did *not* constitute Deloitte's recommendation to approve or disapprove the loan, but rather was the result of HHS's scoring guidance.[97] HHS received all Deloitte reviews for the 12 failed CO-OPs by June 2012 and approved the applications by September 27, 2012.

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[92] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., *CO-OP Program Loan Funding Opportunity Announcement,* 38 (Dec. 9, 2011).
[93] *Id.*
[94] Deloitte Review – Utah 1.
[95] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., *CO-OP Program Loan Funding Opportunity Announcement,* 38-42 (Dec. 9, 2011).
[96] Interview with Deloitte (Mar. 2, 2016); *see* Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., *CO-OP Program Loan Funding Opportunity Announcement* (Dec. 9, 2011) (setting maximum point value).
[97] *Id.*; Interview with Kelly O'Brien, CO-OP Division Dir., Ctrs. for Medicare & Medicaid Serv. (Mar. 1, 2016).

Once submitted to HHS, Deloitte's evaluations were reviewed by an HHS "Selection Committee" that made final decisions about CO-OP approval. The Selection Committee was made up of internal subject-matter experts, internal actuaries, and others.[98] The Selection Committee reviewed the prospective CO-OP's application, considered Deloitte's reports, and conducted its own interviews with CO-OP officials.

According to HHS, the Deloitte reports were an important part of this review and approval process.[99] Indeed, Deloitte's reports were the *only* written reviews of the applications; HHS did not create a comparable written review of its own.[100] Nor did the Selection Committee produce a formal review or report memorializing the basis for its approval recommendation for a particular CO-OP application.[101]

The Subcommittee obtained and reviewed Deloitte's evaluations of each of the approved CO-OPs, with particular attention to the failed CO-OPs. Each of the failed CO-OPs received a "pass" based on the criteria that HHS instructed Deloitte to consider. Those evaluations reveal that Deloitte identified and, to some extent, foreshadowed problems that contributed to the failure of the CO-OPs.

For some CO-OPs, HHS issued "Requests for Additional Information" (RAIs) in an effort to obtain missing documents, seek clarifications, or ask follow-up questions to inform its review of an application. According to documents received by the Subcommittee, HHS sent RAIs to six of the failed CO-OPs. No evidence was provided to the Subcommittee showing that HHS formally requested *any* additional information to consider in its application process for the other half of the failed CO-OPs. The weaknesses described in detail below take into account HHS's documented attempts to fill in missing or insufficient information through its RAI process.

As explained below, Deloitte called HHS's attention to weaknesses in three crucial evaluation criteria across all plans. *First*, Deloitte identified substantial weaknesses in enrollment strategy and enrollment forecasts. *Second*, Deloitte identified many budget-planning and financial-projection deficiencies. *Third*, Deloitte raised concerns about the proposed management (and in some cases, the sponsors) of the now-failed CO-OPs.

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[98] Interview with Kelly O'Brien, CO-OP Division Dir., Ctrs. for Medicare & Medicaid Serv. (Mar. 1, 2016).
[99] Interview with Kevin Counihan, Dir., Ctr. for Consumer Information and Insurance Oversight (CCIIO) (Mar. 1, 2016).
[100] *Id.*; Interview with Kelly O'Brien, CO-OP Division Dir., Ctrs. for Medicare & Medicaid Serv. (Mar. 1, 2016).
[101] *Id.*

1. Enrollment Strategy Weaknesses.

Enrollment is a central component of any health insurer's business plan. As outlined in Part III, the enrollment projections for all but two of the failed CO-OPs' business plans diverged dramatically from reality. Based on our review of Deloitte's evaluations, it is clear that HHS knew that there were significant problems in the enrollment plans of 7 of the 12 failed CO-OPs well *before* HHS approved their loan applications.[102]

Those problems ranged from inadequate actuarial analysis, to unsupported assumptions about sustainable premiums, to a lack of demonstrated understanding of the health demographics of the target patient population. Overall, HHS knew that nearly half of the now 12 failed CO-OPs expected to gain market share by underpricing competitors but were unable to provide sufficient documentation and evidence that those lower premiums would be financially sustainable.[103] According to Deloitte, when its employees discovered informational gaps or insufficient detail, it sought the missing information from HHS, and Deloitte wrote its reports based on all records provided.[104]

Deloitte raised especially pointed concerns about two failed CO-OPs that ultimately missed their 2014 enrollment projections by extreme margins: Arizona and Tennessee.[105] Deloitte advised HHS that the Arizona CO-OP's enrollment forecasts were "aggressive, particularly for a start-up" and that the CO-OP's strategy was "unlikely to achieve the target enrollment figures in accordance with its timeline."[106] According to Deloitte, the CO-OP's "financial projections related to enrollment appear[ed] to be unreasonable and lacking in thoroughness based on the actuarial review of [the CO-OP's] feasibility study."[107] The Arizona CO-OP responded to HHS's request for additional information on its aggressive enrollment strategy by restating its projections and stating it was "in the process of developing" detailed staffing plans and expanding its provider network, among other steps.[108]

The Tennessee CO-OP suffered from a similar problem. It proposed an enrollment strategy that counted on underpricing its competitors and attracting new customers seeking to escape the individual mandate penalty, but it "fail[ed] to explain how a competitive price [would] be achieved and can be offered recognizing

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[102] *See* Deloitte Review – Kentucky 7; Louisiana 8; Tennessee 7; Arizona 5; Colorado 7; Michigan 8; and Nevada 8.
[103] *See* Deloitte Review – Kentucky 6; Louisiana 6; Tennessee 6; Utah 7; Oregon 6.
[104] Interview with Deloitte (Mar. 2, 2016).
[105] *See* Part III.B.2, *infra*. The Arizona CO-OP and Tennessee CO-OPs missed their base-case enrollment projections for 2014 by 85%, 64%, and 91%, respectively. *See id.*
[106] Deloitte Review – Arizona 7.
[107] Deloitte Review – Arizona 7.
[108] HHS RAI – Arizona 58.

that affordability may challenge growth."[109] CO-OP executives "did not explain how they would be able to offer a price competitive product or how savings would be achieved."[110]

Deloitte also noted during their application evaluation process that a number of the now extinct CO-OPs failed to identify and analyze the *types* of enrollees their plans would attract—that is, their target market. That weakness was significant: An insurer's largest expenditure is the cost of paying medical claims, and no insurer can accurately forecast its claims costs without understanding its target market and its risk profile. For example, Deloitte concluded that both Kentucky's enrollment forecasts and "the likelihood that [its] enrollment will be sufficient to create a financially viable CO-OP" were "difficult to determine since the market is highly concentrated and [the CO-OP] has not provided a thorough enough enrollment forecast analysis or details on why their plans will be attractive to its target market."[111] Likewise, the Louisiana CO-OP did "not provide any relevant health demographics related to illnesses."[112] Nor did the Tennessee CO-OP "address why the plans they intend to offer would be appropriate for their target market."[113]

As explained in Part III.B, *infra,* unexpected enrollment levels and higher than expected claims costs contributed significantly to financial difficulties of the failed CO-OPs. Although Deloitte's evaluations foreshadowed those problems, HHS nevertheless approved the applications.

2. Budgetary and Financial Planning Weaknesses.

As part of their applications, all prospective CO-OPs submitted operating budgets and pro forma financial statements (that is, long-term projections of revenue, profit, assets, liabilities, etc.). HHS instructed Deloitte to evaluate the proposed budgets for completeness as well as "reasonableness and cost-effectiveness."[114] The Department told Deloitte to review the pro forma financial statements for completeness, clarity of assumptions, and consistency with each CO-OP's business plan.[115] In its review, Deloitte identified numerous problems ranging

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[109] Deloitte Review – Tennessee 7.
[110] Deloitte Review – Tennessee 9.
[111] Deloitte Review – Kentucky 5–6. In response to an RAI concerning its enrollment strategy, the Kentucky CO-OP answered vaguely that it would to seek to "understand fully the diverse Commonwealth-wide population" through community meetings and market research and "develop benefit plans based on understanding of the diverse target markets." HHS RAI – Kentucky 5.
[112] Deloitte Review – Louisiana 6.
[113] Deloitte Review – Tennessee 5.
[114] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., *CO-OP Program Loan Funding Opportunity Announcement,* 12 (Dec. 9, 2011).
[115] *Id.* at 34.

from comparatively minor issues, such as omitting needed expenses, to more significant concerns, like presenting an unreasonable budget.

Deloitte reported that the budgets submitted by 10 of the 12 failed CO-OPs were incomplete to varying degrees, and only *one* of them fully remedied those concerns through supplemental information.[116] The Michigan and Nevada CO-OPs, for example, failed to account for all uses of their requested loan funds,[117] while the Colorado CO-OP failed to link its loan drawdowns to "milestones" (such as building out a provider network) as required.[118] Several of the budgets also suffered from inconsistencies. For example, the Arizona CO-OP's application contradicted itself concerning when the CO-OP would spend its start-up loan funds, and Deloitte noted that "inconsistencies such as this are common throughout the [Arizona CO-OP's] budget."[119] The Louisiana CO-OP similarly listed conflicting start-up costs and filled out "several sections of [its budget form] incorrectly."[120]

In addition to inconsistencies, Deloitte noted that many of the CO-OPs' budgets appeared to be unreasonable or did not align with their own financial projections. The Arizona CO-OP's budget "lack[ed] reasonableness and cost-effectiveness," and its loan drawdown schedule was also unreasonable "due to the risk involved in using premiums in 2014 to fund start-up costs."[121] The Utah CO-OP's budget narrative also "may not be reasonable or cost-effective," Deloitte warned, because the budget "does not link to their loan funding and repayment schedule or pro forma financials."[122] The Nevada CO-OP's budget "may not be reasonable, as they do not clearly lay out how start-up costs will be funded," and their loan requests conflicted with their budget and "other parts of their application."[123] The Kentucky CO-OP's start-up costs did "not appear to be well thought out," and the timing of its loan drawdown "cannot be tied to any of the financial[]" projections.[124] Similarly, the budget for Iowa and Nebraska's CoOportunity CO-OP did not align with its financial statements.[125]

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[116] *See* Deloitte Review – New York 4; South Carolina 4; Colorado 8; Michigan 9; Nevada 10; Louisiana 7, CoOportunity Health 4; Arizona 6; and Oregon 4. Deloitte expressed similar concerns about the Tennessee CO-OP, but the CO-OP addressed those concerns fully in its response to an HHS request for additional information. *See* HHS RAI – Tennessee 15.
[117] Deloitte Review – Michigan 6; Nevada 7.
[118] Deloitte Review – Colorado 8.
[119] Deloitte Review – Arizona 6. In response to an RAI, Arizona stated that its 2014 "operational costs" would be covered by premiums for three quarters and loan dollars for one quarter. HHS RAI – Arizona 3.
[120] Deloitte Review – Louisiana 7.
[121] Deloitte Review – Arizona 6.
[122] Deloitte Review – Utah 6.
[123] Deloitte Review – Nevada 7.
[124] Deloitte Review – Kentucky 6.
[125] Deloitte Review – CoOportunity 3.

Deloitte also expressed skepticism about the risk-taking and unreasonable assumptions reflected in some of the CO-OPs' financial projections. The Colorado CO-OP, for example, assumed "a potentially unreasonable level of growth in revenue compared to growth in membership" using a growth rate that "far exceeds the average annual premium increase for individuals and families" without justification.[126] Deloitte also warned that the Colorado CO-OP planned to be overleveraged, with a debt-to-equity ratio that is "more than triple the health insurance industry average" and raises the risk that "the applicant may have potential loan repayment problems."[127] Deloitte noted that both the Louisiana CO-OP and Utah CO-OP might be counting on "an unreasonable level of growth in revenue as compared to growth in membership," and the Utah CO-OP *planned* to "operate at a loss until 2018."[128] Turning to CoOportunity's financial projections, Deloitte noted that the CO-OP's target profit margin was "much lower than the industry benchmark" of 4.8% and "substantially low even for a nonprofit company."[129] That was perhaps tongue-in-cheek: CoOportunity's target "profit margin" was *zero*.[130] HHS requested additional information from the CO-OP regarding its low profitability, but CoOportunity did not change its projections.[131] In addition, many of the CO-OPs' financial projections did not align with their business plans and budgets. Colorado's income statement, for example, could not be "tied to the applicant's start-up budget" and Deloitte could not determine "whether or not the applicant's income statement ties to the business plan/operations forecast."[132] The Nevada CO-OP, Tennessee CO-OP, and Kentucky CO-OP each produced financial projections using "key assumptions" that Deloitte was unable to trace to their actual business plans.[133]

3. Management Weaknesses.

Each CO-OP loan applicant was required to "identify its management team, explain their qualifications and experience, and submit an organizational chart and detailed position descriptions, including the qualifications required for each position."[134] Based on its review of this portion of the CO-OP's business plans,

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[126] Deloitte Review – Colorado 11.
[127] *Id.*
[128] Deloitte Review – Utah 8–9; Louisiana 9.
[129] Deloitte Review – CoOportunity 5.
[130] *Id.*
[131] HHS RAI – CoOportunity 15.
[132] Deloitte Review – Colorado 11.
[133] Deloitte Review – Nevada 10; Tennessee 10; Kentucky 9.
[134] Dep't of Health & Human Servs., *Funding Opportunity Announcement* OO-COO-11-001, 33 (Dec. 9, 2011).

Deloitte consultants expressed concern over key leadership position gaps or thin industry expertise for all of the 12 failed CO-OPs.[135]

For starters, despite the HHS requirement, several prospective CO-OPs had not even *identified* their senior leadership team. The Kentucky CO-OP's interim management team had "adequate health plan experience," but it had identified no permanent CEO and its description of job responsibilities did "not adequately describe an organization capable of leading, managing, and implementing the [CO-OP] project."[136] The Louisiana CO-OP's management team was "limited to just three individuals" and its application failed to identify "most key management positions."[137] The Nevada CO-OP, too, had no chief operating officer or medical director, and its application "lack[ed] a strong vetting process."[138] The Tennessee CO-OP also had openings for leadership positions, but had no "strong vetting process" for applicants.[139] Colorado had identified no medical director.[140] Michigan had assembled a complete team, but its senior executives had "limited direct commercial experience in managing a health plan"—the core work of CO-OP management—and would be relying on external advisors.[141]

Deloitte conducted background checks on proposed CO-OP executives identified in loan applications. That vetting turned up red flags in more than half of the failed CO-OPs—problems that, in Deloitte's view "could influence the likelihood of the CO-OP's success and should be brought to the attention of CMS."[142] The problems varied but included insider trading, personal bankruptcy, racketeering lawsuits, labor disputes, and various liens and unpaid money judgments. The top executive who ran both the Louisiana CO-OP and the Kentucky CO-OP, for example, had been charged by the SEC with unlawful insider trading in his previous role as CEO at a health care management firm. That 1998 case resulted in a permanent injunction and court order requiring the executive to disgorge ill-gotten gains and pay a civil penalty.[143] In one case, a proposed Chief Financial Officer had declared a personal bankruptcy. After Deloitte brought this to the HHS's attention, the individual withdrew his name for consideration.[144]

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[135] Deloitte Review – New York 3; South Carolina 6; Tennessee 5; Colorado 5; Michigan 4; Nevada 4; Louisiana 5, CoOportunity Health 3; Arizona 4; Oregon 3; Utah 4; Kentucky 4.
[136] Deloitte Review – Kentucky 4.
[137] Deloitte Review – Louisiana 7, 9.
[138] Deloitte Review – Nevada 4.
[139] Deloitte Review – Tennessee 5.
[140] Deloitte Review – Colorado 5.
[141] Deloitte Review – Michigan 4.
[142] Deloitte Review – Utah 4–5; Arizona 4; Tennessee 5; Kentucky 4; Louisiana 5; Michigan 4–5.
[143] Deloitte Review – Louisiana 5; Kentucky 4–5.
[144] HHS RAI – Tennessee 19.

Deloitte's background check of the CO-OPs' sponsoring organizations also turned up problems. For example, sponsors and personnel of the Nevada CO-OP "demonstrate[d] a record of involvement in multiple federal civil cases, liens and judgments."[145] In total, Deloitte identified 285 ongoing, completed, or dismissed federal cases involving one of the Nevada CO-OP's sponsors. Deloitte provided additional detail of the records in some cases "due to the significant nature of the matters" involving the sponsor.[146] In addition, Deloitte noted that the sponsor was the subject of nine outstanding liens or unpaid monetary judgments nationwide, ranging up to $96,000.[147]

* * *

Adhering to HHS's criteria and scoring methodology, Deloitte gave a passing score to each of the now-failed CO-OPs. HHS approved their awards between February and September of 2012.

B. Despite Glaring Financial Warning Signs, HHS Failed To Take Any Corrective Action or Enhance Oversight Until The Second Enrollment Year.

The loan agreements with the CO-OPs gave HHS several valuable tools to monitor and ensure the viability of CO-OPs in financial distress. Yet, as this section explains, even after it became apparent that the failed CO-OPs were suffering losses well beyond worst-case projections and deviating dangerously from their enrollment targets, the agency took *no* corrective action, nor did it put any CO-OP on enhanced oversight. Five of the 12 failed CO-OPs were *never* subject to these measures, and HHS waited until September 2015 to put five others on corrective action or enhanced oversight. Two months later, all twelve CO-OPs had failed.

1. HHS Scarcely Used the Major Accountability and Oversight Measures Available for Distressed CO-OPs.

The CO-OP loan agreements armed HHS with powerful tools to heighten its monitoring of CO-OPs in financial distress and require reforms as needed. Beyond routine monitoring, three key instruments available to HHS were *corrective action plans*, *enhanced oversight plans*, and *termination* of the loan agreement.[148]

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[145] Deloitte Review – Nevada 4.
[146] Deloitte Review – Nevada 5.
[147] Deloitte Review – Nevada 5.
[148] Dep't of Health & Human Servs., *Funding Opportunity Announcement* OO-COO-11-001, 48 (Dec. 9, 2011). *See, e.g.*, Loan Agreement Between Louisiana CO-OP and HHS, § 11.1 (executed June 19, 2012) ("Loan Agreement").").

The first tool, the corrective action plan, allows HHS to direct a CO-OP not in compliance with program requirements to develop and implement a plan specifying "the actions that the loan recipient will take to . . . correct any deficiencies and remain in compliance with program requirements."[149] During a corrective action plan, HHS monitors the CO-OP to ensure deficiencies are corrected.[150] HHS also has authority to place financially distressed CO-OPs on an enhanced oversight plan, which would consist of "detailed and more frequent review of the loan recipient's operations and financial status."[151] Under the CO-OPs' loan agreements, an enhanced oversight plan could be imposed when a CO-OP "consistently underperforms relative to the [CO-OP's] Business Plan."[152] The loan agreements provided that HHS could supply technical assistance to correct the problems that gave rise to a corrective action plan or enhanced oversight.[153] Finally, HHS had the authority to cut its losses by terminating the loan agreements and cease all loan disbursements—if it no longer believed that the loan recipient could establish a "viable and sustainable CO-OP that serves the interests of its community and the goals of the CO-OP program."[154]

Although each of the failed CO-OPs dramatically underperformed their business plans, HHS made sparing use of these accountability tools. Indeed, five of the 12 failed CO-OPs were *never* subject to corrective action or enhanced oversight measures,[155] and despite severe industry-wide financial distress beginning in January 2014, HHS did not place any of the others on a corrective action plan or enhanced oversight plan for over a year. Two of the failed CO-OPs were placed on corrective action or enhanced oversight plans in the first quarter of 2015—in reaction to dire warnings from state insurance commissioners concerning "hazardous financial condition[s]" in one case[156] and violation of state and federal

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[149] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., *CO-OP Program Loan Funding Opportunity Announcement,* 49 (Dec. 9, 2011).
[150] *Id.*
[151] *Id.*
[152] *Id. see also* Loan Agreement.
[153] Dep't of Health & Human Servs., Centers for Medicare & Medicaid Servs., *CO-OP Program Loan Funding Opportunity Announcement,* 48 (Dec. 9, 2011).
[154] *See* Loan Agreement § 16.2 ("Lender may elect to terminate this Agreement if it determines in its sole and absolute discretion that Borrower will not be likely to be able to establish a viable and sustainable CO-OP that serves the interests of its community and the goals of the CO-OP Program.").
[155] Specifically, the Utah, New York, Nevada, South Carolina, and Iowa/Nebraska CO-OPs were never placed on an enhanced oversight or corrective action plan.
[156] Letter from Kelly O' Brien, Dep't of Health & Human Servs. to Ron Bramm, Community Health Alliance (Feb. 3, 2015); Letter from Commissioner Julie McPeak, Tennessee Dep't. of Ins., to Secretary Burwell, Dep't of Health & Human Servs. (Jan. 8, 2015).

law in the other.[157] As for the remaining five failed CO-OPs, the agency waited until September 2015 to place them on a corrective action or enhanced oversight plan; within less than two months, all five had gone under.[158]

The CMS CO-OP Program Director, Kelly O'Brien, told the Subcommittee that both corrective action and enhanced oversight plans were valuable tools.[159] But according to O'Brien, despite receiving information about the CO-OPs' financial performance on a monthly basis, the agency never developed a standard for when enhanced oversight would be triggered.[160] Based on our review of financial data available at the time each corrective action plan or enhanced oversight plan was implemented, it is difficult to discern any objective basis for whether a CO-OP was "consistently underperform[ing]" such that an enhanced oversight plan was advisable.[161]

The Subcommittee also sought to determine how frequently HHS made use of two other important tools—audits and site visits—but HHS has not responded to the Subcommittee's request for that information despite repeated efforts.

2. HHS Knew In 2014 That The CO-OPs Were Performing Worse Than Even The Worst-Case Net-Income Scenarios Outlined In Their Business Plans.

As part of their 2011 loan applications to HHS,[162] each CO-OP provided HHS with a feasibility study outlining financial projections for a number of potential scenarios—such as variations in enrollment and variation in claims costs.[163] The actuarial consulting firm Milliman prepared the feasibility studies for 9 of the 12

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[157] Letter from Kelly O'Brien, Dep't of Health & Human Servs. to William Oliver, Louisiana Health Cooperative (Jan. 2, 2015); Letter from Louisiana Insurance Commissioner to Kelly O'Brien, Dep't of Health & Human Servs. (Dec. 11, 2015).

[158] *See* Letter from Kevin Counihan, CCIIO Director, to Thomas Zumtobel, Meritus Health Partners (Sept. 28, 2015) (advising Arizona CO-OP of placement in an EOP); Letter from Kevin Counihan, CCIIO Director, to Dennis Litos, Consumers Mutual of Michigan (Sept. 22, 2015) (advising Michigan CO-OP of placement in a CAP and an EOP); Letter from Kevin Counihan, CCIIO Director, to Julia Hutchins, CEO, Colorado CO-OP (Sept. 10, 2015) (advising Colorado CO-OP of placement in an EOP); Letter from Kevin Counihan, CCIIO Director, to Glenn Jennings, CEO, Kentucky Health Cooperative (Sept. 18, 2015); Letter from Kevin Counihan, CCIIO Director, to Dawn Bonder, CEO, Oregon Health Republic Insurance Company (Sept. 22, 2015).

[159] Interview with Kevin Counihan, Director, CCIIO (Mar. 1, 2016); Interview with Kelly O'Brien, CO-OP Division Dir., Ctrs. for Medicare & Medicaid Serv. (Mar. 1, 2016).

[160] *Id.*

[161] *Id.*

[162] *See* Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., *CO-OP Program Loan Funding Opportunity Announcement* (Dec. 9, 2011).

[163] *See, e.g.*, Milliman Feasibility Study Prepared for New York CO-OP (Oct. 15, 2011).

failed CO-OPs.[164] Milliman's studies were based on a number of key assumptions provided by the CO-OPs, including enrollment projections.[165] Two other actuarial consulting firms, Wakely Consulting Group and Optum, prepared similar feasibility studies for the other three failed CO-OPs.[166] All of the Milliman feasibility studies included projected net income under different enrollment and pricing scenarios.[167] The feasibility studies reveal that every failed CO-OP underperformed their *worst-case* net-income expectations in 2014 (except for the two that did not provide worst-case projections).[168]

The losses came fast. One of the failed CO-OPs experienced losses greater than even its worst-case year-end projection *within the first quarter* of 2014.[169] That trend continued: By the second quarter of 2014, six of the 12 failed CO-OPs had exceeded their worst-case year-end net income projections.[170] By the third quarter of 2014, that number was seven;[171] by the fourth quarter, ten.[172] Cumulatively, the failed CO-OPs exceeded their projected worst-case scenario net income losses for 2014 by at least $263.7 million—four times greater than the expected amount.[173]

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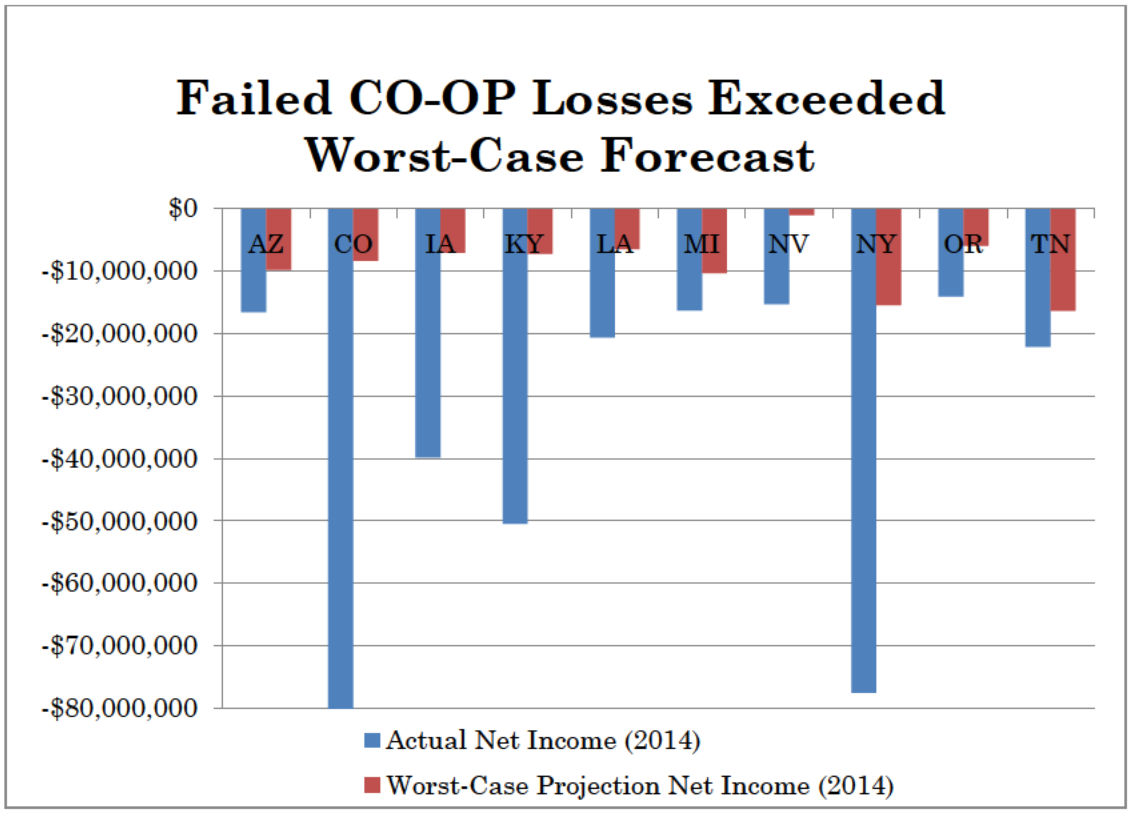
[164] Milliman Feasibility Study Prepared for New York CO-OP (Oct., 15, 2011); Milliman Feasibility Study Certification and Analysis Prepared for Arizona CO-OP (Oct. 23, 2011); Milliman Feasibility Study Certification and Business Plan Prepared for Nevada CO-OP (Dec. 21, 2011); Milliman Feasibility Study Certification and Business Plan Support Prepared for Kentucky CO-OP (Dec. 28, 2011); Milliman Feasibility Study Certification and Business Plan Support Prepared for Louisiana CO-OP (March 30, 2012); Milliman Feasibility Study Certification and Business Plan Support Prepared for Michigan CO-OP (Dec. 23, 2011); Milliman Feasibility Study Certification and Business Plan Support Prepared for Oregon CO-OP (Oct. 14, 2011); Milliman Feasibility Study Certification and Business Plan Support Prepared for Iowa CO-OP (Oct. 14, 2011); Milliman Feasibility Study Certification and Business Plan Support Prepared for Utah CO-OP (March 20, 2012);
[165] Interview with Milliman (Dec. 21, 2015). Milliman reviewed the enrollment forecasts for reasonableness but relied on the CO-OPs' assumptions.
[166] Optum Feasibility Study for Tennessee CO-OP (Mar. 31, 2012); Optum Feasibility Study for South Carolina CO-OP (Mar. 27, 2012); Wakely Feasibility Study Prepared for Colorado CO-OP (Mar. 30, 2012).
[167] Interview with Milliman (Dec. 21, 2015).
[168] Appendix A is a data spreadsheet that is available on the PSI website at http://www.hsgac.senate.gov/subcommittees/investigations/hearings/review-of-the-affordable-care-act-health-insurance-co-op-program. All original sources for the data are identified. For "worst-case" net income projections, we identified the feasibility study scenarios that resulted in the largest projected net loss in 2014.
[169] *Id*. The CO-OP is Nevada.
[170] *Id*. The six CO-OPs are Arizona, Colorado, Iowa, Kentucky, Louisiana, and Nevada.
[171] *Id*. The seven are Arizona, Colorado, Iowa, Kentucky, Louisiana, Nevada, and Oregon.
[172] *Id*. The ten are Arizona, Colorado, Iowa, Kentucky, Louisiana, Nevada, Oregon, Michigan, New York, and Tennessee.
[173] *Id*.

In most cases, the difference between projected and actual performance was staggering. As outlined below, the losses of 11 of the 12 failed CO-OPs ranged from of 261% to 7,196% of their base projections—displayed in the far right column below.[174]

CO-OP Projections v. Reality Actual Net Income as a % of Base Projection (2014)[175]				
CO-OP State	**Actual Net Income (2014)**	**Worst Case Projection Net Income (2014)**	**Base Case Projection Net Income (2014)**	**Actual Net Income as a % of Base Projection**
AZ	-$16,593,439	-$9,820,000	-$6,140,000	270%
CO	-$80,080,349	-$8,326,000	-$5,659,000	1,415%
IA	-$39,847,903	-$7,059,000	-$7,059,000	564%
KY	-$50,445,923	-$7,263,000	-$1,047,000	4,818%
LA	-$20,655,020	-$6,481,000	-$287,000	7,196%
MI	-$16,336,646	-$10,307,000	-$2,756,000	592%
NV	-$15,295,456	-$1,067,000	$371,000	4,122%
NY	-$77,539,370	-$15,457,000	-$5,306,000	1,461%
OR (HRI)	-$12,920,763	-$5,983,000	-$2,268,000	570%
SC	-$3,808,177	None Listed	-$8,016,000	47%
TN	-$22,130,737	-$16,378,000	-$8,474,095	261%
UT	-$21,001,844	None Listed	-$5,729,000	366%

[174] The feasibility studies for three (IA, NY, OR) of the failed CO-OPs express net losses as "margin." Six others (AZ, KY, LA, MI, NV, UT) express net losses as "projected change in unrestricted net assets." Those figures serve as the net loss projections described above. This is the same methodology that the HHS IG used to assess net income projections by the CO-OP. *See* Dep't of Health & Human Servs., Office of Inspector Gen., *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*, at 10 (July 2015), http://oig.hhs.gov/oas/reports/region5/51400055.pdf.

[175] *See* Appendix A.



HHS was well aware of the CO-OPs' devolving financial picture. The failed CO-OPs sent HHS key financial information on a regular basis, in the form of monthly reports reflecting enrollment, total premiums and considerations, total uncollected premiums, total claims paid, total claims unpaid, accrued administrative expenses, and cash on-hand.[176] Those reports were submitted within 30 days after each month's end.[177] Although HHS did not require net income to be included in these reports until March 2015, the 2014 monthly reports provided the agency all the revenue and expense data necessary to recognize the large deficits the CO-OPs were running.

[176] *See* CMS Monthly Enrollment Reports Submitted by CO-OPs, Appendix B is a data spreadsheet that is available on the PSI website at http://www.hsgac.senate.gov/subcommittees/investigations/hearings/review-of-the-affordable-care-act-health-insurance-co-op-program. All original sources for the data are identified.
[177] Interview with Kevin Counihan, Dir., CCIIO (Mar. 1, 2016); Interview with Kelly O'Brien, CO-OP Division Dir., Ctrs. for Medicare & Medicaid Serv. (Mar. 1, 2016).

HHS also received copies of the CO-OPs' standard audited quarterly financial statements required of all health insurers.[178] Those statements were generally submitted within two months after the end of each quarter.[179] The first quarterly reports for 2014 were submitted to HHS mid-May 2014.[180] At that point, *all but one* failed CO-OP reported a negative net income of $1.7 million or worse.[181] By the end of June 2014,[182] 11 of the 12 failed CO-OPs had negative net incomes of $4 million or worse.[183] And at the end of 2014, all but two failed CO-OPs had a negative net income of at least $14 million.[184]

Despite these financial warning signs, HHS entered 2015 open enrollment season with *no* corrective action or enhanced oversight plans in place. Worse, the pace of HHS's large disbursements of start-up and solvency loans to the failed CO-OPs did not abate. Indeed, as described in Part III.D, *infra*, throughout 2014 and 2015, HHS disbursed money to the CO-OPs almost as fast as they were losing it.

3. HHS Knew Early In 2014 That Enrollment Numbers For The Failed CO-OPs Deviated Sharply From Normal Projections.

Enrollment is a key determinant of a health insurer's financial performance and viability, and sharp deviation (in either direction) from the insurer's planned enrollment can be spell trouble.[185] Low enrollment can weaken an insurer by reducing expected premium income. Higher-than-expected enrollment can be even more destabilizing for insurers who underprice their premiums by setting their rates too low to cover claims and expenses.[186] As one leading health insurance scholar has explained, "[r]apid customer growth with inadequate prices and adverse claims experience has played a major role historically in insurance company insolvencies."[187]

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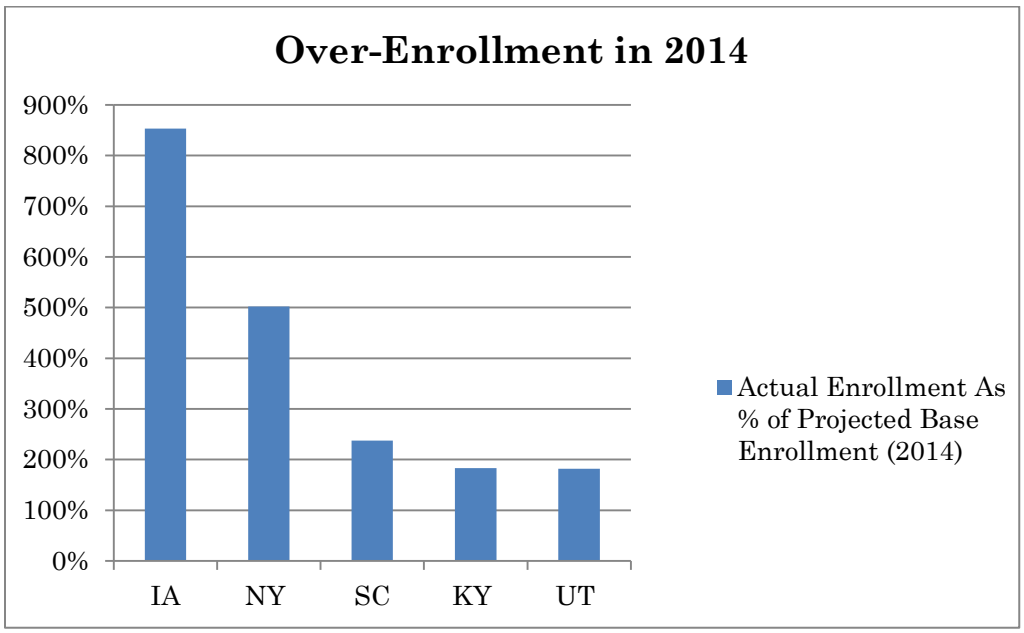
[178] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., *CO-OP Program Guidance Manual,* 8 (July 29, 2015), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CO-OP-Guidance-Manual-7-29-15-final.pdf.
[179] *Id.*
[180] *Id.*
[181] Appendix A.
[182] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., *CO-OP Program Guidance Manual,* 8 (July 29, 2015), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CO-OP-Guidance-Manual-7-29-15-final.pdf.
[183] Appendix A.
[184] *Id.*
[185] Scott E. Harrington, *The Financial Condition and Performance of CO-OP Plans*, Univ. of Penn. Leonard Davis Institute of Health Economics, Data Brief, 6 (Feb. 2015).
[186] *Id.*
[187] *Id.*

The failed CO-OPs were plagued by both varieties of enrollment trouble, and HHS knew it early in 2014. Throughout 2014, the CO-OPs submitted regular monthly and quarterly reports to HHS that showed that their enrollment projections were widely off the mark—in many cases, by financially hazardous margins. A comparison between projected and actual enrollment tells the story. The CO-OPs' business plans included annual enrollment projections,[188] and those enrollment projections were built into feasibility studies that projected financial performance in three enrollment scenarios: low, normal (also called "base"), and high.[189]

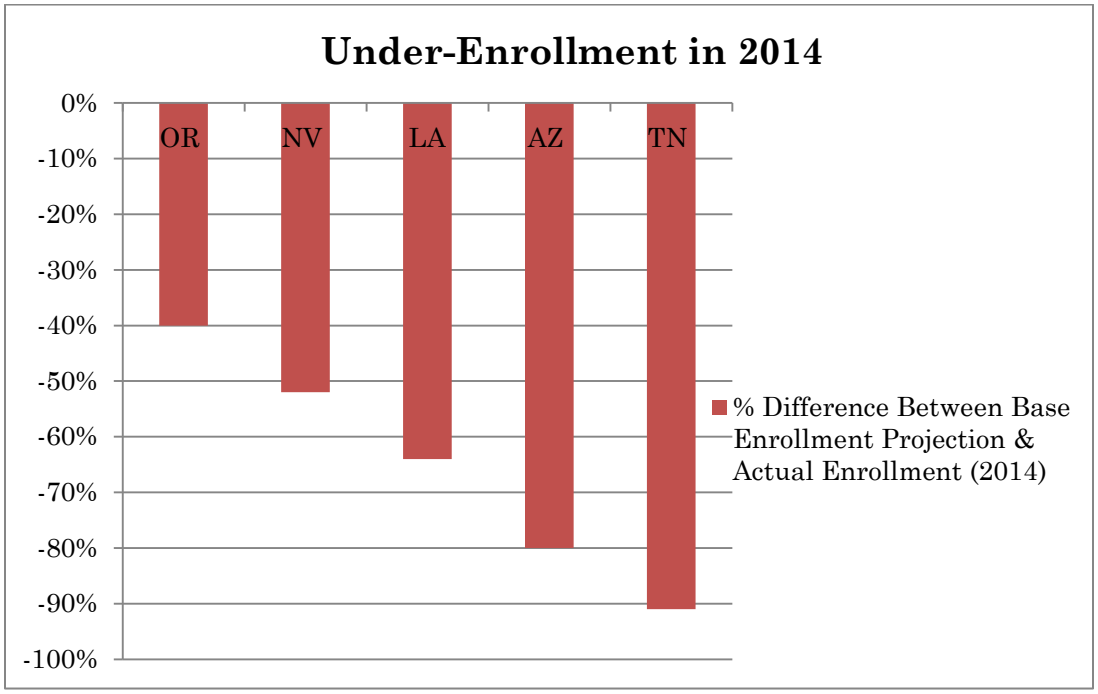
The failed CO-OPs' 2014 enrollment reports to HHS showed dramatic deviation from their plans and key financial assumptions.[190] Five of the failed CO-OPs underperformed their base enrollment projections by 40% or more—with one CO-OP missing its projection by 90%.[191] Two of the 12 failed CO-OPs did not even achieve half of their *low* enrollment scenarios forecast in the feasibility studies.[192] Another five CO-OPs *overshot* their base enrollment projections by 81% or more, with CoOportunity enrolling eight times more consumers than projected.[193]



[188] *Supra*, note 90.
[189] *Id.*
[190] This is based on a comparison of the start-up loan disbursement schedules set forth in the loan agreements, solvency loan disbursement schedules set forth in the business plans, and actual disbursement records.
[191] Appendix B.
[192] *Id.*
[193] *Id.*

These deviations manifested themselves early in 2014. By March 2014, two CO-OPs (CoOportunity and the New York CO-OP) had already exceeded their *high* enrollment projections for the year.[194] CoOportunity exceeded its high enrollment scenario by more than 150% within the first month of enrollment.[195] And by the end of March 2014, the New York CO-OP attracted 89,577 enrollees—more than double the high enrollment scenario in its feasibility study.[196] Because both fast-growing CO-OPs had mispriced their plans, that dramatic enrollment growth multiplied the CO-OPs' *losses* rather than gains—as HHS was seeing on a monthly and quarterly basis throughout 2014.[197]

CO-OPs with low enrollment also manifested problems early. By the end of the fourth month of 2014 open enrollment (January 2014), it was evident that many CO-OPs had seriously failed to attract their projected enrollees. At that point, five CO-OPs enrolled less than 2,000 members, and two CO-OPs enrolled less than 1,000 members.[198] Because open enrollment was the prime period for a surge in sign-ups, failure to perform well during that period was an important warning sign of deepening financial difficulties.



[194] *Id.*
[195] *Id.*
[196] *Id.*
[197] *See* Deloitte Additional Solvency Loan Review – CoOportunity; Deloitte Additional Solvency Loan Review – New York.
[198] Appendix B.

Because the CO-OPs reported enrollment data to HHS on a monthly basis, the Department was aware of these deviations from targets early in 2014—even as HHS continued to make multimillion-dollar start-up and solvency loan disbursements. Enrollment reports did not prompt HHS corrective action or place any failed CO-OP on an enhanced oversight plan throughout 2014.

As the CO-OPs with weak enrollment struggled to generate revenue, the CO-OPs with dangerously high enrollment racked up massive losses throughout 2014—losses reported on a regular basis to HHS.[199] CoOportunity and the New York CO-OP lost $39.8 million and $77.5 million, respectively, in 2014; they would go on to lose another $60 million and $544 million, respectively, in 2015.[200] Rapid enrollment growth, combined with underpriced premiums, contributed to the demise of both CO-OPs.[201] In the case of CoOportunity, 120,000 enrollees were sent searching for new insurance beginning on December 14, 2014, when the CO-OP was placed under supervision by the Iowa Insurance Division.[202] Likewise, in New York, 150,000 enrollees were informed that they would need to find new health insurance for 2016.[203]

C. Through 2014 And 2015, The Failed CO-OPs Were Losing Money Faster Than HHS Could Disburse It.

Despite serious financial warning signs, HHS did not withhold any planned disbursements from the now-failed CO-OPs—every dollar was paid, many on an accelerated basis compared to the CO-OPs' business plans.[204] Nor did it terminate

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[199] Appendix A. In the case of CoOportunity, cumulative net income was -$3,700,252 for Q1, -$13,421,327 for Q2, and -$39,847,903 for Q3. In the case of the Kentucky CO-OP, cumulative net income was -$1,720,156 for Q1, -$23,531,532 for Q2, -$24,033,077 for Q3, and -$50,445,923 at the end of 2014.

[200] Appendix A.

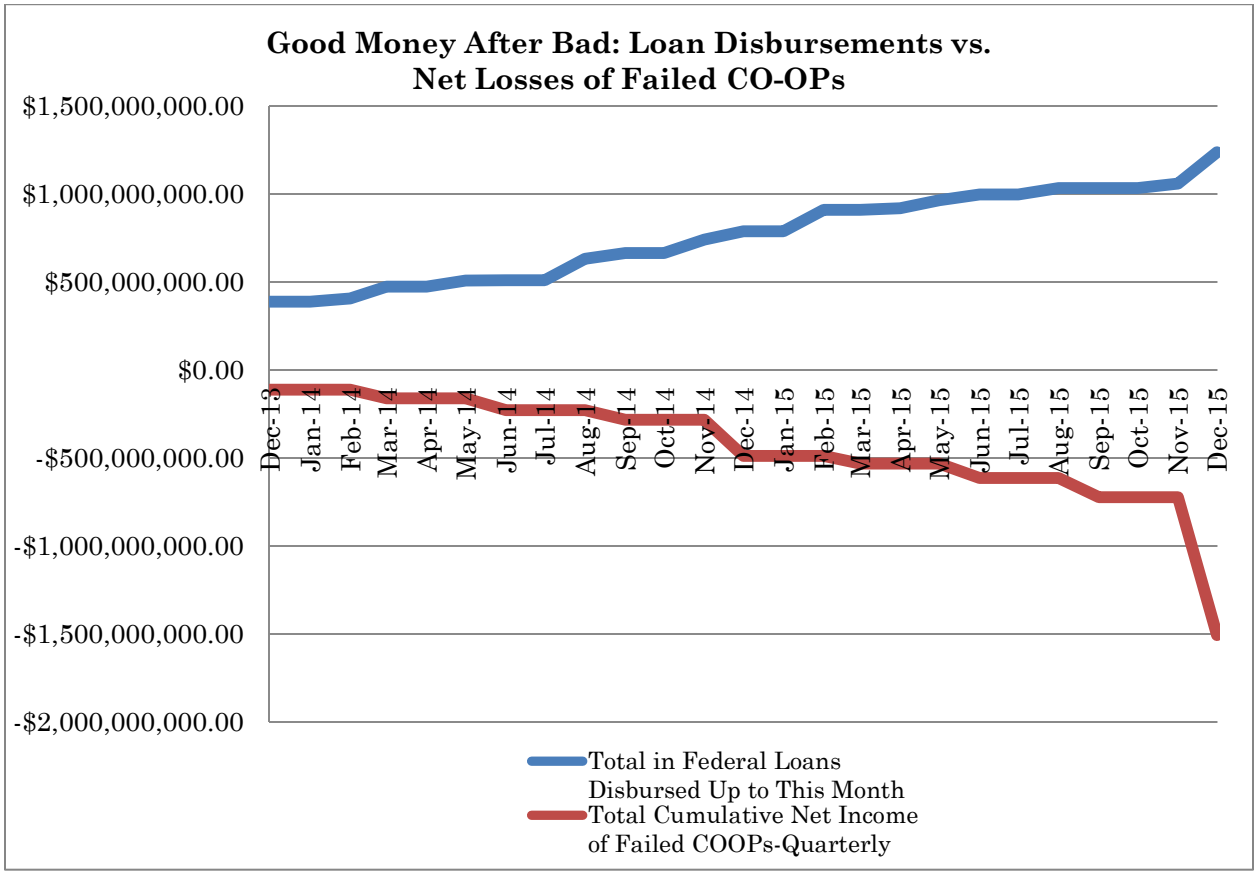
[201] Final Order of Liquidation, *Iowa ex rel. Gerhart, Comm. of Ins. v. CoOportunity Health, Inc.*, Equity No. EQCE077579, at 4 (Mar. 2, 2015), http://www.doi.nebraska.gov/legal/cooportunity/FINAL%20ORDER%20OF%20LIQUIDATION.pdf.; Scott E. Harrington, *The Financial Condition and Performance of CO-OP Plans*, U. Penn. Leonard Davis Institute of Health Economics, Data Brief, 6 (Feb. 2015).

[202] Pet. for Order of Liquidation, *Iowa v. Gerhart,* Equity Case No. EQCE077579, ¶ 14, http://www.iid.state.ia.us/sites/default/files/press_release/2015/01/29/petition_pdf_11438.pdf.

[203] Grace Marie-Turner, *400,000 Citizens to Lose Health Insurance (Again) Because of Obamacare CO-OP Failures*, GALEN INSTITUTE (Oct. 13, 2015).

[204] For example, the Michigan CO-OP received $19.4 million in solvency loan disbursements in 2014 against $3 million planned in its business plan. Similarly, the Arizona CO-OP received $26.9 million in 2015 in solvency loans against $15.4 million projected. *See* Disbursement Spreadsheets Submitted to PSI by Arizona CO-OP in Response to Nov. 23, 2015 Request; Michigan CO-OP Start-Up and Solvency Loan Disbursement Schedule, Ex. 1.0d (May 15, 2012); Arizona CO-OP Start-Up and Solvency Loan Disbursement Schedule.

any loan agreements. Instead, the agency continued to disburse taxpayer-backed loans to entities despite alarming signs of financial deterioration—and, ultimately, inability to repay the taxpayer. The Subcommittee analyzed the annual net incomes identified in the quarterly and annual financial statements of the now-failed CO-OPs and compared them on a quarterly basis to the HHS disbursement records provided by the CO-OPs.[205] Over the course of 2014 and 2015, HHS disbursed approximately $840 million[206] in federal loan dollars to the failed CO-OPs, even as they lost more than $1.5 billion.[207] For every $1 that HHS sent them during this period, the failed CO-OPs lost more than $1.65.



[205] Appendix D is a data spreadsheet that is available on the PSI website at http://www.hsgac.senate.gov/subcommittees/investigations/hearings/review-of-the-affordable-care-act-health-insurance-co-op-program. All original sources for the data are identified.
[206] *Id.*
[207] Appendix A. Net income losses are based on annual and quarterly NAIC filings by the CO-OPs, in addition to the 2015 year-end balance sheets provided to the Subcommittee. The 2015 year-end balance sheets have not yet been filed and finalized. Actual losses are likely to be significantly larger as several CO-OPs have not yet reported or provided their losses for the second half of 2015.

Indeed, HHS's disbursements of taxpayer loans continued well after several of the CO-OPs had announced their plans to close. The Utah CO-OP received $10.25 million on November 23, 2015—about a month after it announced its closure.[208] On July 7, 2015, the Louisiana CO-OP's Board of Directors agreed to wind down its activities, yet it received $9.2 million on November 27, 2015.[209] And Michigan received $5.4 million two weeks after it was placed on rehabilitation.[210]

D. HHS Approved Additional Solvency Loans For Three Of The Failed CO-OPs Despite Obvious Financial Warning Signs.

As financial reports poured into HHS, it soon became apparent that many of the CO-OPs were running out of money—some projecting cash shortfalls that could place them in conflict with risk-based capital requirements set by state regulators. If a CO-OP failed to meet those capital requirements, its state insurance regulator could effectively shut it down.

In response, HHS moved forward with awarding large additional solvency loans, well in excess of what was previously requested in the CO-OPs' applications and business plans. According to HHS, these additional solvency loans "were intended to assist applicants with meeting the capital reserve requirements of states in which the applicants sought to be licensed to issue health insurance."[211] After the start of coverage on January 1, 2014, HHS started an application and award process for additional funds specifically to assist with these state solvency requirements.[212] As of this report, six CO-OPs (three failed and three surviving) received additional solvency loan awards totaling more than $350 million.[213]

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[208] Kristen Moulton, *Utah Shuts Down Arches, The State's Nonprofit Insurance CO-OP*, THE SALT LAKE TRIBUNE (Oct. 28, 2015), *available at* http://www.sltrib.com/home/3108049-155/utah-shuts-down-arches-utahs-nonprofit.

[209] Pet. for Rehabilitation, Injunctive Relief, and Rule to Show Cause of Louisiana Health Cooperative, Inc., *Donelon v. Louisiana Health Cooperative, Inc.*, No. 641928, ¶ 11 (Sept. 1, 2015), https://www.ldi.la.gov/docs/default-source/documents/financialsolvency/receivership/Louisiana-Health-Cooperative/petition-for-rehabilitation.pdf?sfvrsn=0.

[210] *Michigan Places Consumers Mutual Insurance in Rehabilitation,* INSURANCE JOURNAL (Nov. 25, 2015), http://www.insurancejournal.com/news/midwest/2015/11/25/390170.htm.

[211] Dep't of Health & Human Servs., Office of Inspector Gen., *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,* 5-6 (July 2015), http://oig.hhs.gov/oas/reports/region5/51400055.pdf.

[212] Ctrs. for Medicare & Medicaid Servs., Ctr. for Consumer Information & Insurance Oversight, *Loan Program Helps Support Customer-Driven Non-Profit Health Insurers* (Dec. 16, 2014), https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html.

[213] *Id*.

Failed CO-OPs	Additional Solvency Loan Award
Health Republic Insurance of New York (New York)	$90,688,000
Kentucky Health Care Cooperative (Kentucky/West Virginia)	$65,000,000
CoOportunity Health (Iowa/Nebraska)	$32,700,000

Surviving CO-OPs	Additional Solvency Loan Award
HealthyCT (Connecticut)	$48,427,000
Maine Community Health Options (Maine)	$64,810,000
Common Ground Healthcare Cooperative (Wisconsin)	$51,117,899

To obtain additional solvency loans, CO-OPs were required to submit applications to HHS, including modified and updated business plans showing how the CO-OP would use the additional funds.[214] According to Mandy Cohen, CMS's Chief Operating Officer, "CMS undertook a rigorous review process substantially similar to what was conducted for the initial round of loans. This included both an external and internal review of updated business plans."[215] As with the initial loan review process, Deloitte completed the external assessment for all additional solvency loan applications. Deloitte evaluated the applicant CO-OPs based on the following criteria: enrollment, pricing, medical costs and losses, financials, and the quality of their contingency plans.[216]

According to Deloitte, HHS required a quick turnaround on analysis of each additional solvency loan application. While the firm initially requested two months to complete its work, HHS asked for responses in just four weeks.[217] As a result, Deloitte told the Subcommittee that it did not provide the same in-depth analysis as it did for the initial loan application.[218] For example, Deloitte specifically refrained from evaluating or commenting on "the reasonableness of the proposed changes to

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[214] *See, e.g.,* Deloitte Additional Solvency Loan Review – Kentucky 1.
[215] *Review of Obamacare Consumer Operated and Oriented Plans (Co-Ops): Hearing Before the Subcommittee on Health Care, Benefits, and Administrative Rules*, 114th Cong. (Feb. 25, 2016) (statement of Dr. Mandy Cohen MD, MPH, Chief Operating Officer and Chief of Staff, Ctrs. for Medicare and Medicaid Servs.).
[216] Deloitte Additional Solvency Loan Review – Utah 1.
[217] Interview with Deloitte (Mar. 2, 2016).
[218] *Id.*

each CO-OP business plan" or "the likelihood of each CO-OP achieving sustainable operations based on the revised business plan."[219] Further, Deloitte did not provide any comment on "the reasonableness or the propriety of any of the amounts of the 3Rs" provided by the CO-OPs.[220] That meant neither Deloitte nor HHS analyzed whether the CO-OPs were correct to rely on funds from reinsurance, risk corridors, and risk adjustment.

The findings that Deloitte did express were troubling. This section examines Deloitte's reviews of the three approved additional solvency funding requests of the failed CO-OPs operating in Kentucky, New York, and Iowa and Nebraska.

1. The Kentucky CO-OP Receives $65 Million in Additional Solvency Loan Funding.

In October 2014, Deloitte submitted its report on the Kentucky CO-OP's additional solvency loan request to HHS. The CO-OP had previously been awarded $20.2 million in expansion funding in November 2013 and additional start-up funding of $2.5 million in December 2013.[221] According to its application, the Kentucky CO-OP requested "additional solvency loan funding because of higher than expected enrollment and primarily to address solvency issues caused by the treatment of the risk corridors receivable as a nonadmitted asset."[222] Deloitte found that without further solvency loans and if its 3R receivables were not treated as admitted assets, "the CO-OP will have both critical liquidity and solvency issues."[223]

Notwithstanding these serious outcomes if the Kentucky CO-OP did not receive additional solvency awards, the documents it provided to Deloitte were incomplete in several key areas—leaving the firm without sufficient information to analyze many of the proposed strategies. As with the initial loan application review process, when Deloitte found there was inadequate information, it sought the information from HHS.[224]

The Kentucky CO-OP failed to provide sufficient information in all four key categories examined by Deloitte. First, with respect to enrollment, the CO-OP had experienced greater than predicted total enrollment, but fell dramatically short of

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[219] *See, e.g.,* Deloitte Additional Solvency Loan Review – Kentucky 1.
[220] *Id.*
[221] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., Ctr. for Consumer Information & Insurance Oversight, *Loan Program Helps Support Customer-Driven Non-Profit Health Insurers* (Dec. 16, 2014), https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html.
[222] Deloitte Additional Solvency Loan Review – Kentucky 3.
[223] *Id.* at 4.
[224] Interview with Deloitte (Mar. 2, 2016).

its plans to enroll 10,000 members *outside* the ACA Marketplace (it enrolled none).[225] But its revised enrollment strategy "did not provide any detail on how it plans to achieve its target enrollment" in its planned new markets.[226] Additionally, according to Deloitte, it was unclear how the CO-OP's plans would actually increase small-group enrollment (*i.e.,* small business employer plans)—a key market that Kentucky failed to previously engage.[227]

Second, with respect to the key issue of pricing, Deloitte expressed skepticism and noted gaps in the Kentucky CO-OP's proposal. The CO-OP planned to raise premiums by "an average of 15% in 2015 for individual products."[228] According to Deloitte, the CO-OP claimed "that its additional solvency needs [were] 'not due to inadequate or inappropriate pricing' in 2014," but Deloitte noted that "[t]his statement appears contradictory to the fact that [the Kentucky CO-OP] will remain 5-25% below the lowest priced competitor" even after adopting its premium increases.[229] Deloitte explained that it remains "unclear how [the Kentucky CO-OP] intends to avoid adverse selection if it remains the lowest priced competitor on the Kentucky Marketplace," and that the CO-OP "did not provide sufficient information to determine how [its proposed] premium increase will affect[ ] individual enrollment levels in Kentucky."[230] In yet another important gap, the CO-OP failed to explain how it would "raise its small group rates while also closing the price gap between [the Kentucky CO-OP] and the lowest priced competitor."[231]

Third, the Kentucky CO-OP told HHS that high medical claims costs also posed a financial threat—and were running higher than its 2014 projections. Yet according to Deloitte, "there [was] no information provided in the application detailing how [the CO-OP] intends to return to a normal level [of medical claims]."[232] Deloitte noted that if Kentucky did not reduce its medical loss ratio (*i.e.*, share of premium an insurer spends on medical claims), it would continue to lose money.[233] The Kentucky CO-OP projected an ambitious 74% reduction in medical loss ratio from 2014 (161.3%) to 2015 (86.8%), but there was "not enough

[225] Deloitte Additional Solvency Loan Review – Kentucky 5.
[226] *Id.* at 6.
[227] *Id.*
[228] *Id.* at 8.
[229] *Id.* at 7.
[230] *Id.*
[231] *Id.*
[232] *Id.* at 12.
[233] *Id.*

detail within the application" for Deloitte to even analyze the reasonableness of that decrease.[234]

Fourth, the Kentucky CO-OP's pro forma financial statements showed troubling projections on a number of levels. Even if the CO-OP realized its projected 3R recoveries, the Kentucky CO-OP was effectively requesting one government loan to pay another government loan. Deloitte's analysis found that the CO-OP was not projected "to earn enough net income through 2017 to repay its initial start-up loan payments of $6.3 million. Therefore, it appears [Kentucky] may need to use solvency loans to make the start-up loan repayment in 2017."[235]

The Kentucky CO-OP's precarious financial health depended largely on 3R receivables—including a projected $115.5 million for 2014. Deloitte noted that, without those 3R receivables, the CO-OP was projecting to have "losses of $139.3 million, $63 million, and $7.2 million in 2014, 2015, and 2016, respectively."[236] If those 3Rs did not materialize in full, or if they were not paid until the third quarter of 2015, Deloitte warned that "CMS may want to consider that [the Kentucky CO-OP] could suffer significant liquidity issues."[237] Deloitte noted the alternative: The Kentucky CO-OP had stated that, if its solvency loan request was denied, it could transition its members to other insurers "and remove the health plan from [2015] open enrollment."[238]

Instead, HHS chose to prolong the Kentucky CO-OP's operations, fueled by a $65 million additional solvency loan approved on November 10, 2014.[239] One year and $65 million in federal disbursements later, the Kentucky CO-OP was placed in rehabilitation due to insolvency risk and its health plan was removed from the 2016 open enrollment.[240] By that point, the CO-OP had deepened its losses to $50.4 million for 2014 and another $114.8 million in 2015.[241] Ultimately, more than 50,000 Kentucky CO-OP members would need to find new health insurance when the CO-OP collapsed.[242]

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[234] *Id.*
[235] *Id.* at 14.
[236] *Id.* at 4.
[237] *Id.* at 14.
[238] *Id.*
[239] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., Ctr. for Consumer Information & Insurance Oversight, *Loan Program Helps Support Customer-Driven Non-Profit Health Insurers* (Dec. 16, 2014), https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html.
[240] Order of Liquidation, *Maynard v. Kentucky Health Cooperative, Inc.*, at 3.
[241] Kentucky CO-OP, Statutory Balance Sheet (Dec. 31, 2015).
[242] *See* Appendix B.

2. The New York CO-OP Receives $90.7 Million in Additional Solvency Loan Funding.

On June 18, 2014, the New York CO-OP requested $90.7 million to maintain solvency in the face of far greater enrollment than expected and underpriced premiums.[243] The CO-OP reported a financially precarious position that required an infusion of additional funds to maintain solvency. Deloitte warned that estimating the 3Rs receivables was difficult and "may create issues if relied upon to generate profit,"[244] yet without those receivable the CO-OP was projecting losses of $68.2 million and $23.1 million for 2014 and 2015, respectively.[245] Losses would swell to $77.5 million and an estimated $544 million in 2014 and 2015, respectively.[246]

The New York CO-OP's 2014 enrollment was dramatically higher than anticipated "due to its rates being among the lowest in most products and markets across the state."[247] The CO-OP's principal solution was to increase premiums by 10% above market trend, but Deloitte noted that the CO-OP failed to include "estimates of the sensitivities of demand to prices"—that is, the effect that proposed premium increases would have on consumer demand for its health plans.[248] In addition, the effectiveness of its proposed plan to raise premiums was "only substantiated in [the CO-OP's] *assertion*" that it performed an "in-depth" analysis, "but no concrete data was provided from the study in the business plan or the Milliman feasibility study."[249] More broadly, Deloitte found that while the CO-OP had laid out a strategy for maintaining its enrollment figures and market competitiveness, it failed to "quantify the impact this business strategy will have on enrollment projects and financial sustainability."[250]

The CO-OP also appeared to be seeking enrollment growth in some respects. Unplanned enrollment growth had been a main driver of the CO-OP's financial difficulties, but the New York CO-OP projected to grow substantially in 2015 and 2016—to levels 319% and 339% (respectively) greater than original projections.[251] In fact, the CO-OP told HHS that it planned to *expand* its offering into "the

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[243] Deloitte Additional Solvency Loan Review – New York 1; Letter from Debra Friedman, President and CEO, Health Republic Insurance of New York to Nicole Gordon, Dep't of Health & Human Servs. (June 18, 2014).
[244] Deloitte Additional Solvency Loan Review – New York 9.
[245] Deloitte Additional Solvency Loan Review – New York 1.
[246] New York CO-OP, Statement of Financial Performance (Dec. 31, 2015).
[247] Deloitte Additional Solvency Loan Review – New York 6.
[248] *Id.* at 3.
[249] *Id.* at 6 (emphasis added).
[250] *Id.* at 6.
[251] *Id.* at 2.

remaining 30 New York counties in which it does not currently serve."[252] The CO-OP planned to "move into the large group market starting in 2015" in order to "diversify its business," among other goals, but it provided "no substantiation" for its enrollment projections in that more profitable market.[253]

Finally, there were obvious concerns about the New York CO-OP's ability to meet state and federal capital requirements. As previously discussed, the governing loan agreements required CO-OPs to maintain a risk-based capital (RBC) level of 500% of its authorized control level (ACL). According to HHS, "RBC is a method of measuring the minimum amount of capital appropriate for an issuer to support its overall business operations in consideration of its size and risk."[254] But HHS decided to deviate from its recommended capital requirements.[255] Deloitte wrote: "Based on discussions with CMS, Deloitte confirmed that CMS has chosen to fund [the New York CO-OP] based on state solvency requirements rather than a risk-based capital (RBC) level of 500% of authorized control level (ACL) normally recommended by CMS."[256] According to Deloitte, "The amount of funding required to meet the recommended RBC level of 500% of ACL is greater than the amount required [by the New York state standard]"—meaning that HHS lowered its own standard to accommodate the New York CO-OP.[257]

Deloitte summarized the "contingency plan" submitted by the New York CO-OP in the event it did not receive its solvency loan. "If [the New York CO-OP] does not receive the requested solvency loan funding, it may identify outside financing or scale down operations in order to meet solvency requirements. However, [the CO-OP] still projects that it will be able to repay both the start-up and current solvency loan funding in this scenario."[258] Deloitte explained that, failing private financing,

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[252] *Id.* at 3–4.
[253] *Id.* at 4.
[254] Dep't of Health & Human Servs., Ctrs. for Medicaid and Medicaid Servs., *CO-OP Program Guidance Manual* (July 29, 2015), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CO-OP-Guidance-Manual-7-29-15-final.pdf.
[255] Deloitte Additional Solvency Loan Review – New York 2.
[256] *Id.*
[257] *Id.*; New York CO-OP, CMS First Amended Loan Agreement, 2 (Feb. 17, 2012). The New York State Department of Financial Services (NYDFS) later effectively reversed HHS's decision to lower the bar for the New York CO-OP. NYDFS required the CO-OP to revert to the 500% RBC level, and that prompted the New York CO-OP to ask for an additional $70.5 million in a second request for additional solvency loan funding in September of 2014. HHS denied that second request in mid-December 2014—by which point it had exhausted its CO-OP loan award authority.
[258] Deloitte Additional Solvency Loan Review – New York 2.

the CO-OP intended to "scale down its operation by increasing its rates, by reducing its membership . . . and by eliminating all non-essential administrative costs."[259]

But rather than scale down, in September 2014, the New York CO-OP sought and obtained from HHS a $90.7 million additional solvency loan that would allow it to *scale up*—in every respect but profits.[260] Twelve months and $109 million in federal loan disbursements later, the New York Department of Financial Services directed the CO-OP to cease writing new health insurance policies and announced that the CO-OP will commence an orderly wind down after the expiration of its existing policies in December 2015.[261] By that point, the CO-OP had deepened its net losses to $77.5 million in 2014 and *more than $544 million* in 2015,[262] while adding 58,208 enrollees in 2015. All of those enrollees were sent searching for new health insurance policies when the New York CO-OP became insolvent.

3. CoOportunity Health Receives $32.7 Million in Additional Solvency Loan Funding.

On May 5, 2014, CoOportunity applied for an additional $32.7 million in solvency loan funds on top of the $112 million HHS originally awarded.[263] The CO-OP told HHS that it needed the infusion of cash to head off "cash flow and liquidity problems" driven by unexpectedly high losses, rapid growth and a "higher risk profile" than expected.[264] To slow its losses, the CO-OP planned to increase its rates and to focus on urban areas and other markets it had not penetrated (among other steps). But given the unsupported assumptions underlying the CO-OP's proposed solutions, Deloitte warned that the additional funds sought by CoOportunity may *not* be enough to maintain its solvency for long. "Due to the uncertainty of its enrollment projections and the risk profile of future enrollees," Deloitte wrote, "*it is unclear* that the requested amount of additional solvency loan

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[259] *Id.* at 14.
[260] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., Ctr. for Consumer Information & Insurance Oversight, *Loan Program Helps Support Customer-Driven Non-Profit Health Insurers* (Dec. 16, 2014), https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html.
[261] Appendix C is a data spreadsheet that is available on the PSI website at http://www.hsgac.senate.gov/subcommittees/investigations/hearings/review-of-the-affordable-care-act-health-insurance-co-op-program. All original sources for the data are identified; *see* Press Release, New York Dep't of Fin. Servs. (Oct. 30, 2015), http://www.dfs.ny.gov/about/press/pr1510301.htm.
[262] Appendix A.
[263] Letter from Comm. Stephen Ringlee, Dir. and Chief Fin. Officer, CoOportunity Health to CO-OP Program Division, Dep't of Health & Human Servs. (May 5, 2014).
[264] Deloitte Additional Solvency Loan Review – Iowa 3.

funding reflects the amount required to meet the CO-OP's future capitalization and liquidity requirements during growth projected during 2014–2017."[265]

Deloitte also pointed to concerns about CoOportunity on the crucial issue of enrollment. The firm's consultants noted that "no documentation or explanation is provided substantiating the reason or discrepancies in the actual current enrollment level"[266]—an obvious first step in addressing the problem. More fundamentally, CoOportunity's enrollment projections rested on a "list of assumptions," but it failed to "provide additional information discussing the impacts of these assumptions on its ability to meet enrollment projections in a specific target market or targeted market."[267] Finally, CoOportunity provided, without explanation, conflicting enrollment projections that "differ, at times, by over 20,000 per year."[268]

CoOportunity Health's forecast of financial health relied heavily on the 3Rs, despite uncertainty concerning its projections.[269] The CO-OP projected a net profit of $8.5 million for 2014–2016, but "[a]bsent recoveries from risk sharing, risk corridors, and risk adjustment," the CO-OP stood to lose $86.1 million from 2014–2016. Deloitte cautioned that "[t]he 3R receivables are difficult to estimate and may create issues if relied upon to generate a profit."[270] The largest receivable on CoOportunity's books for 2014, however, was a $41 million risk corridor payment.[271]

This was not CoOportunity's only additional solvency loan request. On September 22, 2014, four days before HHS approved CoOportunity's $32 million application, HHS received a second request from the CO-OP asking for an additional $55 million.[272] Knowing this information, however, HHS still approved the first application. Less than three months later, on December 16, 2014, it was placed under supervision by the Iowa Insurance Division and later liquidated.[273] CoOportunity had operating losses of over $163 million and $50 million more in

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[265] *Id*. at 6 (emphasis added).
[266] *Id*. at 2.
[267] *Id*. at 3.
[268] *Id*. at 5.
[269] *Id*. at 11.
[270] *Id*. at 11.
[271] *Id*.
[272] Letter from Commissioner Stephen Ringlee, Director and Chief Financial Officer, CoOportunity Health to CO-OP Program Division, Dep't of Health & Human Servs. (Sept. 22, 2014).
[273] Pet. for Order of Liquidation, *Iowa v. Gerhart,* Equity Case No. EQCE077579, ¶ 14, http://www.iid.state.ia.us/sites/default/files/press_release/2015/01/29/petition_pdf_11438.pdf.

liabilities than in assets.[274] The CO-OP's closure left its 120,000 members scrambling with little time to find a new insurance plan that best fit their needs. There were still nearly 10,000 former CoOportunity members without a new insurance plan by the time of the CO-OP's liquidation.[275]

E. HHS Permitted The CO-OPs To Rely On Massive Risk Corridor Projections With No Sound Basis For Doing So.

The risk corridor program is a temporary measure in the ACA that requires health insurers to share gains and losses. Insurers are required to calculate a "risk corridor ratio" that reflects their profitability using a formula prescribed by the ACA.[276] Using that ratio, more profitable insurers must remit a portion of their profits to HHS, and those collections are in turn to be directed to unprofitable insurers to offset a portion of their losses.[277]

As HHS has repeatedly acknowledged in the past, the risk corridor program was intended to be budget-neutral—meaning payments to insurers suffering losses would come entirely from those experiencing gains. The Congressional Budget Office (CBO) originally scored the cost of the risk corridor program on the assumption that "aggregate collections from some issuers would offset payments made to other issuers."[278] Subsequent CBO scores have varied, but all have projected either budget-neutrality or better.[279] More importantly, in 2013 and 2014, HHS stated that the agency "intend[s] to implement [the risk corridor] program in a budget neutral manner, and may make future adjustments either upward or

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[274] Final Order of Liquidation, *Iowa ex rel. Gerhart v. CoOportunity Health, Inc.*, Equity No. EQCE077579, at 4 (Mar. 2, 2015), http://www.doi.nebraska.gov/legal/cooportunity/FINAL%20ORDER%20OF%20LIQUIDATION.pdf.

[275] Joe Gardyasz, *Insurers still scrambling to process former CoOportunity members,* IOWA BUS. RECORD (Feb. 10, 2015), http://www.businessrecord.com/Content/Default/-All-Latest-News/Article/Insurers-still-scrambling-to-process-former-CoOportunity-members/-3/248/67513#ixzz42BbdzuvY.

[276] The formula is: (Medical claims + quality improvement) / (Premiums collected – administrative costs).

[277] *See generally* The Robert Wood Johnson Foundation, *Analysis of HHS Final Rules On Reinsurance, Risk Corridors And Risk Adjustment* (Apr. 2012); *see also* Angela Boothe & Brittany La Couture, *The ACA's Risk Spreading Mechanisms: A Primer on Reinsurance, Risk Corridors and Risk Adjustment*, AMERICAN ACTION FORUM (Jan. 9, 2015), http://americanactionforum.org/research/the-acas-risk-spreading-mechanisms-a-primer-on-reinsurance-risk-corridors-a#_edn11.

[278] *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014*, 78 Fed. Reg. 15516 (Mar. 11, 2013).

[279] Congressional Budget Office, The Budget and Economic Outlook: 2014 to 2024 (Feb. 4, 2014), https://www.cbo.gov/publication/45010; Congressional Budget Office, The Budget and Economic Outlook: 2015 to 2025 (Jan. 26, 2015), https://www.cbo.gov/publication/49892.

downward to this program . . . to the extent necessary to achieve this goal."[280] In April 2014, the agency explained that "if risk corridors collections are insufficient to make risk corridors payments for a year, all risk corridors payments for that year will be *reduced pro rata to the extent of any shortfall*. Risk corridors collections received for the next year will first be used to pay off the payment reductions issuers experienced in the previous year."[281] In other words, HHS would not spend more in risk corridor payments in a given year than it collected. A December 2014 appropriations law codified that commitment to budget-neutrality in the risk corridor program.[282]

But the gains necessary for the risk corridor program to work as intended did not materialize—as many analysts had warned. In an October 2014 report, Citibank concluded that HHS would not collect "nearly enough" from profitable insurers to meet the risk corridor requests of unprofitable insurers. The report was based an analysis of mid-year financial statements of 85 health plan subsidiaries representing "approximately 80% of the total individual market."[283] Remarkably, Citibank reported that, as of June 2014, the insurers that it studied had accrued $410 million in risk corridor receivables (*owed to them*) and only $2.3 million in risk corridor payments *owed by them* to HHS. In other words, it was a staggering imbalance. The study's authors concluded: "The sizeable risk corridor receivable assumptions by the plans make us nervous. . . . With no change in assumptions, we estimate the full year liability to HHS could exceed $1 billion. There won't be nearly enough plan contributions to fund these requests."[284] Citibank also questioned the empirical basis for HHS's assumption that any 2014 risk corridor shortfall could be covered by excess risk corridor collections in 2015: "[I]t isn't clear to us why health plans will suddenly start earning excess individual profits in 2015,"[285] the analysts noted, particularly considering "the losses being incurred by many plans this year."[286] Citibank's study echoed earlier skepticism in a publication by the Society of Actuaries, which concluded that it is "likely" that risk

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[280] *Patient Protection and Affordable Care Act*; HHS Notice of Benefit and Payment Parameters for 2015, 45 CFR Parts 144, 13,787 (Mar. 11, 2014), https://www.gpo.gov/fdsys/pkg/FR-2014-03-11/pdf/2014-05052.pdf.

[281] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., *FAQ: Risk Corridors and Budget Neutrality* (Apr. 11, 2014) (emphasis added), https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq-risk-corridors-04-11-2014.pdf.

[282] Consolidated and Further Continuing Appropriations Act, Pub. L. 113–235, 128 Stat. 2130 (Dec. 16, 2014).

[283] Carl McDonald and Sahil Choudhry, *Blessed Are Those Who Can Give Without Remembering & Take Without Forgetting: Analyzing The Industry's Individual 3 R Accruals In 1H14*, Citi Research 1, 2, 5 (Oct. 21, 2014), https://ir.citi.com/T75ur7JO9TmjgZE8xXjGDxftykEMbKPXghCs4GqkDqE%3D.

[284] *Id.* at 1.

[285] *Id.*

[286] *Id.* at 5.

corridor collections would not be sufficient to cover receivables.[287] And Citibank was not alone in its analysis.[288]

Deloitte warned HHS that several struggling CO-OPs were relying heavily on large, uncertain risk corridor projections to boost their balance sheets.[289] Throughout 2014, HHS received information showing that most of the now-extinct CO-OPs were booking massive projected payments from the risk corridor program—payments that were crucial to their forecasts of profitability.[290] For example, at the time of its first additional solvency loan application, CoOportunity's largest receivable for 2014 was its projected risk corridor payments. In its review of each additional solvency loan application, however, Deloitte cautioned HHS against the risks of relying on risk corridor projections to sustain CO-OPs experiencing losses.[291]

HHS did not heed these warnings. Rather than caution the CO-OPs against relying too heavily on risk corridor receivables that were very much in doubt, HHS issued repeated assurances throughout 2014 and 2015 that risk corridor collections would be sufficient to cover receivables. As recently as July 21, 2015, the agency continued to assure state insurance commissioners: "As stated in our final payment notice for 2016, 'We anticipate that risk corridor collections will be sufficient to pay for all risk corridors payments. HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers.'"[292]

When asked about this July 2015 letter in an interview, HHS officials stated that the letter was not referring to 2014 in isolation but rather to the three-year

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[287] Doug Norris, *Risk Corridors Under the Affordable Care Act*, HEALTH WATCH, SOCIETY OF ACTUARIES (Oct. 2013). The article continued: "The risk corridor program appears to be symmetric, with some plans paying into the program and some plans receiving funds from the program …. However, if all of the plans in a market (or even just the most popular ones) end up pricing their products too low and so suffer losses, the government will end up needing to fund this program, and the required funds could be substantial." *Id.*

[288] A May 2014 report by Standard and Poor added to the chorus of skepticism about the risk corridor payments and projected a pro rata shortfall that would permit payment of only 10 cents on the dollar. *See* Zachary Taylor, *Obamacare Risk Fund May Pay Just 10% of Insurer Claims, S&P Says* (May 1, 2015), http://www.bloomberg.com/news/articles/2015-05-01/obamacare-risk-fund-may-pay-just-10-of-insurer-claims-s-p-says.

[289] *See* Part III. E, *supra.*

[290] *Id.*

[291] Deloitte cautioned that "[t]he 3R receivables are difficult to estimate and may create issues if relied upon to generate a profit." *See* Part III.E, *supra* (additional solvency loan applications).

[292] Letter from Kevin Counihan, Director, CCIIO, to State Insurance Commissioners (July 21, 2015); *see also* CMS Public Mem., Risk Corridors & Budget Neutrality (Apr. 11, 2014) ("We anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments."); The Affordable Care Act's Premium Stabilization Programs: Hearing Before House Comm. on Oversight & Gov't Reform, 113th Cong. (June 18, 2014) (statement of Dr. Mandy Cohen MD, MPH, Acting Deputy Administrator and Director, CCIIO) (same).

period 2014–2016.[293] To say the least of it, that explanation is certainly not clear from the face of the letter, which specifically addresses "the 2014 reinsurance program" and "2014 risk corridor payments."[294] But even accepting HHS's reading, those assurances were no less unfounded: A November 2015 report by Standard & Poor's has already estimated that "the 2015 ACA risk corridor will be significantly underfunded, as was the case the previous year."[295] If true, that means there will be no surplus in 2015 to make up the 2014 shortfall—as Citibank predicted in October 2014.

Widespread concerns about booking risk corridor payments were ultimately justified. On October 15, 2015, HHS announced that 2014 risk corridor collections from profitable insurers had fallen far short of risk corridor payments requested by unprofitable insurers: HHS was able to pay only 12.6 cents on the dollar.[296] As predicted, the ensuing risk corridor shortfall further destabilized the CO-OPs.

F. The Heavy Costs of Failed CO-OPs Will Be Borne By Taxpayers, Doctors, And Other Insurers.

1. Financial Information Obtained By The Subcommittee Indicates That No Significant Share of the $1.2 Billion in Failed CO-OP Loans Will Likely Be Repaid.

None of the failed CO-OPs have repaid a single dollar, principal or interest, of the $1.2 billion in federal solvency and start-up loans they received.[297] The Subcommittee asked each of the failed CO-OPs to describe any "planned payments" on any principal or interest payments on any of their federal CO-OP loans. All twelve responded that, as of February 2016, there are no planned payments.[298]

The most up-to-date balance sheets obtained by the Subcommittee confirm that eight of the failed CO-OPs report multimillion-dollar deficits, *excluding their federal CO-OP loans*. In the aggregate, the failed CO-OPs' currently estimated *non-loan* liabilities exceed $1.13 billion—which is 93% greater than their $585 million in

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[293] Interview with Kevin Counihan, Director, CCIIO (Mar. 1, 2016); Interview with Kelly O'Brien, CO-OP Division Dir., Ctrs. for Medicare & Medicaid Serv. (Mar. 1, 2016).
[294] Letter from Kevin Counihan, Director, CCIIO, to State Insurance Commissioners (July 21, 2015).
[295] Sarah Ferris, *ObamaCare Risk Fund Nearly Depleted, S&P Warns*, THE HILL (Nov. 5, 2016), http://thehill.com/policy/healthcare/259337-obamacare-risk-fund-nearly-depleted-sp-warns.
[296] Dep't of Health & Human Servs., Cntrs. for Medicare & Medicaid Servs., *Risk Corridors Payment Proration Rate for 2014* (Oct. 1, 2015), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RiskCorridorsPaymentProrationRatefor2014.pdf.
[297] CO-OP Resp. to Nov. 23, 2015 PSI Request (on file with Subcommittee).
[298] *Id.*

reported assets.[299] Their debt to the U.S. government stands at over $1.2 billion.[300] Several of the CO-OPs owe substantially more in unpaid medical claims alone than they hold in assets. The New York CO-OP, for example, estimates that it has $379.5 million in unpaid claims to doctors, hospitals, and patients, while it registers only $157 million in assets (including expected 3R receivables).[301] Only three failed CO-OPs report greater assets than non-loan liabilities and those surpluses represent only a fraction of their federal loans.[302]

Below are the best estimates of the CO-OPs' current deficits or surpluses, *assuming zero repayment* of any federal CO-OP loan. Specifically, the Subcommittee asked each CO-OP to produce their most recent available balance sheet, and the tables below summarize those documents. "Assets" refers to cash and investments as well as projected receivables from 2015. "Liabilities" refers to unpaid medical claims and other liabilities, *excluding* the CO-OP's federal start-up and solvency loans. We estimated current "deficit" or "surplus" by subtracting non-loan liabilities from assets. On separate lines, each table identifies the current amounts of solvency and start-up loans owed to the federal government; start-up loans that were subsequently converted to surplus notes are identified as solvency loans.

[299] The total numbers for liabilities, assets, and the percentages do not include the Nevada CO-OP because it was not able to provide a complete, recent balance sheet.
[300] Arizona CO-OP, Balance Sheet (Dec. 31, 2015); Colorado CO-OP, Balance Sheet (Dec. 31, 2015); Iowa CO-OP, Balance Sheet (Jan. 29, 2016); Kentucky CO-OP, Balance Sheet (Jan. 2016); Louisiana CO-OP, Balance Sheet (Jan. 31, 2016); Michigan CO-OP, Balance Sheet (Dec. 31, 2015); Nevada CO-OP, Balance Sheet (Dec. 31, 2015); New York CO-OP, Balance Sheet (Dec. 31, 2015); Oregon CO-OP, Balance Sheet (Jan. 31, 2015); South Carolina CO-OP, Balance Sheet (Jan. 31, 2016); Tennessee CO-OP, Balance Sheet (Jan. 31, 2016); Utah CO-OP, Balance Sheet (Dec. 31, 2015).
[301] New York CO-OP, Statement of Financial Position (Dec. 31, 2015).
[302] Oregon CO-OP, Balance Sheet (Jan. 31, 2016); Tennessee CO-OP, Balance Sheet (Jan. 31, 2016); Utah CO-OP, Balance Sheet (Dec. 31, 2015).

Arizona CO-OP	
Total Assets	$27,474,302
Subtotal Liabilities	$31,752,963
Deficit	**$(4,278,661)**
Solvency Loan	$93,313,233
Source: Dec. 31, 2015 Statement	

Colorado CO-OP	
Total Admitted Assets	$48,891,384
Total Liabilities	$130,792,031
Deficit	**$(81,900,647)**
Solvency Loan	$72,335,129
Source: Dec. 31, 2015 Statement	

Iowa CO-OP	
Total Assets	$61,567,500
Total Liabilities	$87,172,375
Deficit	**$(25,604,875)**
Solvency Loan	$132,000,000
Start-up Loan	$14,700,000
Source: Jan. 29, 2016 Statement	

Kentucky CO-OP	
Total Admitted Assets	$70,507,439
Total Liabilities	$105,573,751
Deficit	**$(35,066,312)**
Solvency Loan	$124,497,900
Start-up Loan	$19,568,223
Source: Jan. 31, 2016 Statement	

Louisiana CO-OP	
Total Assets	$34,695,964
Total Current Liabilities	$51,501,925
Deficit	**$(16,805,961)**
Solvency Loan	$52,614,100
Start-up Loan	$13,176,560
Source: January 31, 2016 Statement	

Michigan CO-OP	
Total Assets	$28,483,244
Total Current Liabilities	$30,816,455
Deficit	**$(2,333,211)**
Solvency Loan	$71,534,300
Source: Dec. 31, 2015 Statement	

New York CO-OP	
Total Admitted Assets	$157,544,125
Total Short Term Liabilities	$547,408,164
Deficit	**$(389,864,039)**
Solvency Loan	$241,366,000
Start-up Loan	$23,600,400
Source: Dec. 31, 2015 Statement	

Oregon CO-OP	
Net Admitted Assets	$13,917,872
Total Liabilities	$9,436,938
Surplus (excluding loans)	**$4,480,934**
Solvency Loan	$60,623,505
Source: Jan. 31, 2016 Statement	

South Carolina CO-OP	
Total Assets	$47,066,188
Total Liabilities	$67,443,408
Deficit	**$(20,377,220)**
Solvency Loan	$68,868,408
Start-up Loan	$18,709,800
Source: Jan. 31, 2016 Statement	

Tennessee CO-OP	
Total Assets	$41,777,566
Total Liabilities	$25,082,097
Surplus (excluding loans)	**$16,695,469**
Solvency Loan	$54,802,000
Start-up Loan	$18,504,700
Source: Jan. 31, 2016 Statement	

Utah CO-OP	
Total Assets	$53,514,834
Total Current Liabilities	$43,993,836
Surplus (excluding loans)	**$9,520,998**
Solvency Loan	$79,544,300
Start-up Loan	$10,106,003
Source: Dec. 31, 2015 Statement	

The figures above are, by necessity, estimates. The largest liability—unpaid claims—includes fully processed 2015 claims as well as incurred but unprocessed 2015 claims. The CO-OPs report that they continue to receive some 2015 medical claims through the first quarter of 2016, and many received claims are still being processed to determine coverage. Other liabilities depend to some extent on claims data and could change as well. For example, payments owed by insurers under the federal risk adjustment program will turn on still-incomplete data.

One failed CO-OP—Nevada's—was unable to provide a complete recent balance sheet. The CO-OP did, however, provide the Subcommittee with some currently available figures that suggests a large deficit: $16.75 million in valid unpaid medical claims, $14.7 million in other liabilities, $60.4 in *unadjudicated* medical claims, and only $19 million in cash.[303] Significantly, this does not include expected receivables under the risk-sharing programs, and the CO-OP expects the $60.4 million unadjudicated claims liability to decline.[304] But based on this information, the Nevada CO-OP's assets will not likely be sufficient to cover its *non-loan* liabilities, much less sufficient to repay any significant portion of its federal solvency and start-up loans.[305] Moreover, Nevada has no guaranty fund capable of covering unpaid medical claims.[306]

Based on currently available information, it is unlikely that the failed CO-OPs will be able to repay any significant share of their outstanding $1.2 billion in federal loans. The Subcommittee has repeatedly asked HHS for any projections or

[303] PSI Correspondence with Mark F. Bennett, Receiver, Authorized Representative of the Special Deputy Receiver of the Nevada Health CO-OP (Mar. 4, 2016) (on file with Subcommittee).
[304] *Id.*
[305] *Id.*
[306] Nevada CO-OP Resp. to Feb. 19, 2016 PSI Request (on file with Subcommittee).

estimates of the prospects for repayment by the failed CO-OPs, and the agency provided none. Instead, HHS officials responded that it is too early to assess and stated that the Department of Justice has assumed responsibility for collection on these unpaid debts.[307]

2. Doctors and Hospitals Are At Risk Of Not Getting Paid In Some States, While Guaranty Funds Will Be Hard Hit In Others.

The American taxpayer is not the only creditor that stands to suffer large losses due to the failure of the CO-OP program. Based on the most recent balance sheets provided to the Subcommittee, the failed CO-OPs currently owe an estimated $742 million to doctors and hospitals for plan year 2015, including incurred claims.[308] An insolvent health insurer's debt to providers takes priority over other liabilities, so those claims are likely to be the first to be paid out of remaining assets. But if a CO-OP's medical claims alone exceed assets, payment to providers can be in doubt—as detailed below.

Based on their submissions, at least six CO-OPs currently owe more in medical claims alone than they hold in assets.[309] Three of those CO-OPs—the Colorado CO-OP, the South Carolina CO-OP, and CoOportunity—have access to guaranty associations capable of paying some or all unpaid medical claims.[310] Guaranty associations serve as a mechanism to pay covered claims occurring as a result of an insurer's insolvency. Associations were created to alleviate these problems and ensure the stability of the insurance market.[311] The Colorado CO-OP projects that substantially all of its $96.6 million in unpaid medical claims will be paid by the state's guaranty fund.[312] Similarly, the South Carolina CO-OP

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[307] Interview with Kevin Counihan, Dir., CCIIO (Mar. 1, 2016); Interview with Kelly O'Brien, CO-OP Division Dir., Ctrs. for Medicare & Medicaid Serv. (Mar. 1, 2016).

[308] CO-OP Resp. to Feb. 19, 2016 PSI Request (on file with Subcommittee).

[309] Specifically, the Kentucky CO-OP reports $70.5 million in assets and $77.46 million in unpaid medical claims. Kentucky CO-OP, Jan. 2016 Balance Sheet (Jan. 31, 2016). The Louisiana CO-OP reports $34.4 million in assets and $43.3 million in unpaid medical claims. Louisiana CO-OP, Jan. 2016 Balance Sheet (Jan. 31, 2016). The New York CO-OP reports $157.54 million in assets, $379.5 million in unpaid claims, and $106.9 million in risk adjustment liability. New York CO-OP, Dec. 2015 Balance Sheet (Dec. 31, 2015). The South Carolina CO-OP reports $47 million in assets and $47.7 million in unpaid claims. South Carolina CO-OP, Jan. 2016 Statement of Assets, Liabilities and Surplus (Jan. 31, 2016). The Colorado CO-OP reported $48.9 million in assets and $96.6 million in unpaid claims. Colorado CO-OP, Dec. 2015 Statement of Assets, Liabilities and Surplus (Dec. 31, 2015).

[310] Throughout this report, Subcommittee's references to information provided by a closed CO-OP refers to information from the CO-OP's remaining personnel *or* the CO-OP's receiver.

[311] *See* Nat. Ass'n.of Insurance Commissioners, *Briefing: Guaranty Associations* (Dec. 14, 2015), http://www.naic.org/cipr_topics/topic_guaranty_associations.htm.

[312] PSI Staff Correspondence with Colorado CO-OP on file with Subcommittee.

estimates that all of its $48 million in unpaid claims will be paid by the state's guaranty fund.[313]

The first CO-OP to close, CoOportunity, reports that $114.1 million of its unpaid medical claims have now been paid by the Iowa and Nebraska guaranty associations.[314] These guaranty fund payments are not, however, a proverbial free lunch. To the contrary, large obligations charged to guaranty funds mean that, within those states, "[s]urviving companies—or actually their policy holders—will pay for the co-ops' losses, ultimately in the form of higher premiums."[315] In addition, most states permit the surviving insurers to obtain tax credits for those payments, so state treasuries (and, in turn, taxpayers) will effectively subsidize guaranty fund bailouts for some of the CO-OPs.[316] Importantly, however, the CO-OPs that received guaranty fund coverage are required to reimburse the guarantee funds with the 2015 reinsurance and risk corridor recoveries they receive—which are currently listed as "assets" on the CO-OP balance sheets—before paying back any federal loans.[317]

The other three CO-OPs with serious shortfalls, however, will not be bailed out by guaranty funds. The New York CO-OP reports that it had $379.5 million in unpaid medical claims and $157.54 million in assets as of December 31, 2015—*a $222 million shortfall*, excluding any other liabilities.[318] No portion of that shortfall

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[313] *Id.*

[314] Specifically, the Iowa guaranty association has paid $37 million to date and the Nebraska guaranty association has paid $77 million to date. That amount represents all of CoOportunity's claims, except for claims that exceeded $500,000/person limits. Those excess claims were settled. *See* CoOportunity Resp. to Feb. 19, 2016 PSI Request (on file with Subcommittee). One CO-OP whose medical claims do *not* exceed its assets nevertheless project some degree of guaranty fund coverage. The Michigan CO-OP estimates that $14.3 million in unpaid medical claims will be covered by a guaranty association. *See* Michigan CO-OP Resp. to Feb. 19, 2016 PSI Request (on file with Subcommittee).

[315] Grace-Marie Turner & Thomas P. Miller, *ObamaCare Co-ops: Cause Célèbre or Costly Conundrum?*, AMERICAN ENTERPRISE INSTITUTE & GALEN INSTITUTE 7 (June 29, 2015), http://www.galen.org/assets/ObamaCare-Co-ops.pdf. "For 2015, the Nebraska Guaranty Association assessed commercial carriers the highest amount allowed by law to pay outstanding claims for CoOportunity members. 'Under each state's guaranty fund association laws, $170 million of CoOportunity 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. 'The size of the unpaid claims necessitated the association to secure a line of credit from a commercial bank with additional guarantees.'" *Id.*

[316] Nat. Org. of Life & Health Ins. Guaranty Ass'ns, *State Laws and Provisions Report* (Oct. 12, 2015), https://www.nolhga.com/factsandfigures/main.cfm/location/lawdetail/docid/9.

[317] *See* CoOportunity Resp. to Feb. 19, 2016 PSI Request (on file with Subcommittee).

[318] New York CO-OP, Statement of Financial Performance (Dec. 31, 2015).

will be covered by New York's guaranty fund.[319] Most of the New York CO-OP's unpaid claims are owed to doctors and hospitals, and a non-negligible share—$373,000 as of January 31, 2016—is owed directly to patients.[320] Similarly, the Louisiana CO-OP reports $34.4 million in assets and $43.3 million in unpaid medical claims as of January 31, 2016, and none of that $9 million shortfall will be covered by a guaranty fund.[321] The same is true of the $7 million shortfall on the Kentucky CO-OP's January 2016 balance sheet, which shows $77.5 million in unpaid claims and only $70.5 million in assets.[322] If these claims estimates hold or grow, a significant number of doctors, hospitals, and individual enrollees stand to shoulder part of the financial burden of the CO-OPs' collapse.[323]

Finally, it is important to note that, in 2015, HHS permitted at least four of the failed CO-OPs—the Arizona CO-OP, Michigan CO-OP, Colorado CO-OP, and Oregon CO-OP—to convert their combined $65 million in start-up loans to surplus notes.[324] According to HHS, this action allowed to the CO-OPs to "record those [start-up] loans as *assets* in financial filings with regulators"[325]—an accounting anomaly. As a consequence, those start-up loans are now subordinated below all other liabilities—on par with solvency loans—meaning that they are last in the priority of creditor repayment.[326] HHS told the Subcommittee that it estimated the likely loss to the Treasury from CO-OP start-up loan conversions,[327] but it has thus far failed to provide that estimate to the Subcommittee.

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[319] Interview with Kevin Counihan, Dir., CCIIO (Mar. 1, 2016); Interview with Kelly O'Brien, CO-OP Division Dir., Ctrs. for Medicare & Medicaid Serv. (Mar. 1, 2016).
[320] New York CO-OP Resp. to Feb. 19, 2016 PSI Request (on file with Subcommittee).
[321] Louisiana CO-OP SAP Balance Sheet (Jan. 31, 2016); Louisiana CO-OP Resp. to Feb. 19, 2016 PSI Request (on file with Subcommittee).
[322] Kentucky CO-OP Balance Sheet (Jan. 2016); Kentucky CO-OP Resp. to Feb. 19, 2016 PSI Request (on file with Subcommittee).
[323] The Nevada CO-OP, Oregon CO-OP, Tennessee CO-OP, and Utah CO-OP told the Subcommittee that they do not expect any unpaid medical claims to be covered by a guaranty association. The Arizona Department of Insurance informed the Subcommittee that only $6.8 million of the Arizona CO-OP's estimated $21.8 million in unpaid claims is eligible for coverage by a guarantee fund. Arizona Department of Insurance CO-OP Resp. to Feb. 19, 2016 PSI Request (on file with Subcommittee).
[324] *Review of Obamacare Consumer Operated and Oriented Plans (Co-Ops): Hearing Before the Subcommittee on Health Care, Benefits, and Administrative Rules*, 114th Cong. (Feb. 25, 2016) (statement of Dr. Mandy Cohen MD, MPH, Chief Operating Officer and Chief of Staff, Ctrs. for Medicare and Medicaid Servs.).
[325] Mem. from Kelly O'Brien, CO-OP Division Director, to CO-OP Project Officers (July 9, 2015), http://cagw.org/sites/default/files/users/user98/Converting%20Start-up%20Loans%20to%20Surplus%20Notes%20Guidance%207-9-15%20final.pdf.
[326] Interview with Kelly O'Brien, CO-OP Division Dir., Ctrs. for Medicare & Medicaid Serv. (Mar. 1, 2016).
[327] *Id.*

IV. MISCONCEPTIONS CONCERNING THE CO-OP PROGRAM

A. HHS Data Indicates That The Failed CO-OPs Had, On Average, Healthier Enrollees Than Average Health Insurers In Their States.

HHS officials and others have suggested that adverse selection—that is, attracting enrollees with above-average health risks—played a role in the financial difficulties of the CO-OPs.[328] But the agency's own data from the risk adjustment program indicates otherwise. The risk adjustment program redistributes money from insurers with healthier enrollees (those with lower than average actuarial risk) to insurers with less healthy enrollees (those with higher than average actuarial risk).[329] The basic aim is to offset the cost impact of adverse selection so no single insurer in a state bears the burden.

Interestingly, however, the failed CO-OPs as a group were net *payors* of risk adjustment charges—with combined 2014 liabilities of $116 million.[330] Under HHS's formula, this indicates that the failed CO-OPs as a class enrolled *healthier* people—enrollees with lower risk—than the average health insurer in their states for each market segment.

Risk Adjustment Transfers—2014 Benefit Year

CO-OP	Risk Adjustment (Combined Individual and Small Market)
Louisiana Health Cooperative	-$7,493,608.15
Nevada Health Co-Op	-$3,629,890.49
CoOpportunity Health (NE)	-$6,466,848.45
CoOpportunity Health (IA)	$4,142,837.12
Health Republic Insurance of New York	-$80,235,543.57

[328] *See Review of Obamacare Consumer Operated and Oriented Plans (Co-Ops): Hearing Before the Subcommittee on Health Care, Benefits, and Administrative Rules*, 114th Cong. (Feb. 25, 2016).
[329] *See* Angela Boothe & Brittany La Couture, *The ACA's Risk Spreading Mechanisms: A Primer on Reinsurance, Risk Corridors and Risk Adjustment,* AMERICAN ACTION FORUM (Jan. 9, 2015).
[330]

Michigan Consumer's Healthcare CO-OP	-$1,130,276.61
Consumers Choice Health Insurance Co. (SC)	-$6,257,753.43
Kentucky Health Cooperative	-$7,878,488.98
Community Health Alliance Mutual Insurance (TN)	-$117,298.98
Health Republic Insurance of Oregon	-$1,251,545.14
Colorado Health Insurance Cooperative	-$4,491,378.92
Meritus Mutual Health (AZ)	$788,761.50
Meritus Health Partners (AZ)	$2,044,412.81
Arches Mutual Insurance Company (UT)	-$4,144,806.27
Total	-$116,121,427.56

B. Congressional Budget Cuts Prevented The Creation Of New CO-OPs And Limited Losses To The Taxpayer.

HHS officials have suggested publicly that a series of budget cuts to the CO-OP program—passed by Congress, and signed by President Obama—contributed to the collapse of the 12 failed CO-OPs. For example, Mandy Cohen, CMS's Chief Operating Officer, said that Congress itself also played a role in the CO-OP's failures because of these budget cuts.[331] All available evidence collected by the Subcommittee indicates otherwise. Cuts to the CO-OP program budget clearly prevented the launch of *additional* CO-OPs, including up to 40 complete applications that were summarily disapproved due to lack of funds.[332] But the failed CO-OPs received every dollar promised to them in their loan agreement *and more*.

More importantly, most of the budget cuts at issue took place well before HHS ever even approved the first round of CO-OP applications. The Affordable Care Act appropriated $6 billion for the CO-OP program. The largest budget cut came in April 2011, when Congress passed and President Obama signed a continuing resolution that rescinded $2.2 billion from the program.[333] Eight months later, in December 2011, Congress passed the 2012 omnibus appropriations act that rescinded an additional $400 million.[334] HHS was well aware of those funding reductions *before* it started approving applications in February 2012.[335] Finally, in January 2013, the American Tax Payer Relief Act of 2012 rescinded $2.3 billion in unobligated CO-OP appropriations.[336]

Disbursement schedules provided by the failed CO-OPs confirm that these budget cuts did not deprive them of a single dollar awarded to them. In fact, most of the failed CO-OPs received *more* than they had even requested to begin their

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[331] Robert Pear, *Failed Co-ops Add Ammunition to G.O.P. War on Health Law,* N. Y. TIMES (Nov. 3, 2015), http://www.nytimes.com/2015/11/04/us/politics/failed-co-ops-add-ammunition-to-gop-war-on-health-law.html?emc=edit_tnt_20151103&nlid=58462464&tntemail0=y&_r=1.

[332] Jerry Markon, *Health co-ops, created to foster competition and lower insurance costs, are facing danger,* WASH. POST (Oct. 22, 2013) ("The last-minute cut eliminated the remaining co-op funding, leaving only a small contingency fund, and prevented the administration from lending additional money. Applications from more than 40 proposed co-ops were junked."), https://www.washingtonpost.com/politics/health-co-ops-created-to-foster-competition-and-lower-insurance-costs-are-facing-danger/2013/10/22/e1c961fe-3809-11e3-ae46-e4248e75c8ea_story.html.

[333] Pub. L. No. 112−10, 125 Stat. 38 (April 15, 2011).

[334] Pub. L. No. 112-74, 125 Stat. 786 (Dec. 23, 2011).

[335] Dep't of Health & Human Servs., Ctr. for Consumer Info. & Ins. Oversight, *Consumer Operated and Oriented Plan [CO-OP] Program Amended Announcement Invitation to Apply,* Loan Funding Opportunity No.: 00-COO-11-001, CFDA: 93.545 (Dec. 9, 2011).

[336] Pub. L. No. 112-240, 126 Stat. 2313, 2362 (Jan. 2, 2013).

operations—and many on an accelerated basis. Four received a total of $33.6 million more in start-up loans than they requested in their business plans.[337] In addition, according to information provided by the CO-OPs, HHS ultimately awarded at least $324 million *more* in solvency loans than the failed CO-OPs requested in their loan applications.[338] In short, the failed CO-OPs actually received at least $350 million dollars more than they requested in their 2011 loan applications, based on 10-year business plans.[339]

The primary consequence of the budget cuts was to prevent HHS from launching *additional* CO-OPs—and thus to limit future losses to the taxpayer. The Affordable Care Act specifically required HHS to "ensure that there is sufficient funding to establish at least 1 qualified nonprofit health insurance issuer in each State."[340] Consequently, even if subsequent appropriations laws had not reduced the program's budget, HHS would not have been permitted to freely allocate additional loans to the existing 23 CO-OPs as needed. Instead, the ACA required the agency to conserve its CO-OP loan resources to *ensure* it would have sufficient funds to create still more CO-OPs in the remaining states. Given the failure rate and costs of this program to date, it is probably for the best that Congress conserved those resources itself.

[337] Appendix C.
[338] *Id.*
[339] *Id.*
[340] 42 U.S.C. § 18042(b)(2)(A)(iii).