Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

ACTUAL ENROLLMENT AND PROFITABILITY WAS LOWER THAN PROJECTIONS MADE BY THE CONSUMER OPERATED AND ORIENTED PLANS AND MIGHT AFFECT THEIR ABILITY TO REPAY LOANS PROVIDED UNDER THE AFFORDABLE CARE ACT

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Office of Inspector General

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EXECUTIVE SUMMARY

We determined that member enrollment and profitability for most Consumer Operated and Oriented Plan health insurance issuers were considerably lower than their initial loan application projections and might limit their ability to repay loans.

WHY WE DID THIS REVIEW

The Patient Protection and Affordable Care Act (ACA) established health insurance exchanges (commonly referred to as "marketplaces") to allow individuals and small businesses to shop for health insurance in all 50 States and the District of Columbia. To expand the number of health insurance plans available in the marketplaces, the ACA established the Consumer Operated and Oriented Plan (CO-OP) program. The ACA directed the Secretary of Health and Human Services to provide loans to help establish new consumer-governed, nonprofit health insurance issuers, referred to as CO-OPs, in every State. Beginning January 1, 2014, CO-OPs were able to offer health insurance through the new health insurance marketplaces for their States, as well as outside the marketplaces.

A prior Office of Inspector General (OIG) audit examined the selection process for CO-OP loans and identified factors that could adversely affect the CO-OP program, including some CO-OPs having limited private monetary support and having budgeted startup expenditures that exceeded available funding. OIG also issued a report on CO-OPs' progress during the startup phase and the Centers for Medicare and Medicaid Services' (CMS) strategy for overseeing the CO-OPs during the startup phase and after the launch of the exchanges. As described in our fiscal year 2015 Work Plan, we launched additional audits at 19 of the 23 CO-OPs to verify their eligibility for Federal funding and their use of startup and solvency loans. We selected 19 CO-OPs for on-site review on the basis of available audit resources and to provide broad geographical coverage. During those audits, we identified concerns related to low enrollment and financial losses. We also performed a more limited review of enrollment and profitability for the four remaining CO-OPs.

This report addresses the financial and operational status of the 23 CO-OPs as of December 31, 2014. Our objective was to determine whether enrollment and profitability met the CO-OPs' projections on their loan applications. This report provides an analysis for policymakers and others interested in the CO-OP program. We are continuing to review other aspects of the CO-OPs' operations for future reports.

BACKGROUND

The ACA authorized the Secretary of Health and Human Services to make startup and solvency loans to qualified applicants that intended to become nonprofit, consumer operated and oriented health insurance issuers. Startup loans were intended to assist CO-OP applicants with approved costs for beginning operations. 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 qualified health insurance. State regulators have primary oversight of CO-OPs as health insurance issuers.

CMS awarded loans totaling $2.4 billion. As of January 1, 2014, 23 CO-OPs offered health coverage in 23 States. Three of the 23 CO-OPs are offering coverage to neighboring States beginning in 2015, and one CO-OP plans to offer coverage to a neighboring State beginning in 2016.

Pursuant to the statute, CMS solicited loan applications from private, nonprofit organizations that were not preexisting issuers of insurance. Loans were to be awarded only to entities that demonstrated a high probability of becoming financially viable. All CO-OP loans must be repaid with interest. Startup and solvency loans must be repaid no later than 5 years and 15 years, respectively, from the disbursement date of the loan.

CMS may place a CO-OP on an enhanced oversight plan if the CO-OP underperforms or has difficulty meeting program milestones identified in its loan agreement and these difficulties are chronic or significant. Under an enhanced oversight plan, CMS conducts more frequent and thorough reviews of the CO-OP's operations and financial status. CMS may also place a CO-OP on a corrective action plan developed by the CO-OP and approved by CMS to correct any failure to meet a CO-OP program requirement or term and condition of the agreement.

CMS may request that a CO-OP terminate its loan agreement if CMS no longer believes that the CO-OP can be viable and sustainable and serve the interests of its community and the goals of the CO-OP program. Additionally, CMS may terminate the loan agreement if the CO-OP fails to meet quality and performance standards, including implementation of milestones and enrollment targets as specified in the loan agreement or any other contractual obligation with CMS. If a CO-OP's loan agreement is terminated, the organization forfeits all unused loan funds received under the CO-OP program and the remaining loan funds, interest, and, if applicable, penalty, must be repaid in accordance with the terms of the loan agreement. A CO-OP must resolve any outstanding debts or other accommodation of outstanding claim obligations before repaying the loan funds to CMS.

WHAT WE FOUND

Most of the 23 CO-OPs we reviewed had not met their initial program enrollment and profitability projections as of December 31, 2014. Each CO-OP submitted a loan application that included details on its annual projected number of enrolled members and projected net income. Specifically, member enrollment for 13 of the 23 CO-OPs that provided health insurance in 2014 was considerably lower than the CO-OPs' initial annual projections, and 21 of the 23 CO-OPs had incurred net losses as of December 31, 2014. Year-end net income data were not available for the Iowa/Nebraska CO-OP as the Iowa Insurance Commissioner took control of the CO-OP in December 2014 because of financial concerns. The Iowa/Nebraska CO-OP was liquidated in March 2015.

The low enrollments and net losses might limit the ability of some CO-OPs to repay startup and solvency loans and to remain viable and sustainable. Although CMS recently placed four CO-OPs on enhanced oversight or corrective action plans and two CO-OPs on low-enrollment-warning notifications, CMS had not established guidance or criteria to assess whether a CO-OP was viable or sustainable.

WHAT WE RECOMMEND

We recommend CMS:

- continue to place underperforming CO-OPs on enhanced oversight or corrective action plans, in accordance with Federal requirements;

- work with State insurance regulators to identify and correct underperforming CO-OPs;

- provide guidance or establish criteria to determine when a CO-OP is no longer viable or sustainable; and

- pursue available remedies for recovery of funds from terminated CO-OPs, in accordance with the loan agreements.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In written comments on our draft report, CMS concurred with our recommendations. CMS stated it has taken a number of steps to further oversee CO-OP compliance by requiring external audits, site visits, and additional financial reporting.

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INTRODUCTION

WHY WE DID THIS REVIEW

The Patient Protection and Affordable Care Act[1] established health insurance exchanges (commonly referred to as "marketplaces") to allow individuals and small businesses to shop for health insurance in all 50 States and the District of Columbia. To expand the number of health insurance plans available in the marketplaces, the ACA established the Consumer Operated and Oriented Plan (CO-OP) program. The ACA directed the Secretary of Health and Human Services to provide loans to help establish new consumer-governed, nonprofit health insurance issuers, referred to as CO-OPs, in every State. Beginning January 1, 2014, CO-OPs were able to offer health insurance through the new health insurance marketplaces in their States, as well as outside the marketplaces.

A prior Office of Inspector General (OIG) audit examined the selection process for CO-OP loans and identified factors that could adversely affect the CO-OP program, including some CO-OPs having limited private monetary support and having budgeted startup expenditures that exceeded available funding.[2] OIG also issued a report on CO-OPs' progress during the startup phase and the Centers for Medicare and Medicaid Services' (CMS) strategy for overseeing the CO-OPs during the startup phase and after the launch of the exchanges.[3] As described in our fiscal year 2015 Work Plan, we launched additional audits at 19 of the 23 CO-OPs to verify their eligibility for Federal funding and their use of startup and solvency loans.[4] We selected 19 CO-OPs for on-site review on the basis of available audit resources and to provide broad geographical coverage.[5] During those audits, we identified concerns related to low enrollment and financial losses. We also performed a more limited review of enrollment and profitability for the four remaining CO-OPs.[6]

[1] P.L. No. 111-148 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-152 (Mar. 30, 2010), collectively referred to as "ACA."

[2] *The Centers for Medicare & Medicaid Services Awarded Consumer Operated and Oriented Plan Program Loans in Accordance With Federal Requirements, and Continued Oversight Is Needed* (A-05-12-00043, issued July 30, 2013).

[3] *Early Implementation of the Consumer Operated and Oriented Plan Loan Program* (OEI-01-12-00290, issued July 2013).

[4] The objectives for the ongoing audits are to determine whether selected CO-OPs: (1) met initial loan eligibility requirements, (2) met continuing loan eligibility requirements after startup and solvency loans were disbursed, and (3) appropriately used loan funds in accordance with Federal regulations.

[5] Colorado, Illinois, Iowa/Nebraska, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, New Mexico, Ohio, Oregon (Health Republic Insurance of Oregon), Oregon (Oregon's Health CO-OP), South Carolina, New Jersey, New York, Tennessee, Utah, and Wisconsin.

[6] Arizona, Connecticut, Montana, and Nevada.

OBJECTIVE

Our objective was to determine whether enrollment and profitability met the CO-OPs' projections on their loan applications.

BACKGROUND

Consumer Operated and Oriented Plan Program Loan Award Administration

The ACA authorized the Secretary of Health and Human Services to use CO-OP program funding to make startup and solvency loans to qualified applicants that intended to become nonprofit, consumer operated and oriented health insurance issuers. Startup loans were intended to assist CO-OP applicants with approved costs for beginning operations. 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. State regulators have primary authority for oversight of CO-OPs as health insurance issuers.

CMS solicited loan applications from private, nonprofit organizations that were not preexisting issuers of insurance. All CO-OP loans must be repaid with interest. Startup and solvency loans must be repaid no later than 5 years and 15 years, respectively, from the disbursement date of the loan.

Loans were to be awarded only to entities that demonstrated a high probability of becoming financially viable. CMS's evaluation of a loan applicant included but was not limited to whether the applicant had: (1) an enrollment strategy likely to achieve target enrollment figures within an established timeline; (2) thorough and reasonable projections of such factors as enrollment, expenditures, and income; (3) a financial sensitivity analysis based on alternative enrollment scenarios; (4) thorough and reasonable descriptions of milestones that would trigger and justify each disbursement of loan funds, tentative dates for achieving these milestones, and evidence to demonstrate that the conditions for disbursement had been satisfied; (5) reasonable enrollment estimates over the life of the loan; (6) reasonable estimates of anticipated capital needs over the life of the loan; (7) a commitment to price premiums in a way that ensures stable coverage; and (8) a plan for reducing dependency on loans and using revenue to fund additional reserve and solvency requirements as enrollment grows and premiums increase over time.

The CMS Funding Opportunity Announcement,[7] dated December 9, 2011, and loan agreements specify that CMS may place a CO-OP on an enhanced oversight plan if the CO-OP underperforms or has difficulty meeting program milestones identified in its loan agreement and these difficulties are chronic or significant. Under an enhanced oversight plan, CMS conducts more frequent and thorough reviews of the CO-OP's operations and financial status. The loan agreement between CMS and the CO-OP also specifies that CMS may place the CO-OP on a corrective action plan developed by the CO-OP and approved by CMS to correct any failure to

[7] Loan Funding Opportunity Number OO-COO-11-001 was released July 28, 2011, and revised effective December 9, 2011.

meet a CO-OP program requirement or term and condition of the agreement. In addition, CMS may provide technical assistance if CMS determines that doing so would improve the performance of the CO-OP and increase the likelihood of loan repayment.[8]

The goals of the CO-OP program are to improve consumer choice, while maintaining plan accountability to ensure that new insurance issuers are financially stable and provide long-term coverage. The Funding Opportunity Announcement and loan agreements specify that CMS may request that a CO-OP terminate its loan agreement if CMS no longer believes that the CO-OP can be viable and sustainable and serve the interests of its community and the goals of the CO-OP program. CMS may also terminate the loan agreement if the CO-OP fails to meet quality and performance standards, including implementation of milestones and enrollment targets as specified in the loan agreement, or any other contractual obligation with CMS.[9] If a CO-OP's loan agreement is terminated, the organization forfeits all unused loan funds received under the CO-OP program and the remaining loan funds, interest, and, if applicable, penalty, must be repaid in accordance with the terms of the loan agreement. A CO-OP must resolve any outstanding debts or other accommodation of outstanding claim obligations before repaying the loan funds to CMS.[10]

Consumer Operated and Oriented Plan Monitoring

To assist CMS in its monitoring of CO-OP loans, the CO-OPs must provide CMS with financial reports, enrollment data, governance and election information, annual independently audited financial statements, and other reports.[11] CMS monitors the CO-OPs' overall financial condition using several factors of the Federal Deposit Insurance Corporation's Uniform Financial Institutions Rating System. These factors include the adequacy of a CO-OP's capital, the quality of its assets, the capability of its management, its sensitivity to changes in the marketplace, and its ability to earn and sustain profits.

Federal Funding for the Consumer Operated and Oriented Plan Program

The ACA provided $6 billion in initial funding for the CO-OP program. Subsequent legislation[12] reduced the amount appropriated for the CO-OP program from $6 billion to $3.4 billion. The American Taxpayer Relief Act of 2012, signed on January 2, 2013, further reduced the $3.4 billion appropriation to the amount of already obligated funds plus 10 percent

[8] Sections 11 and 12 of the CO-OP loan agreement.

[9] Sections 16.2 and 16.3 of the CO-OP loan agreement.

[10] Sections 4.4, 5.6, and 16.3 of the CO-OP loan agreement.

[11] Section 10 of the CO-OP loan agreement.

[12] Section 1857 of the Department of Defense and Full-Year Continuing Appropriations Act, 2011, (P.L. No. 112-10) rescinded $2.2 billion for the CO-OP program, and section 524 of the Consolidated Appropriations Act, 2012, (P.L. No. 112-74) rescinded another $400 million.

of the unobligated balance.[13] CMS awarded loans totaling $2.4 billion. As of January 1, 2014, 23 CO-OPs offered health coverage in 23 States.[14] Three of the 23 CO-OPs are offering coverage to neighboring States beginning in 2015, and one CO-OP plans to offer coverage to a neighboring State beginning in 2016.

Risk-Sharing Programs of the Affordable Care Act

The ACA established three programs that are intended to protect health insurance issuers against market risk while stabilizing premiums in the individual and small-group markets. The three programs are Reinsurance, Risk Corridor, and Risk Adjustment. Reinsurance and Risk Corridor are temporary programs that will operate from 2014 to 2016.[15] Risk Adjustment is a permanent program. Not all types of health insurance issuers can participate in these programs, but CO-OPs are able to participate in all three.

HOW WE CONDUCTED THIS REVIEW

Our review covered the 23 CO-OPs that offered health insurance in their corresponding States during 2014.[16] This report addresses the financial and operational status of the 23 CO-OPs as of December 31, 2014. We reviewed the CO-OPs' loan applications, loan agreements, and financial reports dated June 30 and December 31, 2014. In addition, we examined factors that may affect the CO-OPs' ability to repay the loans, such as enrollment, revenue, claims' expense, and general administrative expense. This report provides an analysis for policymakers and others interested in the CO-OP program.

We did not review the overall internal control structure of each CO-OP because our objective did not require us to do so.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Federal requirements for the CO-OP program are included as Appendix A, and the details of our audit scope and methodology are included as Appendix B. A detailed list of the CO-OPs' revenue, expense, and net income data are in Appendix C.

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[13] P.L. No. 112-240, § 644.

[14] A total of 24 CO-OPs were awarded loans. However, the Vermont Health CO-OP was closed prior to offering health coverage.

[15] ACA, §§ 1341, 1342, and 1343.

[16] We selected 19 CO-OPs for onsite review on the basis of available audit resources and to provide broad geographical coverage. We also performed a more limited review of enrollment and profitability for the four remaining CO-OPs.

FINDINGS

Most of the 23 CO-OPs we reviewed had not met their initial program enrollment and profitability projections as of December 31, 2014. Each CO-OP submitted a loan application that included details on its annual projected number of enrolled members and projected net income. Specifically, member enrollment for 13 of the 23 CO-OPs that provided health insurance in 2014 was considerably lower than the CO-OPs' initial annual projections, and 21 of the 23 CO-OPs had incurred net losses as of December 31, 2014. Year-end net income data were not available for the Iowa/Nebraska CO-OP as the Iowa Insurance Commissioner took control of the CO-OP in December 2014 because of financial concerns. The Iowa/Nebraska CO-OP was liquidated in March 2015.

The low enrollments and net losses might limit the ability of some CO-OPs to repay startup and solvency loans and remain viable and sustainable. Although CMS recently placed four CO-OPs on enhanced oversight or corrective action plans and two CO-OPs on low-enrollment-warning notifications, CMS had not established guidance or criteria to assess whether a CO-OP was viable or sustainable.

ENROLLMENT IN CONSUMER OPERATED AND ORIENTED PLANS WAS GENERALLY LOWER THAN THEIR INITIAL PROJECTIONS

CMS required each CO-OP to submit with its loan application a feasibility study, which examined the CO-OP's likelihood of success and its ability to repay the loans. The feasibility study was supported by an actuarial analysis that projected the number of enrolled members per year. This projection was one of the key factors in determining the amount of startup and solvency loan funds requested by and ultimately awarded to the CO-OPs.

On January 1, 2014, CO-OPs began offering health insurance through the new health insurance marketplaces in their States, as well as outside the marketplaces. The 2014 marketplace open enrollment period ended on March 31, 2014.[17] We determined that as of December 31, 2014, the member enrollment for 13 of the 23 CO-OPs was considerably lower than initial annual enrollment projections contained in the loan award application feasibility studies. (See Table 1.)

The CO-OPs experienced lower-than-projected enrollment for a variety of reasons, including:

- **Marketplace technical difficulties—**When the marketplaces opened, many experienced Web site crashes, long wait times, and failures to accurately capture all information submitted by consumers.

- **Delays in obtaining required licenses—**One CO-OP obtained its license to sell insurance a few days before the start of the open enrollment period, and its health insurance plans were not available on the marketplace.

[17] The Federal and State marketplaces created a special enrollment period that extended the time period for an applicant to finish the application and enrollment process. Generally, the special enrollment period was open to applicants who started their applications by March 31, 2014, but did not complete them by that date.

- **CO-OP management changes—**Several CO-OPs experienced management changes, which affected their ability to adequately market and sell health plans to consumers.

- **High-priced health insurance plans—**Several CO-OPs priced their health insurance plans higher than other health insurers with more name-brand recognition and therefore, according to CO-OP officials, failed to attract customers.

Some CO-OPs updated their business plans to include strategies to address low enrollment. For example, one CO-OP said it intended to lower its health insurance rates and focus on selling to individuals and small groups outside of the marketplace to increase enrollment for the remainder of 2014. Another CO-OP said it planned to focus on different educational and outreach activities, such as developing flyers, posters, and social media platforms to support brand awareness and educate consumers. Between June 30, 2014, and December 31, 2014, enrollment increased at these two CO-OPs. However, net losses also increased.

Although a number of CO-OPs did not meet projected enrollment levels, others exceeded projected enrollment. One of the main reasons for higher-than-anticipated enrollment levels was that some CO-OPs offered lower-priced health insurance plans than competing insurers. We have not reviewed the CO-OPs pricing of health insurance plans for 2015.

Table 1: Consumer Operated and Oriented Plans' 2014 Enrollment

CO-OP[18]	Actual Enrollment as of 6/30/2014[19]	Actual Enrollment as of 12/31/2014[20]	Projected Enrollment at 12/31/2014[21]	Percentage of Projected Enrollment
AZ	353	869	23,998	4%
IL	3,221	3,461	94,249	4%
MA	1,907	1,700	38,853	4%
OR (OHC)[22]	1,055	1,582	34,466	5%
TN[23]	1,588	2,287	25,082	9%
OH	3,816	6,677	60,352	11%
CT	3,197	7,966	40,589	20%
NJ	3,111	4,254	17,984	24%
MI	1,510	11,122	37,874	29%
LA	13,022	9,980	28,106	36%
MD	1,589	11,694	32,556	36%
NV	15,551	16,523	33,748	49%
OR (HRI)[24]	5,230	8,813	14,579	60%
NM	9,412	14,297	14,185	101%
UT	18,865	22,397	20,524	109%
MT	12,052	13,160	11,250	117%
CO	13,466	14,657	12,067	121%
KY	55,852	56,680	30,929	183%
SC	49,554	45,668	19,204	238%
ME	38,226	39,742	15,486	257%
WI	27,475	26,034	10,000	260%
NY	126,738	155,402	30,864	504%
IA/NE[25]	79,762	N/A	11,142	N/A

[18] The CO-OPs are reported in order of actual enrollment as a percentage of projected enrollment.

[19] Per quarterly statement data submitted by the CO-OPs to the National Association of Insurance Commissioners (NAIC) as of June 30, 2014 (unaudited).

[20] Per annual statement data submitted by the CO-OPs to the NAIC as of December 31, 2014 (unaudited).

[21] Per CO-OP loan award applications.

[22] Oregon's Health CO-OP (OHC) is one of two CO-OPs that offered health insurance in Oregon.

[23] In a January 8, 2015, letter to the Secretary of Health and Human Services, the Tennessee Department of Commerce and Insurance requested an immediate enrollment freeze for Community Health Alliance because of its tenuous financial condition.

[24] Health Republic Insurance of Oregon (HRI) is one of two CO-OPs that offered health insurance in Oregon.

[25] On December 23, 2014, the Iowa Insurance Commissioner took control of CoOportunity Health because of financial concerns.

NET LOSSES FOR MOST CONSUMER OPERATED AND ORIENTED PLANS WERE HIGHER THAN THEIR INITIAL PROJECTIONS

Most CO-OPs submitted loan applications that budgeted for operating losses in the first year, or years, of operations as enrollment was built to a sustainable level. According to CMS officials, CMS's view of viability includes both the long-term financial health of the CO-OPs and the adequacy of capital available to fund the CO-OPs' growth. CMS evaluated these expectations, among other factors, during the loan application process and awarded loans to CO-OPs that demonstrated a high probability of becoming financially viable based on the CO-OPs' loan application feasibility studies.

We determined that 21 of the 23 reviewed CO-OPs incurred net losses from January 1 through December 31, 2014. (See Table 2.) Year-end net income data was not available for the Iowa/Nebraska CO-OP as the Iowa Insurance Commissioner took control of the CO-OP because of financial concerns. More than half of the 23 CO-OPs had net losses of at least $15 million for this period. For 19 of the 23 CO-OPs with net losses, claims' expense exceeded premium revenue for this period. The remaining CO-OPs with net losses reported higher premium revenues than claims' expense, but revenue was insufficient to meet general administrative expenses.

The NAIC updated its accounting principles in December 2014 to allow CO-OPs to reflect all anticipated payments for ACA risk-sharing programs (i.e., the Reinsurance, Risk Corridor, and Risk Adjustment programs) on their financial statements. However, the Consolidated and Further Continuing Appropriations Act, 2015,[26] restricted the use of Federal funds for payments relating to the Risk Corridor program. As such, the only funding source available for the Risk Corridor program was provided by payments made into the program by health insurers, and the extent of funding provided by this source was uncertain.[27] As a result, the amount and timing of payments due to the CO-OPs under the Risk Corridor program and the potential effect on the CO-OPs' net income are uncertain.

Low enrollment and claims' expense that exceeded premium income contributed to the net losses at many CO-OPs. Claims' expense exceeding premium income can be attributed to higher-than-estimated enrollment of members with more expensive health conditions, enrolling fewer-than-expected young and healthy members, or inaccurate pricing of health insurance premiums.

Detailed revenue, expense, and net income data are provided in Appendix C.

[26] P.L. No. 113-235 (Dec. 16, 2014).

[27] The Government Accountability Office (GAO) issued a decision finding that the ACA did not enact an appropriation to make payments to health insurers under the Risk Corridor program. It did, however, find that the CMS program management appropriation for fiscal year 2014 would have allowed CMS to make funds available to make payments under the Risk Corridor program. GAO Decision, B-325630 (Sept. 30, 2014), http://www.gao.gov/assets/670/666299.pdf. Accessed on May 6, 2015.

Table 2: Consumer Operated and Oriented Plans' Net Income for January 1 through December 31, 2014[28]

CO-OP	Premium Income	Claims' Expense	General Administrative Expenses	Other Revenues and Adjustments	Net Income
AZ	$5,027,197	($7,085,568)	($6,743,275)	$1,582,760	($7,218,887)
IL	$14,024,000	($21,825,002)	($14,067,937)	$4,199,604	($17,669,335)
MA	$2,870,576	($2,802,595)	($18,508,445)	($1,797,865)	($20,238,329)
OR (OHC)	$3,795,760	($6,661,590)	($6,386,825)	$2,471,380	($6,781,274)
TN	$6,558,715	($8,605,080)	($8,598,359)	($11,486,013)	($22,130,737)
OH	$14,953,597	($18,130,677)	($7,193,918)	$4,454,144	($5,916,854)
CT	$22,637,954	($30,734,751)	($13,435,425)	($6,474,633)	($28,006,855)
NJ	$19,624,329	($27,351,881)	($12,379,714)	$3,655,037	($16,452,229)
MI	$15,265,539	($16,539,869)	($9,502,316)	($5,560,000)	($16,336,646)
LA	$46,288,143	($48,536,416)	($13,999,634)	($4,407,113)	($20,655,020)
MD	$12,108,334	($14,285,628)	($12,875,536)	$519,533	($14,533,296)
NV	$51,526,023	($57,010,544)	($19,041,284)	$9,230,349	($15,295,456)
OR (HRI)	$25,817,580	($31,501,659)	($9,128,025)	$727,171	($14,084,933)
NM	$31,699,642	($27,531,504)	($14,576,009)	$6,116,597	($4,291,274)
UT	$53,498,760	($61,194,928)	($20,126,770)	$7,915,578	($19,907,360)
MT	$41,822,476	($53,213,809)	($10,198,352)	$18,060,283	($3,529,402)
CO	$54,662,981	($73,788,606)	($18,729,213)	$14,853,877	($23,000,961)
KY	$243,649,581	($307,454,476)	($24,344,936)	$37,703,908	($50,445,923)
SC	$164,809,889	($172,793,604)	($25,126,353)	$29,301,891	($3,808,177)
ME	$167,910,503	($165,815,674)	($26,954,510)	$30,725,138	$5,865,457
WI	$123,519,935	($167,293,023)	($11,698,239)	$18,926,661	($36,544,666)
NY	$528,972,985	($556,280,776)	($76,760,152)	$68,878,564	($35,189,379)
IA/NE[29]	N/A	N/A	N/A	N/A	N/A

Although CMS stated that the CO-OPs, as new companies, were expected to have significant losses during the startup period, as of December 31, 2014, we found that 19 of the 23 CO-OPs had exceeded their 2014 calendar year projected losses as reported in the loan award application feasibility studies. (See Table 3.)

[28] Per annual statement data submitted by the CO-OPs to the NAIC as of December 31, 2014 (unaudited).

[29] On December 23, 2014, the Iowa Insurance Commissioner took control of CoOportunity Health because of financial concerns. On March 2, 2015, the Iowa District Court for Polk County found that CoOportunity Health was insolvent and issued a Final Order of Liquidation. The Final Order of Liquidation for CoOportunity Health reported an operating loss of $163 million for calendar year 2014. CoOportunity Health did not file a December 31, 2014, NAIC annual statement.

The Maine and South Carolina CO-OPs each exceeded their enrollment and profitability projections as of December 31, 2014. In Maine, only two insurance companies, including the CO-OP, offered health plans on the marketplace. The Maine CO-OP had the lowest priced health insurance plans in nearly every category and had attracted approximately 80 percent of marketplace consumers in Maine.

Table 3: Consumer Operated and Oriented Plans' Net Income Reported for January 1 through December 31, 2014,[30] and Projected Net Income for 2014 through 2016[31]

CO-OP	Net Income Reported as of 12/31/2014	Projected Net Income at 12/31/2014	2015 Projected Net Income	2016 Projected Net Income
AZ	($7,218,887)	($7,213,000)	$352,000	$3,066,000
IL	($17,669,335)	$28,223,000	$62,588,000	$68,126,000
MA	($20,238,329)	($504,000)	$5,134,000	$11,770,000
OR (OHC)	($6,781,274)	$4,989,000	$12,132,000	$16,473,000
TN	($22,130,737)	($8,636,957)	($3,676,302)	$79,043
OH	($5,916,854)	($7,148,000)	($2,824,000)	$4,254,000
CT	($28,006,855)	$7,076,000	$14,939,000	$19,399,000
NJ	($16,452,229)	($3,298,000)	($1,812,000)	($5,000)
MI	($16,336,646)	($2,629,000)	$4,291,000	$9,279,000
LA	($20,655,020)	($1,892,000)	$1,662,000	$4,468,000
MD	($14,533,296)	$1,861,000	$5,789,000	$8,924,000
NV	($15,295,456)	$371,000	$3,775,000	$6,601,000
OR (HRI)	($14,084,933)	($2,305,000)	($1,189,000)	($5,000)
NM	($4,291,274)	$1,043,000	$2,603,000	$4,577,000
UT	($19,907,360)	($5,729,000)	($6,274,000)	($5,600,000)
MT	($3,529,402)	($2,742,000)	($1,139,000)	$9,000
CO	($23,000,961)	($5,659,000)	($2,854,000)	$1,890,000
KY	($50,445,923)	($2,952,000)	($1,327,000)	$516,000
SC	($3,808,177)	($8,135,435)	($3,852,901)	$1,050,934
ME	$5,865,457	($1,530,000)	$2,313,000	$6,606,000
WI	($36,544,666)	($1,055,000)	$872,000	$3,353,000
NY	($35,189,379)	($5,352,000)	($3,043,000)	($6,000)
IA/NE	N/A[32]	($1,249,000)	($807,000)	$333,000

[30] Per annual statement data submitted by the CO-OPs to the NAIC as of December 31, 2014 (unaudited).

[31] Per CO-OP loan award applications.

[32] CoOportunity Health did not file a December 31, 2014, NAIC annual statement.

CONCLUSION

Although CMS awarded CO-OP loans to applicants on the basis of their ability to become financially viable, we found that many CO-OPs had lower-than-expected enrollment numbers and significant net losses. Financial concerns noted by State Insurance officials in Iowa and Tennessee led to significant actions to liquidate or limit the operations of the Iowa/Nebraska and Tennessee CO-OPs. CMS terminated the loan agreement with the Iowa/Nebraska CO-OP on February 28, 2015.

CMS recently placed four CO-OPs on enhanced oversight or corrective action plans, and two CO-OPs on low-enrollment-warning notifications. CMS will have to assess these CO-OPs to determine whether they are viable and sustainable and continue to serve the interests of their communities and the goals of the CO-OP program.

CMS interacts with State regulators, which are the primary regulatory entities that oversee CO-OPs as health insurance issuers, to obtain additional insights about CO-OP performance and experience; it is essential that CMS work with State regulators to address the issues we identified.

RECOMMENDATIONS

We recommend CMS:

- continue to place underperforming CO-OPs on enhanced oversight or corrective action plans, in accordance with Federal requirements;

- work with State insurance regulators to identify and correct underperforming CO-OPs;

- provide guidance or establish criteria to determine when a CO-OP is no longer viable or sustainable; and

- pursue available remedies for recovery of funds from terminated CO-OPs, in accordance with the loan agreements.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In written comments on our draft report, CMS concurred with our recommendations. CMS stated it has taken a number of steps to further oversee CO-OP compliance by requiring external audits, site visits, and additional financial reporting. CMS's comments are included in their entirety as Appendix D.

APPENDIX A: FEDERAL REQUIREMENTS FOR THE CONSUMER OPERATED AND ORIENTED PLAN PROGRAM

ESTABLISHMENT OF THE CONSUMER OPERATED AND ORIENTED PLAN PROGRAM

Section 1322 of the ACA directs the Secretary of Health and Human Services to establish the CO-OP program; 45 CFR part 156 implements section 1322.

The regulations at 45 CFR part 156, Patient Protection and Affordable Care Act, Establishment of CO-OP Program, (1) set forth the eligibility standards for the CO-OP program, (2) establish the terms for loans, and (3) provide basic standards that organizations must meet to participate in this program and become CO-OPs.

The ACA expressly prohibits the participation of an organization or a sponsor of the organization that is a preexisting health insurance issuer, related entity, or the predecessor of either in the CO-OP program. A CO-OP is a loan recipient that satisfies the standards of 45 CFR section 156.515 within the timeframes specified (45 CFR § 156.505). Those standards define eligibility, governance requirements, and health insurance issuance. To remain consumer-run, private, and nonprofit, a CO-OP must be consumer governed, its board of directors must be elected by its membership, and the consumers should play a role in its development.

Section 1322(b)(2)(A) of the ACA directs the Secretary of Health and Human Services to ensure that there is sufficient funding to establish at least one CO-OP in each State and to give priority to organizations that can offer qualified health insurance statewide, provide integrated care, and have significant private support.

FUNDING FOR THE CONSUMER OPERATED AND ORIENTED PLAN PROGRAM

The ACA, section 1322(g), appropriation provided $6 billion in initial funding for the CO-OP program. Two subsequent acts rescinded portions of that appropriation. Section 1857 of the Department of Defense and Full-Year Continuing Appropriations Act, 2011, (P.L. No. 112-10) rescinded $2.2 billion made available for the CO-OP program, and section 524 of P.L. No. 112-74 (Consolidated Appropriations Act, 2012) rescinded another $400 million. As a result of these acts, Congress appropriated $3.4 billion for the CO-OP program.

Section 644 of the American Taxpayer Relief Act of 2012 states the Secretary of Health and Human Services must establish a fund to provide assistance and oversight to qualified nonprofit health insurance issuers that have been awarded loans or grants under section 1322 of the ACA (42 U.S.C. 18042) before its enactment date. From the funds appropriated under section 1322(g) of the ACA, 10 percent of the unobligated balance of funds are transferred to a CO-OP contingency fund and will remain available until expended, and any remaining unobligated amounts, as of the date of enactment of the American Taxpayer Relief Act of 2012, are rescinded.

FUNDING OPPORTUNITY ANNOUNCEMENT

The Funding Opportunity Announcement,[33] as established by the Catalog of Federal Domestic Assistance Number 93.545, provides detailed information regarding the application and award administration process for the CO-OP program. Section V(B)(2) of the Funding Opportunity Announcement indicates that CMS will obtain the services of a contractor to "provide, establish, and manage qualified expert, objective panels responsible for reviewing the applications received under the CO-OP program and provide recommendations to CMS staff on the reasonableness of the application; financial models and business plan; the likely long-term sustainability of the plan; and adherence to the health policy goal of consumer operation and orientation."

As described in the Funding Opportunity Announcement, CMS may place a CO-OP on an enhanced oversight plan if the CO-OP underperforms or has difficulty meeting program milestones identified in its loan agreement and these difficulties are chronic or significant. Under an enhanced oversight plan, CMS conducts stronger and more frequent review of the CO-OP's operations and financial status. In addition, CMS may provide technical assistance if CMS determines that doing so would improve the performance of the CO-OP and increase the likelihood of loan repayment.

The Funding Opportunity Announcement specifies that CMS may request that a CO-OP terminate its loan agreement if CMS no longer believes that the organization can establish a viable and sustainable CO-OP that serves the interests of its community and the goals of the CO-OP program. Additionally, CMS may terminate the loan agreement if the CO-OP fails to meet quality and performance standards, including implementation of milestones and enrollment targets as specified in the loan agreement, or any other contractual obligation with CMS.

CONSUMER OPERATED AND ORIENTED PLAN LOAN AGREEMENT

CMS established a loan agreement with each of the 23 CO-OPs covered by our audit. CMS agreed to provide startup and solvency loan funding if the CO-OPs continued to meet all terms, conditions, and provisions included in the loan agreement and applicable Federal requirements for the CO-OP program. The loan agreement includes terms and conditions, such as permitted and prohibited use of loan funds, base provisions for startup and solvency loans, data reporting and program requirements, administration requirements, termination rights, and loan disbursement procedures.

Section 12.2 of the loan agreement specifies that the borrower may be placed on a corrective action plan, which will be a plan developed by the CO-OP and approved by CMS to correct any failure to meet a CO-OP program requirement or term and condition of the agreement.

Section 16.2 of the loan agreement specifies that CMS may elect to terminate the loan agreement if it determines the 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. Section 16.3 of the loan agreement specifies that CMS may elect to terminate the loan agreement if the CO-OP fails to meet quality and performance standards, including implementation of

[33] The Funding Opportunity Announcement was released July 28, 2011, and revised effective December 9, 2011.

milestones, enrollment targets, consumer governance responsiveness requirements as specified in the loan agreement, or any other contractual obligation with CMS.

Sections 4.4, 5.6, and 16.3 of the loan agreement specify that if a loan recipient's loan agreement is terminated, the CO-OP forfeits all unused loan funds received under the CO-OP program. The loan recipient must repay any unused loan funds to CMS within 60 days following the resolution of any outstanding debts and run out of outstanding claim obligations or immediately following the resolution of any outstanding debts. The remaining loan funds, interest, and, if applicable, penalty, must be repaid in accordance with the terms of the loan agreement.

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered 19 of the 23 CO-OPs that offered health insurance in the corresponding States. We reviewed each CO-OP's loan application, loan agreement, and NAIC financial reports dated June 30 and December 31, 2014. In addition, we examined factors that may have affected each CO-OP's ability to repay loans, such as enrollment, revenue, claims' expense, and general administrative expense. We also performed a more limited review of enrollment and profitability for the four remaining CO-OPs.[34]

We did not review the overall internal control structure of each CO-OP because our objective did not require us to do so.

We conducted our audit from April to December 2014 and performed our fieldwork at each of the 19 CO-OPs' office locations.[35]

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal statutes, regulations, and other guidance;
- selected 19 CO-OPs for onsite review on the basis of available audit resources and to provide broad geographical coverage;[36]
- reviewed the loan application and loan agreement for each of the 23 CO-OPs;
- reviewed the unaudited NAIC quarterly statements dated June 30, 2014, and the NAIC annual statements dated December 31, 2014, for each of the 23 CO-OPs;[37]
- determined the enrollment and revenue for each of the 23 CO-OPs as of December 31, 2014;
- determined the net income for each of the 23 CO-OPs as of December 31, 2014; and
- discussed the results of our review with CMS officials.

[34] Arizona, Connecticut, Montana, and Nevada.

[35] We obtained the December 31, 2014, NAIC annual statements in March 2015, after the completion of our audit field work and exit conference with CMS officials.

[36] Colorado, Illinois, Iowa/Nebraska, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, New Mexico, Ohio, Oregon (HRI), Oregon (OHC), South Carolina, New Jersey, New York, Tennessee, Utah, and Wisconsin.

[37] CoOportunity Health did not file a December 31, 2014 NAIC annual statement.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX C: CONSUMER OPERATED AND ORIENTED PLANS' NET INCOME REPORTED FOR THE PERIOD JANUARY 1 THROUGH DECEMBER 31, 2014[38]

CO-OP	Premium Income	Other Revenue	Net Reinsurance Recoveries	Claims' Expense	General Admin Expenses	Change in Reserves	Net Income
ME	$167,910,503	($424,370)	$31,149,508	($165,815,674)	($26,954,510)	$0	$5,865,457
MT	$41,822,476	$9,464,629	$8,595,654	($53,213,809)	($10,198,352)	$0	($3,529,402)
SC	$164,809,889	$6,494,850	$26,217,730	($172,793,604)	($25,126,353)	($3,410,689)	($3,808,177)
NM	$31,699,642	($1,719,104)	$2,588,086	($27,531,504)	($14,576,009)	$5,247,615	($4,291,274)
OH	$14,953,597	$487,373	$791,771	($18,130,677)	($7,193,918)	$3,175,000	($5,916,854)
OR (OHC)	$3,795,760	$696,341	$534,039	($6,661,590)	($6,386,825)	$1,241,000	($6,781,274)
AZ	$5,027,197	$106,123	$1,476,637	($7,085,568)	($6,743,275)	$0	($7,218,887)
OR (HRI)	$25,817,580	$4,830	$3,280,820	($31,501,659)	($9,128,025)	($2,558,479)	($14,084,933)
MD	$12,108,334	$1,756,944	$862,950	($14,285,628)	($12,875,536)	($2,100,361)	($14,533,296)
NV	$51,526,023	$45,769	$9,184,580	($57,010,544)	($19,041,284)	$0	($15,295,456)
MI	$15,265,539	$95,827	$290,034	($16,539,869)	($9,502,316)	($5,945,861)	($16,336,646)
NJ	$19,624,329	$33,634	$6,241,403	($27,351,881)	($12,379,714)	($2,620,000)	($16,452,229)
IL	$14,024,000	$289,336	$3,910,268	($21,825,002)	($14,067,937)	$0	($17,669,335)
UT	$53,498,760	$522,205	$7,393,373	($61,194,928)	($20,126,770)	$0	($19,907,360)
MA	$2,870,576	$64,307	$3,733	($2,802,595)	($18,508,445)	($1,865,905)	($20,238,329)
LA	$46,288,143	$636,669	$4,948,537	($48,536,416)	($13,999,634)	($9,992,319)	($20,655,020)
TN	$6,558,715	$239,865	$130,122	($8,605,080)	($8,598,359)	($11,856,000)	($22,130,737)
CO	$54,662,981	$317,870	$19,136,007	($73,788,606)	($18,729,213)	($4,600,000)	($23,000,961)
CT	$22,637,954	$74,353	$2,549,916	($30,734,751)	($13,435,425)	($9,098,902)	($28,006,855)
NY	$528,972,985	$171,030	$68,707,534	($556,280,776)	($76,760,152)	$0	($35,189,379)
WI	$123,519,935	($23,438)	$37,650,099	($167,293,023)	($11,698,239)	($18,700,000)	($36,544,666)
KY	$243,649,581	$198,040	$42,505,868	($307,454,476)	($24,344,936)	($5,000,000)	($50,445,923)
IA/NE	N/A	N/A	N/A	N/A	N/A	N/A	N/A

[38] Per annual statement data submitted by the CO-OPs to the NAIC as of December 31, 2014 (unaudited).

APPENDIX D: CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

To: Daniel R. Levinson
Inspector General
Office of the Inspector General

JUN 19 2015

From: Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services

Subject: Low Enrollment and Financial Losses May Affect Consumer Operated and Oriented Plans' Ability to Repay Loans Provided under the Affordable Care Act (A-05-14-00055)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of the Inspector General's (OIG) draft report on Consumer Operated and Oriented Plans (CO-OPs). CMS takes its commitment to both the CO-OP beneficiaries and taxpayers seriously throughout the management of the program.

The Affordable Care Act established the CO-OP program to foster the creation of non-profit health insurance issuers to give more choices and control to consumers, promote competition, and improve quality in the health insurance market. Implementation of the CO-OP program has been a collaborative effort among CMS, state departments of insurance (DOIs), and the new CO-OP plans. States are the primary regulator of health insurance issuers and market rules, and state DOIs oversee the financial stability of issuers and protect consumers in those markets. CMS takes its responsibility to oversee the CO-OP program seriously. CMS monitors CO-OPs for compliance with program requirements and the ability to repay their loans. CMS has taken a number of steps to further oversee CO-OP compliance by requiring external audits, site visits and additional financial reporting. The CO-OPs enter the health insurance market with a number of challenges, including building a provider network to pricing premiums that will sustain the business for the long-term. As with any new set of business ventures, it is expected that some CO-OPs will be more successful than others, but CMS will continue to actively monitor each CO-OP's progress, and remains committed to facilitating access to affordable, high-quality health insurance for all Americans.

OIG Recommendation

The OIG recommends that CMS continue to place underperforming CO-OPs on enhanced oversight or corrective action plans in accordance with Federal requirements.

CMS Response

CMS concurs with this recommendation, and takes its oversight responsibilities of the CO-OP program seriously CMS is currently implementing this recommendation by placing relevant CO-OPs on corrective action plans. CMS has regular status meetings during which CO-OPs report on progress in achieving milestones, as well as progress on operational experience. To facilitate strong financial management, CO-OPs are required to submit quarterly financial statements, including cash flow data, receive site visits, and undergo annual external audits in order to promote sustainability and capacity to repay loans. This monitoring is concurrent with ongoing financial and operational monitoring by state insurance regulators. This regular financial and operational review of CO-OP performance allows CMS to identify underperforming CO-OPs, and place those CO-OPs on enhanced oversight or corrective action plans, as needed.

OIG Recommendation

The OIG recommends that CMS work with State insurance regulators to identify and correct underperforming CO-OPs.

CMS Response

CMS concurs with this recommendation. CMS has recently increased the data and financial reporting requirements for CO-OPs. CO-OPs are required to provide a quarterly statement that they are in compliance with all relevant State licensure requirements or an explanation of any deficiencies, warnings, additional oversight, or any other adverse action or determination by State insurance regulators received by the CO-OP since the last-filed quarterly report. If the CO-OP is experiencing compliance issues with State regulators, the CO-OP is required to describe the steps being taken to resolve those issues. In addition, CO-OPs have monthly and quarterly reporting requirements, including, financial statements (audited financial statements when available), balance sheets, income statements, and statements of cash flow as well a statement of enrollment statistics. This additional financial data collection will help CMS identify underperforming CO-OPs and will give CMS the opportunity to work with State insurance regulators to help correct any issues identified.

OIG Recommendation

The OIG recommends that CMS provide guidance or establish criteria to determine when a CO-OP is no longer viable or sustainable.

CMS Response

CMS concurs with this recommendation. CMS is in the process of establishing enhanced criteria and processes regarding financial viability and sustainability.

OIG Recommendation

The OIG recommends that CMS pursue available remedies for recovery of funds from terminated CO-OPs, in accordance with the loan agreement.

CMS Response

CMS concurs with this recommendation. Loan recipients that fail to make loan payments consistent with the repayment schedule established in their loan agreement will be subject to any and all remedies available to CMS under law to collect the debt.