RPTR BAKER

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EXAMINING THE COSTLY FAILURES OF OBAMACARE'S CO-OP INSURANCE LOANS

THURSDAY, NOVEMBER 5, 2015

House of Representatives,

Subcommittee on Oversight

and Investigations,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 10:00 a.m., in Room 2322, Rayburn House Office Building, Hon. Tim Murphy [chairman of the subcommittee] presiding.

Present: Representatives Murphy, McKinley, Burgess, Blackburn, Griffith, Bucshon, Brooks, Collins, DeGette, Castor, Tonko, Yarmuth, Clarke, Kennedy, Green, Welch, and Pallone (ex officio).

This is a preliminary, unedited transcript. The statements within may be inaccurate, incomplete, or misattributed to the speaker. A link to the final, official transcript will be posted on the Committee's website as soon as it is available.

Staff Present: Jessica Donlon, Counsel, O&I; Emily Felder, Counsel, O&I; Brittany Havens, Oversight Associate, O&I; Charles Ingebretson, Chief Counsel, O&I; Dylan Vorbach, Legislative Clerk, CMT; Christine Brennan, Minority Press Secretary; Ryan Gottschall, Minority GAO Detailee; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; Chris Knauer, Minority Oversight Staff Director; Una Lee, Minority Chief Oversight Counsel; Elizabeth Letter, Minority Professional Staff Member; and Arielle Woronoff, Minority Health Counsel.

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Mr. Murphy. Good morning. The Subcommittee on Oversight and Investigation of the Committee on Energy and Commerce will come to order.

The subcommittee convenes this hearing today to examine yet another ObamaCare failure, the CO-OP Insurance Loan Program, the Affordable Care Act established Consumer Oriented and Operated Plans or CO-OPs, an experimental program that awarded government-backed loans to nonprofit health insurance issuers. Of the 22 CO-OPs that sold health insurance plans, unfortunately, 12 have failed to date. These failed CO-OPs represent $1.23 billion in Federal taxpayer money. Since CO-OPs must pay any outstanding debts or obligations before repaying the loan funds to CMS, it is unlikely that the Federal Government will ever recover these funds.

Originally intended to increase choice and create competition among insurers, these CO-OPs were structurally flawed and financially risky from the start. As early as 2011, HHS predicted that 36 percent of the loans would go unpaid. In 2012, the Office of Management and Budget projected taxpayers would lose 43 percent of loans offered through the program. The following year, an HHS OIG report expressed concerns about CO-OPs' financial stability and ability to repay loans. Even staunch supporters of the Affordable Care Act predicted the CO-OP programs would fail. Back in 2009, Senator Rockefeller wrote, quote, "There's been no significant research into consumer CO-OPs as a model

for the broad expansion of health insurance." What we do know however is that this model was tried in the earliest part of the 20th century and largely failed. The Senator also called CO-OPs a, quote, "dying business model for health insurance," unquote.

Despite these widespread concerns CMS awarded $2.4 billion in Federal loans to 23 CO-OPs operating 23 States. This total does not include the CO-OP that failed before it enrolled a single person. CMS awarded a CO-OP in Vermont, over 30 million taxpayer dollars. However, in 2013, Vermont's State insurance commissioner denied the CO-OP a license, calling its application fatally flawed. The Federal funds that had already been spent to establish Vermont's CO-OPs, about $4.5 million taxpayer, were never recovered. The next CO-OP to fail was CoOpportunity, a CO-OP operating in Iowa and Nebraska. At first, CoOpportunity seemed to be a success. It enrolled over 120,000 individuals, which amounted to one-fifth of CO-OP enrollees nationally. However, CoOpportunity premiums were too low, and it was concerned about its ability to pay claims to providers. CoOpportunity received $145 million in Federal loans, but upon liquidation, it had operating losses over $163 million.

We are grateful today we will be joined later by Senator Ben Sasse, who had to run out to a vote on the Senate side. He will be here to talk about the CO-OP programs in Nebraska. Near the end of 2014, CMS awarded $315 million in last-minute loans to bolster six CO-OPs in dire

financial situations, and of those six CO-OPs, three have since closed. It is doubtful that CMS will recover any of these additional funds.

Several factors have caused the CO-OPs to fail. In some cases, low enrollment was to blame. In other cases, CO-OPs set premiums too low. A July 2015 HHS OIG audit issued before the rush of CO-OP closures found that 21 of 23 CO-OPs incurred net losses. In 2014, it anticipated that low enrollments and net losses might limit the ability of some CO-OPs to repay loans.

Additionally, some CO-OPs have cited low-risk corridor payments from CMS as the reason for their demise because less money was paid into the risk corridor program than was expected. Insurers ended up with 12.6 percent of the payments they were anticipating. Given the CO-OPs' dismal financial situation, CO-OPs inappropriately hoped risk corridor payments would bail them out. However, the risk corridor program was always intended to be budget neutral. Only what was paid into the program would be paid out. In fact, in early 2014, a spokesman from CMS confirmed the risk corridor policy modelled on the risk corridor provision in Part D that was supported on a bipartisan basis was estimated to be budget neutral, and we intend to implement it as designed, unquote.

We are here today to understand what went wrong. We will hear from individuals who were on the ground implementing and regulating CO-OPs from day one. We will hear from State regulators faced with

difficult decisions about how to best protect consumers in their States. We will hear from individuals who have established CO-OPs and the challenges they faced to balance CMS requirements in keeping CO-OPs afloat. We will hear from the auditors of CO-OPs. We will speak to the financial challenges CO-OPs face to pay back their Federal loans. And, lastly, we will hear from CMS about not only what went wrong, but how we can fix it with the goal of recovering taxpayer dollars awarded to the CO-OPs.

I thank all the witnesses for testifying today, and now magically appearing, the Ranking Member Diana DeGette.

[The prepared statement of Mr. Murphy follows:]

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Mr. DeGette. Thank you, Mr. Chairman.

I am sorry this important hearing has been impacted by the votes today because it is an important hearing. From day one I have worked with the State of Colorado and the administration to help our CO-OPs succeed. Across the country, the CO-OPs have provided consumer-focused coverage options and have injected competition into the health insurance market. Yet a number of CO-OPs are facing financial challenges and, unfortunately, will not be able to compete in the 2016 marketplace. We have all seen announcements in the last few weeks about CO-OPs closing their doors, including the CO-OP in my home State of Colorado.

I am very disappointed that the Colorado Division of Insurance was compelled to shut down the CO-OP. Yes, it faced challenges. But it also served the critical needs of 83,000 Coloradoans for 2 years, and the company was well on its way to fiscal sustainability in 2016. I am also disappointed at the way CMS has managed this problem, which I will get to later.

But you know something, equally to blame is us, Congress. I believe Congress has not worked as a partner to support the emerging CO-OP market that is attempting to bring more competition and choice to a market frequently dominated by one or two insurers. Mr. Chairman, I do wish that we had saved the CO-OP in Colorado, but if we can't do that, I hope we will use our time productively today to make sure the

remaining CO-OPs are successful. Unfortunately, I know better than that. I know that a hearing before this subcommittee with the title Affordable Care Act or ObamaCare in the title somehow won't be a productive endeavor. We won't spend the next several hours learning from the experts before us about the challenges faced by the CO-OPs and what we can do to improve them. We could be doing meaningful oversight instead of taking 61 votes to abolish the Affordable Care Act. And, instead, my colleagues on the other side of the aisle prefer to sit on the sidelines and root for the law to fail.

Frankly, Congress has squandered the last 5 years by celebrating every bump in the road as we implemented the law, rather than focusing on how to make it better. Even worse, some of my colleagues have intentionally placed road blocks that have actually made it harder for their own constituents to access care.

Now, look, I am not suggesting the Affordable Care Act has been perfect, far from it, but I think that the important thing from these bumps in the road is to recognize the problems and to try to move the ball forward. If we could do that, we could work together to improve health care coverage for millions of Americans. In his op-ed, the Senator -- I guess he is not going to testify -- he said in an ope-ed last weekend, quote, this isn't about spreadsheets. It is about people. And, frankly, I couldn't agree more. It is about people who, before the Affordable Care Act, faced skyrocketing health care costs.

It is about people who were at the mercy of health insurance companies that could raise rates or deny coverage for arbitrary reasons to protect their profits. It is about people who feared that an unexpected medical cost would bankrupt them. But thanks to the Affordable Care Act, they don't have to face these uncertainties anymore. Americans are no longer one accident or illness way from financial ruin.

So, Chairman, our constituents should be able to depend on Congress to work productively in a bipartisan manner to improve the healthcare landscape in this country. That is what I hope to do today. I am going to use my time to hear from the experts before us about how we can make the remaining CO-OPs succeed. Frankly, as I said earlier, I have some hard questions for CMS. I want to know what went wrong with the risk mitigation mechanisms that were designed to promote competition and ensure stability in the insurance marketplace. I want answers about how the CO-OPs wound up owing money to the big insurance companies through risk-adjustment programs. I want to understand why CMS said over the summer that risk corridor collections would be sufficient to cover all risk corridor payments while less than 3 months later, they revealed they would only be able to pay 13 percent of the requested amounts to insurers. In short, I want to know whether CMS is thinking outside the box and coming up with a path forward to support this important competitive ingredient in today's health insurance market.

Thanks again to all of our witnesses for coming today. Thanks for waiting while we went to vote. I think you are going to be waiting again in a minute while we go back to vote, but your expertise will improve the law and the lives of our constituents. And I hope that members on both sides of the aisle have come ready to hear your ideas so we can finally have a productive hearing on the Affordable Care Act. I yield back.

[The prepared statement of Ms. DeGette follows:]

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Mr. Murphy. Thank you.

Mr. McKinley is recognized for 5 minutes.

Mr. McKinley. Thank you, Mr. Chairman, and I agree with the lady from Colorado that this is about people. Failure of these CO-OPs have had real-life consequences. People are hurting. They are confused. The collapse of the West Virginia-Kentucky CO-OP leaves 56,000 policyholders frantically searching for new coverage before the close of the enrollment period. Seven years ago, the coal industry in West Virginia was booming, and we enjoyed the seventh best unemployment rate in the country. But now fast forward to 2015, the unemployment rate is the worst in the Nation: 45 percent of our coal miners have lost their jobs in the last 3 years, and thousands more affiliated with the coal industry have lost their paychecks. These individuals and their families, they are hurting.

But they found a peace of mind in knowing that at least their family's health care was secure. Unfortunately, that comfort did not last long. Families enrolled in the West Virginia-Kentucky CO-OP have had that rug jerked right out from under them, all because CMS did not do its job and vet those CO-OPs properly or address the red flags that were raised after the Iowa-Nebraska CO-OP failed. Instead of hitting the pause button, the CMS continued to award $350 million in additional funding. Twelve of the 24 CO-OPs have already failed. At this hearing, I intend to ask now, who will be responsible for the medical

bills that have been incurred by families all across? Who is going to pick up those costs when the CO-OPs are not there? Will CMS give flexibility to families confronting the crisis of their lost health care? What about with only one Statewide exchange available in West Virginia, one Statewide exchange? Failure of this CO-OP will now result in our families in West Virginia paying 120 percent higher premiums than they were last year. Is that fair?

This issue is not just about another failed ObamaCare program costing taxpayers in excess of billions of dollars. It is an opportunity for us in this room and in Congress to express our compassion and empathy for the hardworking families that have lost their sense of security. I look forward to the presentations today, and I yield back the balance of my time.

[The prepared statement of Mr. McKinley follows:]

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Mr. Murphy. Dr. Burgess will take the rest of that time.

Mr. Burgess. Thank you, Mr. Chairman, and thanks for the recognition. I think it is important that we are having this hearing today. There is a lot of policy in the Affordable Care Act. A lot of it was bad policy, and the CO-OP program is no exception. It has wasted millions of taxpayer dollars. It has suffered from a lack of oversight, and it has created instability for millions of patients. The model was fundamentally unsound from the start and was another example of the administration's desire to conduct dangerous experiments with our Nation's health care. Let us not forget that the ultimate in patient protection is the assurance that their insurance carrier will not simply evaporate in the night, leaving patients without the coverage on which they rely. At last count, 12 of the CO-OPs have shut down, accounting for over a billion dollars in taxpayer dollars lost. The rate of failure continues to accelerate. In fact, the subcommittee staff struggled to finalize materials for this hearing because CO-OPs were failing and announcing failures faster than they could finalize the memoranda.

We will hear from witnesses today that the Center for Medicare and Medicaid Services continues to stand in the way of flexibility that the remaining CO-OPs need to become sustainable, so we should not stand by as more and more taxpayer dollars are lost, more taxpayer dollars are invested in failed experiments, and millions remain at risk of

losing their insurance as the coverage for CO-OPs close and continue to close their doors.

So thank you, Mr. Chairman, and I yield to Mrs. Blackburn.

[The prepared statement of Mr. Burgess follows:]

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Mrs. Blackburn. Thank you, Mr. Chairman.

I want to thank our witnesses. Especially I want to thank Commissioner McPeak from Tennessee for joining us. We are fortunate to have you in our State, and we are fortunate to have your guidance, and we look forward to what you will tell us about the failed CO-OP that we have had in our State. We also appreciate CMS taking the time to be here today. There are answers that we need as we conduct our oversight and due diligence on the system.

And, Mr. Chairman, I yield the time back to you.

[The prepared statement of Mrs. Blackburn follows:]

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Mr. Murphy. Thank you. I now recognize Mr. Pallone for 5 minutes.

Mr. Pallone. Thank you, Mr. Chairman.

When we passed the Affordable Care Act into law over 5 years ago, we dramatically changed the healthcare landscape in this country. The law has been a historic success. It has made access to comprehensive health care a reality for the American people. Before the Affordable Care Act was passed, the insurance system in this country was broken. It was a system with rapidly rising costs, gross inefficiencies, and painful inequalities. A February 2010 headline just a month before the ACA was passed declared, and I quote, "Soaring Premiums Reflect Unsustainable Health System." Up to 129 million Americans, nearly one in two people, could be discriminated against for a preexisting medical condition, ranging from diabetes to breast cancer to pregnancy. Many insurance plans lacked important benefits and limited coverage.

These things are no longer true. Because of the Affordable Care Act, people who were previously deemed uninsurable because of a preexisting condition are finally getting coverage. Today, insurers cannot cancel a woman's policy just because she becomes ill. Women are no longer discriminated against, and people who could not afford insurance before are now able to do so. The CO-OPs fill a critical role in this new post-ACA world. They put healthcare choices in consumers' hands. They prioritize their customers instead of their

company overhead. They foster competition in the marketplace by bringing down prices. They do exactly what we had in mind when we passed the Affordable Care Act into law. And today's hearing should be an opportunity to examine how we can ensure the remaining CO-OPs succeed. We should be talking about how to infuse competition into the marketplace to bring premiums down. We should be figuring out ways to help our constituents have access to high-quality affordable health care.

But I am worried that is not what today is going to be about here. This committee has had dozens of hearings on the Affordable Care Act since it was passed into law, and those hearings have had only one purpose, to undermine the Affordable Care Act, regardless of how many people it is actually helping. These hearings have more often served to highlight only the flaws in the program, and I look forward to you one day having a hearing, Mr. Chairman, where experts can talk about what is working, and there is much to applaud in that regard.

Moreover, we should be taking this opportunity to do valuable oversight. The Affordable Care Act oversight of the last 5 years has neither served to enlighten the committee nor improve the law. It has done the opposite. In short it is incredibly frustrating to hear Republicans criticize the law time and time again without offering productive ways to improve it and get better health care to more Americans who need it. With over 60 votes to repeal or undermine the

law, I think the record is clear that most of the majority would rather root for failure than help move the law forward.

Finally, Mr. Chairman, I have suddenly heard many of my colleagues on the other side of the aisle lament that in the closing of the CO-OPs, many beneficiaries will now have to find new policies. Oh, my Republican colleagues are crying. Mr. Burgess in Texas, well, why don't you try to get the Governor and the State Legislature to expand Medicaid? That might help a lot of people. Or, Mrs. Blackburn, well, she didn't bring up TennCare today, but I usually hear about that. The fact of the matter is many of the people that signed up for the CO-OPs today had no insurance prior to their existence. Where were the voices of concern when people couldn't afford insurance or were uninsurable because their child had a preexisting condition? I think it is time to have a productive conversation about how we can improve the Affordable Care Act and the lives of all our constituents. Let this committee get to the place where it can work together to improve the law. I yield back.

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[The prepared statement of Mr. Pallone follows:]

******** COMMITTEE INSERT ********

Mr. Murphy. The gentleman yields back. So they called votes. We are going to get through this as much as possible. We will swear you in, get your testimony. If you don't need the full 5 minutes, you don't have to give the full 5 minutes because we want to hear from you, and then we will come back and ask questions.

You are aware the committee is holding an investigative hearing and when so doing has a practice of taking testimony under oath.

Do any of you have any objections to taking testimony under oath?

They have all answered no. The chair advises you that under the rules of the House and the rules of the committee, you are entitled to be advised by counsel. Do any of you desire to be advised by counsel today?

Dr. Beilenson. [Nonverbal response.]

Mr. Murphy. You desire to be advised by counsel. Could you identify your counsel, please?

Dr. Beilenson. Steve Ross and Tom Moyer.

Mr. Murphy. Will they be testifying?

Okay, thank you.

Anyone else have counsel today? In that case, would you all please rise and raise your right hand. I will swear you in.

[Witnesses sworn.]

Mr. Murphy. Thank you. You are now under oath and subject to the penalties set forth in Title 18, section 1001, of the United States

Code.

We will start with Ms. McPeak, the insurance commissioner from Tennessee. You may give a 5-minute summary of your statement.

STATEMENTS OF JULIE MCPEAK, INSURANCE COMMISSIONER, TENNESSEE; JAMES DONELON, INSURANCE COMMISSIONER, LOUISIANA; PETER BEILENSON, BOARD OF DIRECTORS, NATIONAL ALLIANCE OF STATE HEALTH CO-OPS; AND JOHN MORRISON, VICE CHAIR, MONTANA HEALTH CO-OP

STATEMENT OF JULIE MCPEAK

Ms. McPeak. Thank you. Good morning, Chairman Murphy, Ranking Member DeGette, Representative Blackburn, and members of the subcommittee. Thank you for inviting me to testify. I am Julie Mix McPeak, commissioner of the Tennessee Department of Commerce and Insurance. In addition to my responsibilities in Tennessee, I serve in committee leadership roles at the National Association of Insurance Commissioners, and as executive committee member of the International Association of Insurance Supervisors, and as a member of the Federal Advisory Committee on insurance. I've spent most of my career in insurance regulation, previously serving as the commissioner of the Kentucky Department of Insurance. And I have a strong affinity for the country's State-based system of insurance oversight.

My testimony today will highlight the history of Tennessee's CO-OP, Community Health Alliance Mutual Insurance Company or CHA. My comments will focus on events this year that ultimately led to CHA

voluntarily entering runoff on October 14. CHA was awarded $73.3 million in loans and advances from CMS to launch the company. CHA first offered plans on the federally facilitated marketplace in 2014, with plans in five of Tennessee's eight service areas. The company achieved minimal membership in 2014 due in large part to having plans priced significantly above the FFM leader and having limited network options. The company's membership and rate challenges were compounded by a population that was less healthy and sought more medical services than projected. CHA recorded a net loss of approximately $22 million at year end 2014.

In 2015, CHA saw its enrollment grow exponentially during the open enrollment period. And during the same period of time, projected medical costs continued to significantly increase. The department and CHA quickly recognized that such growth was too much too fast. Our department wrote a letter, which you have as exhibit 1, to HHS Secretary Burwell on January 8 requesting that HHS place an immediate enrollment freeze on CHA due to the company triggering the department's hazardous financial condition standard. The decision to freeze enrollment was and remains the right decision for the company and, most importantly, for Tennessee insurance consumers.

In mid-2015, the department conducted a thorough actuarial review of the company's proposed 2016 rates. After conducting our review, the department approved a rate increase of almost 45 percent for 2016.

Throughout 2015, CHA peaked at more than 40,000 covered lives, but reducing down to almost 25,000 lives on the FFM where they remain today. Though we approved the rates to meet the CMS deadlines, we were not going to formally unfreeze the company until we reviewed initial results from a targeted financial examination called to evaluate the company's expenses, projections, and financial viability, and until CMS released Federal final guidance on the risk corridor program.

In late September, the department was notified by CMS, and I think you have that as exhibit 2 to my testimony, that CHA was being placed on an enhanced oversight plan. That announcement was followed by risk corridor guidance that provided for significantly reduced risk corridor payments. The announcement immediately created a net worth deficiency for CHA. CHA asked the department if the $18.5 million startup loan could be counted as surplus if the loan terms were changed to be identical to the terms of the CMS solvency contribution. The department did not think that option was appropriate but told CHA -- and I think you have that as exhibit 3 -- that statutory accounting principles would require the loan money to be classified as surplus if CMS and CHA bilaterally agreed to the loan agreement terms. After review at the department, CMS ultimately concluded that the loan conversion was not prudent. CHA voluntarily entered runoff on October 14. The Tennessee Department of Commerce and Insurance, CMS and its contractors, and CHA are working in close cooperation to ensure

successful runoff. Our focus is on Tennesseeans first and foremost. My staff will continue to monitor the situation closely.

The runoff will continue well into 2016. And there may be additional surprises. But as of today, cooperation between the three entities has helped ensure a smooth transition.

Thank you for the opportunity to discuss the Tennessee experience with the subcommittee. I look forward to your questions.

[The prepared statement of Ms. McPeak follows:]

******** INSERT 1-1 ********

Mr. Murphy. Thank you.

I now recognize Mr. Donelon, the commissioner from the Louisiana Department of Insurance.

STATEMENT OF JAMES DONELON

Mr. Donelon. Thank you, Mr. Chairman and Ranking Member, for the invitation and the opportunity to be here today to speak briefly about our experience in Louisiana with the creation and now the demise of our CO-OP. Let me start at the outset by telling you a little bit about myself and emphasizing the point that I am here on behalf of my State of Louisiana and not as a representative of the National Association of Insurance Commissioners, though I am an active participant at that level as well, having served as its president during the year 2013. But I have been insurance commissioner in Louisiana since 2006 and was recently, last month, reelected for the third time, beginning my next 4-year term as we speak.

The creation of the Louisiana Health Cooperative, along with cooperatives in 23 States around the U.S., was a welcome part, from my perspective, although I have said repeatedly throughout my time as commissioner that if I had been here, I would have voted "no" on final passage of the Affordable Care Act for other concerns, but not for the opposition to the creation of CO-OPs. I saw that as a mechanism to

address competition, which I believe is the most important aspect of consumer protection in my State, where my top insurer, Blue Cross, has 70 percent of the individual, small group, and large group market. My friends next door in Mississippi have a more dominant Blue than that, and the one next to them in Alabama is even more dominant, so that the well-intentioned purpose of the creation of these CO-OPs, to put consumers in control of an insurer and also to create more competition in our States, I welcomed at the outset.

Having said that, I now have described the effort to create insurers, health insurers, in the environment that existed as the rollout occurred of the Affordable Care Act, in hindsight, I have analogized it to being similar to learning how to sail in a hurricane. It truly was not possible, in my judgment, to succeed under those circumstances.

Much happened in my State that affected that. We licensed our CO-OP in April of 2013. And they began signing up enrollees in accordance with their loan agreement with CMS in October of 2013. That loan agreement called for them to sign up 28,000 lives. They ended up with 9,000 lives instead. In the several months between their approval and the beginning of their doing business, they had the challenges of the issues presented by guaranty issue, no lifetime limits, age caps, et cetera, not to mention the need for them to go out and rent a network of providers in a not very friendly to a purchaser

of such service environment. They had to hire a TPA to do claims, to do their premium collection and payments on. They had to build a marketing network of agents, all of that in a relatively short, 5-month period of time that, frankly, in hindsight, was not functional.

The next challenge came with the rollout on June 30 by CMS of the transitional reinsurance program numbers and the risk adjustment program numbers. And where the CO-OP would receive $10 million under the reinsurance payments, it would owe $7.5 million under the risk adjustment program. That represented a $5 million hit to their bottom line and triggered our calling them in on July 1, the leadership of our CO-OP, to tell them they should actually make the decision to go into runoff before the enrollment period began this October 1.

On July 7, their board voted to accommodate that request from our folks, and they began doing that. The Louisiana CO-OP's financial situation is dire. And we are doing everything we can to preserve its network of providers and to make sure that their policy holders will continue to have coverage through the end of 2015.

Now, us State regulators have the unenviable task, as I have, of trying to wind down a company while at the same time conserving it and doing so in my State, unlike Tennessee, without the protection of a guaranty fund to assure those healthcare providers that their bills would be paid. Let me talk for a few minutes about our relationship --

Mr. Murphy. We don't have a few minutes. You're out of time.

Mr. Donelon. I'm out?

Mr. Murphy. Yes.

Mr. Donelon. I'm sorry.

[The prepared statement of Mr. Donelon follows:]

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Mr. Murphy. That's okay. Here's the thing. We have one vote. We also sent our staff who is here -- so the question is, we have one vote on the floor.

Ms. DeGette. Mr. Chairman, the problem is they are down to about 2 or 3 minutes left in the vote. And I don't think they're going to hold it open for us, unfortunately. So, with all due respect, I am going to ask my members to go down and vote.

Mr. Murphy. So unless some person wants to remain, we are going to have to hold off. This will be very quick. So we'll run down, vote, and come back. So if members just do that, come back as quickly as possible, we should be able to reconvene in about 10 minutes. Thank you.

[Recess.]

Mr. Murphy. We are joined here and bringing back in the junior Senator from Nebraska Senator Ben Sasse, who we understand taught Jeff Fortenberry everything he knows in Congress, so we are thankful.

Senator, you are recognized for 5 minutes.

STATEMENT OF THE HON. BEN SASSE, A SENATOR FROM THE STATE OF NEBRASKA

Senator Sasse. Chairman Murphy, Ranking Member DeGette, and members of the subcommittee. Thank you for inviting me to testify today. I appreciate the opportunity to think along with you about how we should respond to the failure of the CO-OPs in now 13 States. I am tempted to joke after that voting moment that two more CO-OPs have failed while you were off voting. It is an urgent problem that has left hundreds of thousands of Americans scrambling to find new health plans this fall.

Before we dive into the details on the CO-OPs, I would suggest that we should take our partisan hats off. I am a fierce opponent of the Affordable Care Act, and I know that many of you in this room night be strong supporters of the ACA, but I don't think that is what your hearing is about today. I think this is about getting to the bottom of what is actually going on and why so many of our neighbors are losing their healthcare coverage.

The tumultuous failure ACA's CO-OPs began in my own back yard. It began with CoOpportunity, which is actually headquartered in Nebraska but had a majority of its subscribers in Nebraska. The goal of today's hearing is to get to the bottom of what is happening with the CO-OPs, and I want to speak to two issues. First, while there is

much more that we need to understand, what we know so far would suggest a systematic failure of the CO-OP program and an even greater example of bureaucratic incompetence more generally. Secondly, the lack of transparency on this issue is harmful, and the Department of Health and Human Services owes the American public answers.

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EDTR HUMKE

[2:10 p.m.]

Senator Sasse. Republican or Democrat our constituents deserve nothing less than a full accounting for what has happened with this program. The CO-OP program was included in the ACA to purportedly foster competition in the new exchanges by federally funding the start-up of 23 nonprofit health insurers. To get them off the ground, taxpayers loaned these insurers $2.4 billion. After less than 2 years of operation, 12 of the CO-OPs are down and the program has a failure rate over 50 percent.

The first failure, CoOpportunity Health, as I mentioned headquartered in Iowa but with a majority of its subscribers in Nebraska, was arguably the messiest, because the members of the coopportunity program lost their health plan in the middle of a plan year.

CoOpportunity had been awarded it, $145 million of taxpayer-funded loans. The new insurer had garnered about 10 times the numbers of enrollees that they had originally anticipated and was seemingly successful. However, despite ample funding and, obviously, far more enrollees than anticipated, on December 16th of last year, 2014, about a month into the new open enrollment season, the Iowa

insurance commissioner placed CoOpportunity under a supervision order. By January 23rd of this year, 2015, the Iowa insurance commissioner deemed rehabilitation of CoOpportunity impossible and sought a court order for liquidation.

After just one year of operation, the new not-for-profit health insurer abruptly collapsed. This was a terrible midyear shock to the 120,000 CoOpportunity enrollees, again, a majority of them in my State. These people were forced out of their insurance plans and had to go through the grueling process of signing up for coverage on healthcare.gov all over again with lots of uncertainty and fear about how their families might be covered or might not be covered during the transition.

So why did could CoOpportunity fail? Curiously, 9 months later, we don't really have any answers. Sadly, CoOpportunity's messy demise was just the first of the CO-OP dominos to fall this fall. Now, a total of 12 CO-OPs and 13 States will be closed by the end of this year. These 12 CO-OPs were awarded more than $1.1 billion in taxpayer-funded loans and had more than half a million enrollees. Another noteworthy failure is Health Republic of New York, the largest CO-OP in the Nation. It received more in taxpayer loans than any other CO-OP, totaling about $265 million. In late September, they announced they would be ceasing operations at the end of this year, but just last Friday, the State's health insurance regulatory body revealed that the situation was

actually much worse than it had even been understood 6 weeks ago. Apparently, a review conducted in conjunction with CMS now finds that the previously reported filings were not an accurate representation of Health Republic's financial condition. Now, that CO-OP is planning to close down as fast as possible instead of being in business until the end of the year.

That means that more than 200,000 enrollees in Health Republic will have to pick a new insurer and plan in order to maintain health coverage for the month of December as well as planning for next year. Their new coverage, which they will now have to sign up for, will be expiring at the end of the next month, and then they will have to begin the process all over again of trying to find a health insurer.

The sudden disruption and subsequent consumer confusion is eerily similar to what happened to Nebraskans and Iowans earlier this year with CoOpportunity's closure. This brings me to a second point. We still don't have any good answers. With 12 out of 23 insurers rapidly going under, with inaccurate filings on the New York CO-OP, and with more than $1 billion in taxpayer loans out the door, there are more questions than ever, regarding the CO-OP program at large, and if they, those who are responsible for regulating it, knew what they were doing. I believe it is essential that HHS answer some basic questions, and all of us, Republican and Democrat, should be demanding that.

For instance, CMS awarded additional solvency loans to

CoOpportunity to Health Republic in New York and to the Kentucky Health Cooperative, all of which have since closed or are now closing, with CMS doubling down on their initial misjudgments by awarding additional loans. How did they decide to make these additional loans? Did they have any expectation that they were going to be paid back, or are they only going to be used to pay immediate claims?

At the time of these awards, these three insurers were operating at substantial losses that seemingly stemmed from poorly pricing their products. One analysis measured the percentage difference between the CO-OPs' average silver plan premium for a 27-year-old single person in the State, to the corresponding overall insurance market for all other carriers. Here's what they found. CoOpportunity in Nebraska, Health Republic in New York, and the Health Cooperative of Kentucky were all pricing their products more than 20 percent below their competitors. How could this be possible?

Should HHS have given these companies more taxpayer money, given the anomalies of their pricing models? Moreover, HHS has yet to address if and when taxpayers will be repaid for any of the more than $1 billion that have been loaned to these 12 CO-OPs that have closed or are closing. These are the types of questions and the information that HHS should be providing to the American people through the Congress. Why are they not?

The lack of transparency thus far has been terribly

disappointing. I started asking questions right after CoOpportunity failed in my State in May. Without receiving a sufficient response to my questions, I asked more questions when a second CO-OP, Louisiana, failed. By the time eight more CO-OPs had gone under, I elevated my effort to try to get answers to these questions. These are good governance, not partisan questions. I elevated my question by pledging that we will oppose the fast-tracking of all HHS nominations before the U.S. Senate.

Since that announcement less than 3 weeks ago, four more CO-OPs are closing, cementing further that this is a systematic problem, and still, we don't hear from HHS. Consumers who face this coverage disruption and the taxpayers who footed this bill deserve answers. CMS needs to provide a complete accounting of what has gone wrong within this program, and I hope that that starts today with your important hearing. Thank you for the invitation to testify.

Mr. Murphy. I thank you so much, Senator.

[The prepared statement of Senator Sasse follows:]

******** INSERT 2-1 ********

Mr. Murphy. I thank you are going to be leaving now and head back over to the Senate. We do appreciate your insights and your persistence on this, and we want to continue to work with you.

Ms. DeGette. And let me just add, Senator. You didn't hear my opening statement, but I pretty much said the same thing as you did in terms of this should not be a partisan issue. We all need to figure out what's going on with these CO-OPs closing.

Senator Sasse. Congress needs to do better in oversight, not just in health care but in life in general. But that is a conversation for another day.

Mr. Murphy. Thank you. All the best.

We'll now continue with our panel. Next up is Dr. Peter Beilenson. I got it right?

Dr. Beilenson. Yes, sir.

Mr. Murphy. The President, CEO, of Evergreen Health Cooperative. Doctor, you are recognized for 5 minutes.

STATEMENT OF PETER BEILENSON

Dr. Beilenson. Thank you, sir.

Chairman Murphy, Ranking Member DeGette, and members of the subcommittee, thank you for inviting me to testify before you today. As the Chairman said, my name is Peter Beilenson, and I am president

and CEO of Evergreen Health CO-OP, the Maryland-based CO-OP, founded in 2012. I also serve, as do all the CEOs of the CO-OPs, as a board member for the National Alliance of State Health Cooperatives, called NASHCO, and I appreciate the opportunity to appear before you today to discuss the issues affecting Evergreen and the other CO-OPs of NASHCO.

As several of you have already said, while many elements of the ACA have engendered significant partisan disagreement, the notion of establishing local consumer-driven and innovative healthcare options while enhancing competition on the marketplace should be appealing across the ideological spectrum. The question now that we confront with the remaining 11 CO-OPs is how can we succeed? How can they succeed? And how can taxpayer investment be preserved?

Unlike the difficulties experienced by many other State cooperatives in their first 2 years, Evergreen Health Maryland's current fiscal condition is strong due to our quick and nimble response to unforeseen conditions in our first year of operations. Going into the current open enrollment, which just started a few days ago, we have a healthier than average enrolled population, due to a diversified book of business; we have greater than $35 million in assets; we have risk-based capital, a measure of solvency adequacy of almost 800 percent, and for the last 3 months, each month we have been turning a profit. So this can be a profitable mechanism.

In addition, our strong relationship with Maryland Governor Larry Hogan's new insurance commissioner, Al Redmer, and his staff continues to provide us with significant support. Evergreen, like all other CO-OPs, take very seriously our obligation to pay back the loan funds granted to us by the Federal Government. However, several requirements in regulations developed by CMS and CCIIO at their discretion, not as required by provisions of the ACA, are significantly impeding the ability of the 11 remaining CO-OPs, including Evergreen, to successfully innovate and compete with the few carriers left on each State's respective insurance markets.

In light of these concerns, I would like to highlight three solutions that could forge a successful path forward for the remaining CO-OPs. And let me be clear, these do not require an act of Congress; they do not require additional appropriations by the Congress.

First, as the CO-OP successfully market themselves and capture larger enrollments, they will need additional solvency dollars to continue to meet State regulatory requirements, put aside CMS's requirements. However, as you know, CMS has no additional funds to assist with the solvency needs of the growing CO-OPs. The solution to this issue is to allow individual CO-OPs to raise capital to meet these solvency needs. In fact, as you may remember, the ability to obtain private capital in Section 1322, which established the CO-OPs, was one of the measures by which the original CO-OP applications were

judged. CMS should amend the loan agreements to allow flexibility in raising capital, because the restrictions on obtaininG additional capital, are not required under the ACA Section 1322.

Second, risk adjustment under the ACA creates additional issues for the CO-OPs as formulas applied by CMS are skewed to the benefit of large preexisting insurers with enhanced administrative capabilities and years of claims experience with data for their members. The solution: CMS must revise the risk adjustment formula to create a level playing field for all carriers.

Third, and finally, the risk-corridor payments represent another issue for the CO-OPs. The solution: A swift resolution to the current funding deficit for this program will go a long way towards improving CO-OPs' balance sheets and long-term outlook.

Finally, we at Evergreen Health hope that both sides of the aisle and Congress will recognize that the nonprofit member-governed CO-OPs are trying to forge a new and innovative path for health insurance and give consumers increased choices in their coverage. This competition in consumer choice has had demonstrable effects. CO-OPs have brought innovative approaches to the marketplace and, thus, additional choices to consumers. For example, Evergreen Health offers a value-base insurance design product for diabetics, unique in the State of Maryland, which push the marketplace considerably, which removes virtually all financial barriers, co-pays, co-insurance, and

deductibles to services, medications, and -- services, medications, and care that is needed to keep a diabetic patient from developing a myriad of complications of the disease.

In conclusion, I share the Congress' concern with protecting the Federal Government's initial investment in CO-OPs. The solutions I have proposed today, again, do not entail an act of Congress or any additional congressional appropriations. They simply require CMS, the Congress, and the CO-OPs to work together to make sure that the remaining 11 CO-OPs are preserved and that taxpayer dollars are preserved as well. Thank you very much.

Mr. Murphy. Thank you very much, Doctor.

[The prepared statement of Dr. Beilenson follows:]

******** INSERT 2-2 ********

Mr. Murphy. And now finally we hear from Mr. John Morrison, the vice chairman of Montana Health Cooperative. You are recognized for 5 minutes.

STATEMENT OF JOHN MORRISON

Mr. Morrison. Thank you, Chairman Murphy, Ranking Member DeGette, members of the subcommittee. Thank you for inviting me to testify. My name is John Morrison. I was Montana's insurance commissioner, in 2001 to 2008, and I chaired NEIC's health insurance committee. I am the founder and past president of the National Alliance of State Health CO-OPs and vice-chair of the Montana Health CO-OP.

CO-OPs entered the marketplace in 22 States in 2014 and are now providing coverage to a million Americans. CO-OPs have brought much needed competition to the marketplaces, giving consumers more choice, introducing innovations and saving consumers and taxpayers money.

Montana, where I live, has a CO-OP. Wyoming does not. Both States are on the FFM. In 2013, Montana's average monthly premium was 18 percent lower than Wyoming. In 2015, with the Montana Health CO-OP in the picture, based on the second lowest silver plan, Montana is now 40 percent lower.

In 2014, States with CO-OPs had average silver plan rates 8

percent lower than States without CO-OPs. In 2015, among FFM States, the Delta was about 13 percent and over $500 per person for the year. Based on the roughly 3.7 million Americans enrolled in CO-OP States in 2015, consumers in those States have already saved more than the total cost of the CO-OP program.

Moreover, when rates are lower, subsidy costs to the Federal Government are lower. Taxpayers have already saved at least hundreds of millions in subsidies and would have saved billions over the decade ahead. One study published in Health Affairs, projected that if CO-OPs held rates down by just 2 to 5 percent, the savings to taxpayers over the next 10 years would be $7 billion to $17 billion. So the question is not how much CO-OP loans have cost the taxpayer. Rather, the better question is this, how much has the closing of CO-OPs and their removal from the marketplaces cost the consumer and the taxpayer for years to come? This question should be studied carefully.

So I thank you for holding this hearing today. Senator Kent Conrad recently said, the long knives came out to kill the CO-OPs in their cribs. We need to get to the bottom of this, as Senator Sasse said, and find out who killed these CO-OPs and how much Americans will pay for that mistake.

I got involved in the CO-OP project at the request of others, because I believe CO-OPs can break the endless inflationary spiral in our health insurance system. In my opinion, the following conduct of

Congress and the administration has contributed significantly to the recent CO-OP closures.

One, the $6 billion in capitalization grants were changed to loans. Two, the CO-OPs were prohibited from using loan funds from marketing. Three, in 2011 when dozens of groups began meeting to turn the CO-OP concept into a nationwide reality, Congress slashed CO-OP loan funding from $6 billion to $3.4 billion. Four, OMB directed CMS to cap CO-OP loans to prevent CO-OPs from achieving more than 5 percent market share. Five, in late 2012, 24 CO-OPs had signed loan agreements, and more than 40 additional groups were awaiting review.

Congress responded in the yearend fiscal cliff deal by rescinding the remaining lending authority and prohibiting CMS from authorizing additional CO-OPs.

Six, although CO-OPs had not yet opened their doors, congressional committees attacked them in hearings and press releases and tied the CO-OPs up with burdensome and expensive document demands.

Seven, CO-OPs reserve requirements were more than twice as high as other insures. Eight, existing insures were allowed to early renew their ACA noncompliant policies and preselected good risk, degrading the marketplace pool. Nine, CO-OPs were prohibited from offering necessary terms to outside investors to access private capital. Ten, in year one, CO-OPs were prohibited from limiting their enrollment on State exchanges and the FFM despite, limited capital.

Eleven, many CO-OPs were forced to pay risk adjustment to large existing carriers without consideration of the effect of early renewals or the CO-OP solvency requirements.

Twelve, most recently, Congress and the administration reneged on risk-corridor commitment, paying less than 13 cents on the dollar for 2014. For some CO-OPs, this was the fatal blow.

Americans will pay billions of dollars more in the years ahead, because these CO-OPs are closing. There are eleven CO-OPs remaining in 13 States. In my written statement, I make recommendations for measures that should be taken to maximize these CO-OPs' chance of long-term survival. I hope we can discuss some of these options today.

Thank you, and I look forward to your questions.

Mr. Murphy. Thank you, Mr. Morrison.

[The prepared statement of Mr. Morrison follows:]

******** INSERT 2-3 ********

Mr. Murphy. Let me start off with some questions here and I recognize myself for 5 minutes.

The CO-OPs and State regulators have cited many factors that contributed to the failure of the CO-OPs. Lower and hire expected enrollments, restrictions on investors, CMS blames risk adjustment formula, low risk corridor payments, lots of those. Let me start off, and Ms. McPeak, what are the top reasons that the CO-OP failed in your State?

Ms. McPeak. Thank you for your question, Mr. Chairman.

Our CO-OP had challenges from inception in that, as Commissioner Donelon mentioned, going into a State without provider networks caused the company to have to lease those. There were administrative costs that were due to the startup that any startup company would have. But then in 2014, we had disastrously low enrollment. Truly, at most, maybe 1,000 people signed up for the CO-OP plan. Mostly because the rates were somewhat higher than the FFM leader, a well establish a company in the State of Tennessee.

So overcoming those challenges became extremely difficult, and that's why we saw significant rate increases for 2015 and beyond because of the enrollees across the market and Tennessee. We had higher than expected utilization, high claims costs, and insufficient premiums.

Mr. Murphy. Did the other plan also lose money, then, too when they had lower costs for the premiums?

Ms. McPeak. Yes. Actually, every plan on our federally facilitated marketplace on the exchange lost --

Mr. Murphy. That's what I understand. Kind of nationwide, whether they would cost others in the bid to get enrollees, they had to underbid, and then we find out many of them realized the next year, they had to make up for the losses by charging more. And some survived and some didn't. Am I --

Ms. McPeak. That's our experience in Tennessee. We didn't have any company accurately project the claims costs that were going to be coming from these enhanced benefit plans that were sold in the State and mandated under the Affordable Care Act. And so some of our larger established companies could withstand those companies and offer plans, but the CO-OPs just didn't have those resources available.

Mr. Murphy. Dr. Beilenson and Mr. Morrison, what would you say are the top reasons that 12 out of the 23 CO-OPs failed? I think, Mr. Morrison just read off a list, but internal problems too, so not just external. But, Dr. Beilenson, do you have some insight into what are the top reasons why they failed?

Dr. Beilenson. I don't really know specially what happened with the other groups, although the risk corridor was clearly an issue and as John said, the risk adjustment was a big issue as well, because they were surprising payments instead of receivables on risk adjustment and vice versa on risk corridor.

Mr. Murphy. Mr. Morrison?

Mr. Morrison. I don't mean to suggest that there were no mistakes made by management in CO-OPs, but if you look across the marketplace, what you see is that this was a very competitive marketplace, and insurance companies all priced aggressively. Everybody lost money. The difference was that CO-OPs were new entrants. They did not have other business and surplus to be able to offset the losses, and their capital was continuously reduced and capped.

So when Commissioner Donelon talks about learning to sail in a hurricane, that's especially apt in a situation where we were prohibited from building a big boat, and we were not only put into a hurricane, but in some cases given money to build a boat for 50 people --

Mr. Murphy. As the rollout occurred, we heard this, whether it was the Web site or other aspects, too, there was just not a lot that was clearly thought out. It was rolled out, pushed out and maybe is more like it. I know with the Web enrollment and other things, which we found out wasn't ready, they knew wasn't ready. Would you say it wasn't ready when this started up? Should more foresight have gone into setting this up before the CO-OPs were thrown into the hurricane?

Mr. Morrison. To my knowledge, there have never been the situation where 22 new health insurance companies entered the health insurance market across the country in the same year, 2 years after they chartered their business. And so that was certainly a challenging

situation. But it was much more challenging, and indeed, fatal for some, because they did not have adequate capital to deal with the risks that they were put into.

Mr. Murphy. Mr. Donelon, can you comment on that, too, how in your State how that happened?

Mr. Donelon. Absolutely. Thank you.

Mr. Murphy. Microphone.

Mr. Donelon. I'm sorry. Thank you, Mr. Chairman. And, again, thank you for the invitation to be here today. My situation was even worse. We were one of the last CO-OPs to be approved before the termination of the program.

And so the timeframe from licensing in May to selling in October was so constrained that building our company was quite a challenge. I was initially very encouraged, because the group that got approval from CMS for CO-OP loans and from us for licensing, was closely associated with our optional health plan back in New Orleans. A maybe 100-year-old hospital and clinic operation, internationally respected and had been in the health insurance business until the 1990s when they sold off their health plan to Humana. So with their credibility and their experience and expertise, I was hopeful and optimistic that we'd be successful. In hindsight, it was too much in too short a period of time, plus all the other problems that have been described here in testimony today.

Mr. Murphy. Thank you.

Ms. DeGette is recognized for 5 minutes.

Ms. DeGette. Well, this is kind of what I was talking about in my opening statement, because the ACA started in 2010, then these CO-OPs started a couple of years later, and then they had a couple of years to get going. So it wasn't like we were trying to stand up 22 companies all at the same time we were doing the enrollment on the Web site and all that. This was staggered. Is that right, Mr. Morrison? Yes or no will work. I mean, it wasn't all at the same time?

Mr. Morrison. The awarding of the loans was staggered.

Ms. DeGette. Right.

Mr. Morrison. That's true.

Ms. DeGette. So really, part of the problem we have -- I mean, yes, there were problems with the capitalization from the beginning, but part of the big problem is that there was no support as it went along. Wouldn't that be a fair assessment?

Mr. Morrison. Inadequate capital was for the -- was the problem.

Ms. DeGette. Right. That's kind of -- I mean, that's kind of what I want to talk about. The CO-OP program was initially conceived as a grant program, but then the startup funding ultimately ended up being in the form of law; is that right?

Mr. Morrison. Yes.

Ms. DeGette. And then Congress cut the CO-OP loan funding

program from $6 billion to $3.4 billion; is that right?

Mr. Morrison. And then to $2.4.

Ms. DeGette. Right. And then in the 2012 fiscal cliff deal, Congress -- which by the way I voted against, Congress rescinded the remaining lending authority for CO-OPs, which essentially blocked the establishment of further CO-OPs even though 40 additional groups had submitted applications; is that correct?

Mr. Morrison. Very correct.

Ms. DeGette. Now, irrespective of that, 23 CO-OPs got established. And the CO-OPs, like all the other insurers in the health marketplaces, took into account the Affordable Care Act risk stabilization programs, to help insurers mitigate the risk of insuring new populations who had potential losses, the law offered the 3Rs; the reinsurance, risk adjustment, and risk quarter programs, but those don't seem to have worked.

So I wanted to ask you, Dr. Beilenson, the risk adjustment formula has been problematic, as we've been discussing. In fact, a lot of the small CO-OPs are writing checks to large insurance companies under the risk adjustment formula. Does that seem fair to you?

Dr. Beilenson. It does not. And it was actually 21 of the 23 that were writing checks.

Ms. DeGette. 21 of the 23 writing checks to big insurance companies.

I also understand because of Congress' rule of budget neutrality, the risk-corridor program has failed to help the CO-OPs. This was the problem with the Colorado CO-OP failure, and we recently learned that the program lacked sufficient funds to reimburse for 2014 claims.

Now, Mr. Morrison, the risk-corridor program is only reimbursing the CO-OP claims at 12.6 percent of what they're owed; is that correct?

Mr. Morrison. That's correct.

Ms. DeGette. And if Congress had not made this program budget neutral, would it be fair to say that the payments from the risk-corridor program would have likely made a difference in keeping a lot of these CO-OPs solvent?

Mr. Morrison. I have read news accounts from a half a dozen or so CO-OPs that specifically -- before the most recent closures, that specifically attributed their closures to the government reneging on the risk-corridor payments.

Ms. DeGette. Now, Dr. Beilenson and Mr. Morrison, what additional -- let's start with you, Dr. Beilenson. What additional steps do you think that we can take to ensure the continued viability of the CO-OP?

Dr. Beilenson. Well, I think as I was talking about before, revising the risk adjustment formula. And by the way, Medicare advantage's risk-adjustment formula was tweaked several times over a 10-year period.

Ms. DeGette. Right.

Dr. Beilenson. Secondly, pay the risk corridor that was required. And third and probably most -- as important, is allow us to have the flexibility to go after private capital as any truly free market allows you to do.

Ms. DeGette. Mr. Morrison?

Mr. Morrison. I made recommendations in my written statement, but these ones that Peter has suggested are important. I just want to say about the risk corridor, that when you send these little boats into a hurricane to learn how to sail, it's critically important that there be a Federal backstop, because they don't have any other business to balance things against. And that's why the risk-corridor payments are very important.

The other thing I want to say is that the risk-corridor payments and full payment of it was promised repeatedly to the CO-OPs. And so the CO-OPs and their actuaries took that into account from the very beginning with rating.

Ms. DeGette. Now, you said we needed a Federal backstop for these. What's the public interest in having that Federal backstop for these small boats?

Mr. Morrison. Because it takes a few years. We didn't know until 2016 what this risk pool looked like. That's why you had big rate increases this year. And so the Federal backstop allows room for

aggressive competition. The CO-OPs come in and provide -- add to that competition. Now everybody lost money. $2.5 billion, Wall Street Journal said 2 days ago from the McKinsey report on how many -- on how much all the insurers had lost in those --

Ms. DeGette. But the CO-OPs didn't have any way to recoup that. I'm out of time.

Mr. Morrison. The CO-OPs were not outliers in pricing. The CO-OPs were pricing competitively. Everybody lost money, but the CO-OP needed the Federal back stop, because they did not have the corporate depth to do it.

Ms. DeGette. Right. To do it. Thank you very much.

Mr. Murphy. Thank you.

Mrs. Blackburn is recognized for 5 minutes.

Mrs. Blackburn. Thank you, Mr. Chairman.

Thank you, all, for being here.

Mr. Morrison, I think it's important to note that any business in the country can be you can successful if it had a Federal backstop and somebody that was going to be there, and people have grown quite weary of bailouts.

Ms. McPeak, I want to come to you and talk about the CMS enhanced oversight plans. Was the Tennessee CO-OP under an enhanced oversight plan?

Ms. McPeak. The first notification we had about the enhanced

oversight plan for the Tennessee CO-OP was on September 29 when we received a letter that I think I've attached to my testimony. What's problematic about that day is that we were also in discussions with CMS to lift the enrollment freeze for 2016 without any knowledge that the enhanced oversight plan was going to be coming our way.

Mrs. Blackburn. So you were getting conflicting information from CMS. You want to just -- the enhanced oversight plan for the Tennessee CO-OP included what?

Ms. McPeak. There were five pages of issues in the letter that were identified that were areas that the CO-OP needed to focus on to create greater financial stability and create better viability for the plan going forward.

Mrs. Blackburn. So they were giving you conflicting information; on one hand you had this, and on one hand the other?

Ms. McPeak. We were under the impression that CMS felt much more comfortable with the financial stability of the CO-OP, and that's why we were requested to lift the enrollment freeze by October 1, so that the programming could be effectuated to be available for open enrollment starting November 1. So we were surprised by the notification of the enhanced oversight plan.

Mrs. Blackburn. Okay. Now, let's talk about the solvency, because they converted the solvency loans, the startup loans and seven CO-OPs, so that the loans would artificially appear more financially

secure. So did CMS approach you about converting those loans so that the CO-OP would appear to have more capital on its books?

Ms. McPeak. CMS had indicated that they were in agreement with that approach, and so the actual request came from our CO-OP itself, CHA --

Mrs. Blackburn. To recharacterize --

Ms. McPeak. Yes, ma'am.

Mrs. Blackburn. -- to recharacterize those loans.

Did you think it made sense to convert those loans?

Ms. McPeak. In my analysis, we decided that was not a prudent course of action, because, in fact, you are not adding any capital or revenue to the benefit of the company. You're creating the impression on the balance sheet that the debt could be subordinated and the company would appear more financially healthy than we felt that it was.

Mrs. Blackburn. So it's kind of a smoke screen type practice?

Ms. McPeak. Well, it certainly doesn't add any additional dollars to pay claims for the company.

Mrs. Blackburn. Right. Let's see, is it true that you were instrumental in relegating the Tennessee CO-OP so that the premium prices were appropriate and that consumers were protected?

Ms. McPeak. Yes. It's difficult to look at premium increases that have been approved in Tennessee. We took that very, very seriously. But as has been mentioned here today, we need companies

to be able to make good on the claims, and the losses were more problematic for all companies. And so, yes, we definitely took an interest in making sure that our premiums were appropriate for the CHA in 2016.

Mrs. Blackburn. Let me ask you this: Does the CO-OP have enough money to support consumers and pay its claims through the end of the year?

Ms. McPeak. Because we took the decisive action of going into runoff, we do believe that the claims will be paid for all services rendered through the end of the year.

Mrs. Blackburn. Through the end of the year.

Okay. And let me go back to Dr. Murphy's questions. You were talking about the enrollment and it didn't hit a thousand. What was the projected enrollment from the CO-OP, and what did CMS project that enrollment to be for 2016?

Ms. McPeak. I would have to research the number, but I do believe that it was probably close to the 12- to 15,000 enrollee range for the first year growing to something more along the 20,000 enrollee range for 2015.

Mrs. Blackburn. So their projection was 12- to 15,000 people, and what they actually got was about a thousand?

Ms. McPeak. At its highest point.

Mrs. Blackburn. So they were that far off their mark?

Ms. McPeak. Yes, that's correct.

Mrs. Blackburn. Okay. Thank you very much for that.

Mr. Chairman, I will yield back 30 seconds of my time.

Mr. Murphy. There you go. Thank you.

I now recognize Mr. Pallone, if he's ready it, for 5 minutes.

Mr. Pallone. Let me get my questions out here, Mr. Chairman, if I can find them.

Congress established CO-OPs to do a number of things that the private market had not done, and specifically, CO-OPs were created to compete with large for-profit insurance companies and hopefully, put downward pressure on premium prices and serve parts of the country that had fewer, no-good insurance options.

So I wanted to ask Mr. Morrison, remind us of what the landscaped looked like for the consumer prior to the arrival of CO-OPs, particularly in rural regions. Is it accurate to say that there was minimal competition and the policies were often prohibitively expensive?

Mr. Morrison. All of those things are true, Ranking Member Pallone. In Montana the uninsured rate was about 20 percent. As I said, with the introduction of the CO-OP, the difference in average premiums between Montana and Wyoming went from Montana being 13 percent lower to being 40 percent lower. We now have an uninsured rate that's, I think, closer to 11 or 12 percent in our State. Many, many thousands

of people are now covered, who didn't use to have insurance. Many, many thousands of people are now able to afford insurance, who were not able to afford insurance before. And with the CO-OP, consumers now have more choices.

Mr. Pallone. All right. Let me read a passage from a January 2015 study by the Commonwealth Fund, regarding what the landscape looked like prior to the passage of the Affordable Care Act. And it says, and I quote, "Most States' markets for individual health insurance were dominated by one or two carriers that competed primarily on how well they will they were table to screen and select people based on the risk of incurring medical claims. They had little incentive to compete by providing efficient services. Instead, their focus was on reducing their risk of covering people who might have a very high medical cost."

So, Mr. Morrison, that sounds look a rather bleak insurance landscape. Did insurance companies compete largely by denying coverage?

Mr. Morrison. There's no question that segmenting the market and cherry picking to provide health insurance to the healthy people and exclude or price up the people with health issues was what was going on before the ACA, and that was certainly happening in Montana. In my experience, as the chair of the health insurance committee of NAIC, I saw it across rural America.

Mr. Pallone. And, Mr. Beilenson, would you agree with that, what he just said?

Dr. Beilenson. I believe so, but it's not my area of expertise.

Mr. Pallone. Okay. Let me go back to Mr. Morrison. Is it also accurate to say that prior to the passage of the ACA and the establishment of CO-OPs, many rural areas were underserved? And what did that mean for Montana residents?

Mr. Morrison. What it meant for Montana residents was that if they were unable to get health insurance, in many cases, they were unable to get the health care that they needed. And access to health care has improved because access to health insurance has improved.

The other thing that's happened is although BlueCross BlueShield, which is now owned by Health Care Service Corporation, one of the BlueCross corporate groups, still is the dominant carrier in the State of Montana. Their market share is somewhat smaller now, and consumers have the choice of the CO-OP, and so there's more competition.

Mr. Pallone. Well, before the ACA, were there many rural residents being rejected for insurance or only being offered excessively costly policies?

Mr. Morrison. We found, when I was insurance commissioner, that most of the uninsured were people who worked full time for a small business. And the greatest area of difficulty in delivering health coverage to people was through small businesses that wanted very much

to provide health coverage to their employees, but they couldn't afford what the coverage cost in the market. That's why we undertook a program called Insure Montana, before the ACA, before the Massachusetts plan, that provided refundable tax credits to help those small businesses afford health insurance.

Mr. Pallone. All right. Just one more question. Based on your experience, how have CO-OPs served the rural West and States such as Montana? Has it provided important competition and access to health care that previously didn't exist?

Mr. Morrison. Well, CO-OPs have a great tradition in rural America. I think Senator Conrad, when he introduced the idea of a CO-OP at the time of the ACA's enactment, talked about those. But people in our part of the country and across the great expanse between the coasts in the United States have long used the CO-OP model for credit, for electricity, for agriculture, and for other kinds of needs where they want to spread risk and spread expense to be able to deliver the goods and services that they need.

Mr. Pallone. All right. Well, I'm obviously concerned that if we don't shore up the remaining CO-OPs, we may, again, find ourselves lacking adequate competition and choices in rural areas. But thank you.

And thank you, Mr. Chairman.

Mr. Murphy. Thank you.

Dr. Bucshon, you are recognized for 5 minutes.

Mr. Bucshon. Thank you, Mr. Chairman.

I just would like to say at the outset, I'm a strong believer in competition is the way to drive down healthcare costs. And I was a provider before I was a heart surgeon, so I'm also a believer in provider competition, including price transparency, quality transparency, and other measures that help consumers know what product they are getting and help to drive down healthcare costs, and I'm working towards those ideas.

And I think it's unfortunate that we are in the situation we are now with the CO-OPs where -- and we need to figure out why and what we can do to prevent the others from going under.

Mr. Morrison, CMS is -- well let me see -- yeah. I'll say this. CMS has cited enhanced oversight plans is a measure to evaluate troubled CO-OPs. These plans are being critiqued as ineffective and burdensome to CO-OPs. This would be for Mr. Beilenson, too -- Mr. Beilenson first. Has your CO-OP been placed under an enhanced oversight plan from CMS?

Dr. Beilenson. Yes, as far as we know, most of the CO-OPs have been put --

Mr. Bucshon. Most of them have.

And what kind of requirements have they put upon you based on that?

Dr. Beilenson. There are only two. One is enrollment getting

to 30,000. We are at 26,500 today. Clearly, we'll hit that by the end of December. December is a big month. And, second, there's a resolve transition of our TPA, which we've already done. So we expect to come off of the corrective action plan.

Mr. Bucshon. Great. And do you believe that these oversight plans can be effective?

Dr. Beilenson. I think the oversight plans can be effective, yes.

Mr. Bucshon. Mr. Morrison, you have some comments on any of this?

Mr. Morrison. I would just say that it has certainly been a challenge for CO-OPs to face, not only State regulation, but several levels of CMS regulation and congressional oversight investigation, which began before the CO-OPs ever opened their doors. And so there's no question that administrative resources in these CO-OPs have been distracted and diverted to comply with multiple levels of regulation that far exceed the regulation of other carriers.

And at the same time, I understand that the Federal Government needs to look after its money.

Mr. Bucshon. Understood.

And just a personal kind of question, unrelated, really, to CO-OPs. I mean, creating more competition, and anyone can answer this. Is expanding the traditional healthcare private insurance market

across the country rather than having, essentially, State-based or regionally based, is that a concept that would work to create more competition? I think the State regulators would probably want to commend on that. Mr. Donelon?

Mr. Donelon. May I? Thank you very much, Congressman. And great question, doctor.

And I would caution my Republican colleagues, who have made a strong push toward authorizing companies to sell health insurance on a national basis, which they can do already, but subject to the individual State's regulation.

I would be concerned about a race to the bottom and the least regulation, similar to what happened with the AIG failure. And that concern is truly -- I had a meeting with one of my delegation members before coming here this morning and passed on that advice and caution to him.

I do want to point out one other thing when Congresswoman Blackburn and Commissioner McPeak were discussing, Tennessee is better served than Louisiana at this point. Their HMOs are protected by a guarantee fund safety net, unlike Louisiana, where we have tried that in the past but unsuccessfully.

The Ranking Member DeGette, was talking about a Federal backstop. That, really, has traditionally been done at the State level and should be done at the State level.

Mr. Bucshon. Okay.

Mr. Donelon. In closing I would say, please, support State-based regulation. It has served all forms of insurance extremely well for over 100 years. When I was NAIC president 3 years ago and was asked to come the Oval Office and meet with the President, he strongly expressed his continued support for regulation of insurance at the State level.

Mr. Bucshon. Okay. Fair enough. I expected that you and Ms. McPeak would probably have a similar comment. So I would go to the others.

Any other conceptual thoughts on that? Because the whole idea is to create competition for consumers to have more choice, to know what the product they're getting, and to help the consumers drive down the costs of health care.

Ms. McPeak -- Mr. Morrison, then we'll --

Mr. Morrison. I'm a former commissioner, too, and I testified in 2005 in the Senate Small Business Committee about the AHP bill, and I opposed it for the same reasons that Commissioner Donelon articulated.

Mr. Bucshon. Ms. McPeak.

Ms. McPeak. The only point that I would want to add to your question, that I think we would have more interest in companies selling across State lines if we had uniform essential health benefit plan

designs. Because each State has their own essential health benefits, it's very difficult for a company to sell across State lines and program their systems to pay for different benefits and different benefit levels in Kentucky as opposed to Tennessee as opposed to Mississippi or Georgia.

Mr. Bucshon. Yeah, and whose State laws apply, right? If you live in California and have a plan from a company owned in New York City -- New York, which States laws would apply. I know there's some challenges. And my time is up.

Ms. McPeak. Okay.

Mr. Bucshon. So, I appreciate all your comments.

I yield back.

Mr. Murphy. Thank you.

Ms. Castor, you are recognized for 5 minutes.

Ms. Castor. Thank you, all, very much for being here today.

Under the Affordable Care Act, Congress wanted to foster more competition among insurance providers to benefit consumers. This was one of the primary reasons behind the formation of the CO-OPs. And to some extent, as we've heard here this morning, they have achieved their goal, somewhat.

However, the CO-OPs have faced headwinds. And I would like to understand from our witnesses how CO-OPs can continue to meet the original goals of providing the public with more insurance choices and

benefits achieved through greater competition?

Mr. Morrison, for those who may not closely follow healthcare economics, why are CO-OPs an important ingredient in today's insurance market?

Mr. Morrison. The insurance markets were lacking competition to begin with, and now we see in the news that there is increasing mergers of the largest health insurance companies in the country. There's mergers of the largest hospitals in the country. What's happening is consolidation, and the need for competition has never been more greater than it is today.

CO-OPs can come into the marketplace and have a fundamentally different kind of motive. Their motive is not to make as much money as they can. Their motive is to deliver quality health care at an affordable price, and that guides corporate decisions in a different kind of way. And that kind of competitive influence can be very positive in the marketplace.

And in short, to answer your question, what they need in order to succeed in the future, eventually, they will stand on their own, but they need adequate capital until they can get their sea legs in this new marketplace.

Ms. Castor. Okay. Mr. Beilenson, similar question for the lay person, how do CO-OPs foster competition? How can they keep premium prices in check?

Dr. Beilenson. Well, I think as a new competitor on the market and additional competitor, we as, Mr. Donelon, state, have a big insurance company that's 75 percent of the marketplace, and so adding a new competitor is very important.

And I want to point out a couple of things about a CO-OP. First of all, we are member governed. I actually sort of pooh-poohed that when thought -- when we started the company, but it really makes a difference having members enrolled in your insurance company as the board of directors. We've gotten all sorts of great ideas, and it's very consumer-driven, consumer friendly, as the CO-OP program was meant to be.

Secondly, it allows for innovation. We're nimble; we're quick. We're like a, sort of like -- a Titanic I shouldn't use. Sort of like the giganto ship, Lake Erie or whatever. Instead, we're sort of a nimble PT boat, if you will, for Mr. Kennedy over there. And we can do innovative things like our diabetic program, where we get rid of all co-pays, co-insurance, deductibles for proven practices to keep diabetics under control so we get rid of financial barriers to have them staying healthy. That's sort of the sweet spot of healthcare reform.

Ms. Castor. How many Americans are enrolled in CO-OPs today? Do you know?

Dr. Beilenson. Depends on how many are left. I'm not sure,

500 --

Ms. Castor. Does anyone know?

Dr. Beilenson. 400,000 something in the remaining 11.

Ms. Castor. In March 25th, 2015, press release from the National Alliance of State Health CO-OPs, said for the second year in a row, average premium rates in the States with CO-OPs are lower than those without.

Mr. Beilenson, can you explain how, in reality, what has actually happened? How have the CO-OPs affected the premium prices and plan choices in those States where they are still operating?

Dr. Beilenson. Well, predominantly, it was actually being a new competitor in a generally staunchly over the market -- for example, in Maryland, we were the first new commercial insurer in 25 years, and that was the case in many different States.

Ms. Castor. And that same release cites another analysis from 2014 that showed that CO-OP States have premiums that are 8 to 9 percent lower than in non CO-OP States. Is that accurate? Were CO-OPs able to drive down the premium rates in 2014?

Mr. Morrison. The delta between the CO-OP States and the non CO-OP States in 2014 was, as you said, about 8 percent, a little more than that. And apparently, in 2015, it was more like 13 percent. We believe that CO-OPs played a significant role in that, and, frankly, there have been other insurance executives who have commented in the

media that they thought that the CO-OPs were responsible for the rates being lower in those States. But as the question requires further study because, obviously, there are other factors at work.

Ms. Castor. And there are other trends right now, as Mr. Beilenson mentioned. The health insurance industry is facing a wave of consolidation such as Aetna and Anthem are considering merger and purchasing their smaller rivals.

Mr. Morrison, if additional consolidation between large insurance companies occurs, what will this do to prices? Will we expect higher premiums as a result?

Mr. Morrison. Generally, competition drives lower prices. And so if there's less competition, there's higher prices. And so we think that's one of the reasons that the CO-OPs were created, and we take that mission pretty seriously -- the CO-OPs I should say do.

Ms. Castor. Thank you. We have work to do on this for consumers in the country. Thank you very much.

Mr. Morrison. Thank you.

Mr. Donelon. Mr. Chairman, may I be excused? I have a flight that leaves in 38 minutes.

Mr. Murphy. Good luck getting to the airport. You are excused.

Mr. Collins is recognized for 5 minutes.

Mr. Collins. Thank you, Mr. Chairman. And thank the witnesses for coming in today. I'm a private-sector guy that understands how

you're supposed to make money in business, how you capitalize companies, and how you either fail or succeed based on your pricing and your product, and what you've delivered to your customers. And basically, if you make money, you succeed; and if you lose money, you don't.

So, you know, we're here today talking about CO-OPs in particular. And I'm from New York where the New York CO-OP and its failure cost the American taxpayers over $250 million. Well, you know, somebody asked me if I'd be surprised we're here today. Well, no, I predicted this over 2 years ago. I remember sitting down with some insurance executives, health insurance people, in early 2013 and asked them how they were going to be pricing their products for ObamaCare and for the enhanced benefits. And what basically came out of those meetings is they were going to underprice their products because of the risk corridors, and they were confident they would get the money back.

Because I said, well, what are you presuming for the number of healthy subscribers under age 30? Well, a third of our subscribers will be young and healthy. And I said, you know, what are you guys smoking? That's not gonna happen. And they -- and what's going to happen when it doesn't? Well, we are going to lose money, then the government is going to make it up to us. This was set up for failure from day one. The insurance companies knew it was going to fail. They released a product that was underpriced. They could not make

money.

So, you know, Mr. Morrison, when you talk about it being not capitalized properly, would you agree with me if the CO-OPs made money, we wouldn't be having this discussion? You don't need more capital if you start with X and you make money. Isn't that just fundamental common sense?

Mr. Morrison. I would agree with that.

Mr. Collins. So --

Mr. Morrison. All the companies lost money.

Mr. Collins. So we are here because ObamaCare was set up for failure. It was set up to encourage low premiums, to receive the American public.

You know the saying, you can put pig on a lipstick -- lipstick on a pig, but it's still a pig. That's what we've got here. Everyone knew these products were underpriced and they were going to make it up on the backs of the taxpayers, and that's why we're here today. This problem here is a product that was underpriced, knowingly underpriced, meant you lost money, and now the complaint is we didn't -- we cut the money from $2.4 -- from $6 to $2.4 billion, but the $6 billion was based on 50 CO-OPs. The 23 got $2.4 billion. They got every dollar they were supposed to get. Had we not cut from $6 to $2.4, there would be 50 CO-OPs.

So I kind of have to just categorically disregard your comment

that had we thrown $6 billion, but I think you're suggesting throwing $6 billion at 23 CO-OPs would have shored them up. But that was never the intention. The $6 billion was for 50 CO-OPs. The 23 were not harmed in any way. They failed because the product was underpriced. It was knowingly underpriced.

ObamaCare was meant to deceive the public, and all I can say is, as now we're a couple of years in, the deception is obvious. And I don't know what the polls would say, and I'm not a guy to poll, but I think ObamaCare now would be, you know, probably in the 20 percent range.

And now we've got these problems. New York, 150,000 members on the New York plan lose their insurance in 2 weeks. And you know what we're doing, we're forcing the private companies to take those policyholders for 30 days who have all hit their deductibles. So the BlueCross BlueShield, Independent Health, they are going to have to that's these 150,000 people for 30 days, eat those losses, and then have those folks set up a new plan. This is ObamaCare at its worst. It's not surprising to me. I saw this coming 3 years ago, only because I have a certain level of common sense and know in the private sector, if you underprice your product, there will be a price to pay.

And this product was deliberately underpriced from day one. And then when people say, whoa is me, the risk corridor didn't give me as much money as I expected, that's because you expected to lose a lot

of money and thought the taxpayers should shore that up, and it didn't happen. So I can't say I feel sorry for the American taxpayers who are bearing this financial burden who were deceived from day one, and it's all coming home to roost. And we see it every day with the price increases and policies, the turmoil within the American public trying to find doctors day in and day out.

So, again, private sector, you make money, you do fine. You lose money, you don't do fine. Not a surprise we're not doing fine here. The product was never priced correctly.

Mr. Murphy. Mr. Collins --

Mr. Collins. And with that, I yield back.

Mr. Murphy. I was asking, can you give an answer with regard to would you have priced it differently if there were not risk corridors from the onset? Would you price it a higher? Yes or no? Just in response to what he said.

Dr. Beilenson. No, we actually priced conservatively, and we were actually making a profit the last 3 months.

Mr. Murphy. Ms. McPeak, was that a backstop that you saw that would cover those losses and it didn't work?

Ms. McPeak. I don't know that I would characterize as a backstop. But certainly, the incentive to appropriately price was eliminated when any excess profit of needed to be paid back to the other insurers. So unless the entire market priced appropriately, you were going to be

pricing yourself out of the market not having the enrollment.

Mr. Murphy. And that's what you're saying. Got it. Thank you.

Okay. Mr. Yarmuth, 5 minutes.

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

I thank the witnesses. I actually think this has been a very constructive hearing, and the dialogue has been good. It seems to me that what we've heard today is that there are a lot of different experiences with CO-OPs and a lot of different reasons they have had -- some have had problems.

My CO-OP in Kentucky did not have an enrollment problem. As a matter of fact, the initial projection was about 30,000 enrollees. It peaked at 57,000 and was insuring 51,000 when it announced that because of the risk-corridor deductions it cannot sustain itself. But, in fact, it had gone from losing $50 million in its first year to losing $4 million in 2015 and was on track to make a profit in 2016. So not every experience has been right.

And I think looking at the various factors that could affect this, Commissioner McPeak, Tennessee didn't expand Medicaid.

Ms. McPeak. That's right.

Mr. Yarmuth. And this is not partisan statement, but Tennessee did not have an administration that supported, necessarily, the Affordable Care Act. So as opposed to Kentucky's experience, where you had an administration that was very much supportive in marketing

it and running a PR campaign and alerting the population to the options that were available to them, that experience was gonna be different than Tennessee's or Louisiana's, where it seems to me, you had an enrollment problem first and foremost.

Would that be a fair statement that all of these factors would affect how the CO-OPs operated and whether they had a better or worse chance of succeeding?

Ms. McPeak. Certainly. And I will say Statewide, we had a very positive enrollment through the federally facilitated marketplace. So we did not expand Medicaid. But the skewed enrollment of less than 1,000 people for the CO-OP made it extremely difficult to survive.

Mr. Yarmuth. Exactly. And, obviously, we have different health conditions as well. Montana probably has a lot healthier population than Kentucky and Tennessee. I know Kentucky, we have serious challenges in that regard.

But, you know, one of the things that impresses me, and this relates to just Mr. Collins' statements, is that while our CO-OP is going out of business, we have three new private insurers who have joined our exchange. We now have seven insurers who are offering insurance and not relying on risk corridors. So they have seen opportunity in Kentucky and not a disastrous situation.

And so our consumers are going to, as a result partially of the CO-OPs competition and their activities, we're going to see enhanced

competition in the private market through our exchange. So it could have an ancillary benefit as well. Would that not be true, Mr. Morrison?

Mr. Morrison. That's very encouraging, and I think that the benefits of introducing a CO-OP into the dynamics of the marketplace has lots of ripple effects, and that was one that I wasn't even aware of. So glad to know about that.

Mr. Yarmuth. And one other thing. Senator just asked, we talked about the question of how can you offer insurance policies of 20 percent less than commercial insurance company can? Well, if there's no profit margin involved, so you can. I don't know whether it would be a 20 percent different as to the profit versus a nonprofit CO-OP, but there's some factor there that would allow a CO-OP to offer pricing that would be -- you know, even apples to apples would be below what a commercial for-profit insurance company could offer. Would that be correct?

Mr. Morrison. Yes, that's true. But I want to make the point that the CO-OPs generally were not outliers on the low end in price. And McKinsey did a report in late 2013 about those initial prices, and CO-OPs were toward the bottom. They were within 10 percent of the lowest 42 percent of the time. But the point is, when these companies set their prices and file them with the commissioner, they don't know what the other companies are doing. And so the mere fact that the CO-OPs were there caused the other companies to price more

aggressively.

RPTR BAKER

EDTR SECKMAN

[1:08 p.m.]

Mr. Yarmuth. So what I'm taking away from this is that there are lot of different reasons the CO-OPs have either succeeded or not succeeded, and I think this is a very useful hearing to analyze that, not necessarily to ascribe blame, but to take about the factors that are involved. I think what I would conclude is there was not a fundamental flaw in the Affordable Care Act that caused any of those CO-OPs to fail. They were different factors, just as there is in any business situation.

With that, Mr. Chairman, I yield back.

And thanks again to the witnesses.

Mr. Collins. [Presiding.] I thank the gentleman for questions and certainly thank all the witnesses. This will conclude our second panel, and you can rush to the airport if you've got any tight flights. I want to thank the members that did stay. It is a flyout day. We had so many members that had flights to connect. We had two vote series, so to some extent, I apologize for the attendance.

Thank the members that did stay, and your testimony, which is on the record, is very helpful. Thank you very much

So we are now going to bring on our third panel, which is our

representative from CMS and our representative from OIG.

We will begin our third panel here. I want to thank the witnesses, Dr. Cohen and Ms. Jarmon, for joining us today. Before we get going on this committee, we want to make sure the witnesses are aware that we are holding an investigating hearing, and when doing so, we have the practice of taking testimony under oath. Do you have any objection to testifying under oath?

The chair then advises you that under the rules of the House and the rules of the committee, you are entitled to be advised by counsel. Do you desire to be advised by counsel during your testimony today?

No. In that case, if you would, please rise, raise your right hand. I will swear you in.

[Witnesses sworn.]

Mr. Collins. Thank you very much. Be seated. You are now under oath and subject to the penalties set forth in title 18, section 1001, of the United States Code.

We now recognize you to give a 5-minute summary of your written testimony beginning with Dr. Cohen, chief of staff for CMS.

Dr. Cohen?

STATEMENTS OF MANDY COHEN, CHIEF OF STAFF, CENTERS FOR MEDICARE AND MEDICAID SERVICES; AND GLORIA L. JARMON, DEPUTY INSPECTOR GENERAL FOR AUDIT SERVICES, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF MANDY COHEN

Dr. Cohen. Thank you. Good afternoon, and thank you for inviting me here. Chairman Murphy, who I know has gone, but Mr. Collins, Ranking Member DeGette, and other members of the subcommittee. We appreciate the opportunity to talk about the CO-OP program. CMS takes its commitment to both the CO-OP consumers and taxpayers very seriously. Our priority is to make sure that consumers have access to quality affordable coverage.

In the years since the passage of the Affordable Care Act, we have seen an increase in competition and more choices for consumers. In today's dynamic market, consumers can choose from on average 50 plans and five issuers for 2016 coverage. Nearly 9 out of 10 returning consumers will have three or more issuers to choose from, which research shows has typically intensified price competition in the market. New entrance to any market, especially the insurance market, can face pressures particularly in early stages.

CO-OPs entered the insurance market with a number of challenges including building a prior network; no previous claims experience on which to base pricing; and competition from larger, more experienced issuers; as well as the uncertainty that a company is in the early years of a new market. As with any new business venture, some CO-OPs have succeeded while others have encountered more challenges. There have been successful CO-OPs which have provided consumers in their States an additional choice of health insurance and have improved competition. There have also been CO-OPs that for a number of reasons have faced technical, operational, or financial difficulties. In addition, Congress has made a substantial rescission to the initial $6 billion for funding for CO-OPs, impacting program operations and available funding. In the face of multiple pressures, it is not surprising that some new entrants have struggled to succeed.

CMS plays a dual role with the CO-OP program, providing both oversight and support. CMS works to give CO-OPs tools to succeed, including sharing best practices amongst CO-OPs, and looking for additional regulatory flexibilities. At the request of CO-OPs, CMS has approved conversion of surplus notes, and we have approved the infusion of outside capital consistent with legal and regulatory framework of the CO-OP program. CMS also plays an oversight role. CMS along with State departments of insurance, which serve as the primary regulator of insurance in a State, work to ensure that the CO-OPs are

well run and financially sound. CMS has implemented the CO-OP program as required by statute and with the funds available, evaluating applications, monitoring financial performance, and conducting oversight. All CO-OPs are subject to standardized, ongoing oversight activities, including calls to monitor goals and challenges, periodic onsite visits, performance and financial auditing, reporting obligations, and a host of additional measures employed as needed on a case-specific basis, such as the evaluation of CO-OP sustainability. CMS increased the data and financial reporting requirements for CO-OPs required for them to provide quarterly statements saying that they are in compliance with State licensure requirements. If a CO-OP has experienced compliance issues with state regulators, the CO-OP was required to describe the steps being taken to resolve those.

Financial data collection has helped CMS to identify CO-OPs with financial issues and give CMS the opportunity to work with State insurance regulators to help correct issues that are identified. As part of our oversight efforts, CMS has put some CO-OPs on enhanced oversight schedules or corrective action plans. Despite this support and oversight, some new entrants to the insurance market have struggled to succeed.

When States and CMS determine that a CO-OP should wind down, our first responsibility is to make sure current policyholders are able to retain coverage to the end of the year. CMS' priority is to make

sure that customers have access to quality, affordable coverage. We're working with local officials to do everything possible to make sure consumers stay covered, retain access to high quality choices of issuers. Like other consumers, CO-OP enrollees are able to shop for 2016 coverage on the marketplace right now.

In 2016, nearly 8 in 10 returning marketplace consumers will be able to buy a plan with premiums less than $100 a month after tax credits. We continue to encourage those consumers already enrolled in the marketplace coverage to come back to the marketplace, update their information, compare their options, and make sure they're enrolled in the plan that best meets their family's needs. Since the enactment of the Affordable Care Act, CMS has worked to increase access to quality, affordable coverage through the marketplace while being responsible stewards of taxpayer dollars. The CO-OP program was designed to give consumers more choice, promote competition, and improve quality in the insurance market and has done so in a number of States. CMS will closely work and has done so in a number of states. CMS will closely work with the CO-OPs and State departments of insurance to provide the best outcomes for consumers. We appreciate the subcommittee's interest and be happy to answer more questions.

[The prepared statement of Ms. Cohen follows:]

******** INSERT 3-1 ********

Mr. Collins. Thank you, Dr. Cohen.

Now we'll hear from Ms. Jarmon.

STATEMENT OF GLORIA L. JARMON

Ms. Jarmon. Good afternoon, Mr. Collins, Ranking Member DeGette, and other distinguished members of the committee. I am Gloria Jarmon, deputy inspector general for audit services, Department of Health and Human Services, Office of Inspector General. Thank you for the opportunity to testify today about OIG's work as it relates to CMS' oversight of financial loans and the financial solvency of the Consumer Operated and Oriented Plans.

As part of our strategic plan to oversee implementation of ACA programs, OIG has performed three reviews related to CO-OPs. My testimony today focuses on OIG's most recent report issued in July 2015 that reviewed whether enrollment and profitability met the CO-OPs projections on their initial loan applications. Understanding that CO-OPs face numerous challenges, we conducted this audit work to assess the financial and operational status of the CO-OPs once they had experience operating as a health insurer. We reviewed the status of the 23 CO-OPs as of December 31, 2014. We found that most CO-OPs had lower than expected enrollment numbers and significant net losses and that these financial concerns might limit some CO-OPs' ability to repay

loans.

Based on these findings, OIG issued four recommendations to CMS to improve financial oversight and solvency of the CO-OPs. These recommendations include: One, continue to place underperforming CO-OPs on enhanced oversight or corrective action plans; two, providing guidance or establishing criteria to determine when a CO-OP is no longer viable or sustainable; three, working closely with State insurance regulators to identify and correct underperforming CO-OPs; and, four, pursuing available remedies for recovery of funds from terminated CO-OPs. I will briefly discuss each of these recommendations in more detail.

With respect to enhanced oversight, with the 2011 funding opportunity announcement and loan agreements, CMS has the ability to place underperforming CO-OPs on enhanced oversight plans. This vehicle provides authority to CMS to conduct thorough reviews of the CO-OPs' operations and financial status.

With respect to guidance, to ensure that CMS can appropriately identify CO-OPs that pose a high risk of failure, CMS should establish criteria to assess whether a CO-OP is viable or sustainable. With respect to State insurance regulators, CMS should enhance its oversight by working closely with State insurance regulators who are the primary regulatory entities that oversee CO-OPs as health insurance issuers. By doing this, CMS can obtain timely insights as to the CO-OP's

performance and can work with CO-OPs to address and fix ongoing financial and operational problems earlier.

Finally, if CMS no longer believes that a CO-OP is viable and sustainable, CMS should then pursue all available remedies for recovery of funds from CO-OPs. This would include the option to terminate loan agreements which would require the CO-OP to forfeit all unused loan funds. This may allow CMS to recover some portion of the loan with the recognition that a CO-OP must resolve any outstanding debts or other claim obligations before paying the loan funds to CMS.

In closing, we appreciate the subcommittee's interest in this important issue and continue to urge CMS to fully address OIG's recommendations related to improving oversight and financial solvency within the CO-OP program. OIG is committed to providing continued oversight of this program. Our ongoing work will assess whether CO-OPs were in compliance with Federal regulations and program requirements in managing Federal funds. In addition, OIG will reassess the CO-OPs 2015 financial status and identify CMS actions to oversee the loan program and monitoring underperforming CO-OPs. We anticipate issuing these reports in 2016, and we look forward to sharing those results with the committee at that time.

This concludes my testimony. I will be happy to answer any questions. Thank you.

[The prepared statement of Ms. Jarmon follows:]

This is a preliminary, unedited transcript. The statements within may be inaccurate, incomplete, or misattributed to the speaker. A link to the final, official transcript will be posted on the Committee's website as soon as it is available.

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Mr. Collins. Thank you.

I'll now recognize myself for 5 minutes, and I guess, Ms. Cohen, I'm just going to start and accept you at face value when you say CMS does consider themselves responsible stewards of taxpayer dollars. Today's hearing kind of begs the question whether that's totally accurate or not. Before I get into a couple of other questions, there have been comments made that would somehow try to correlate States that did not increase, expand Medicaid to some of these failures on CO-OPs, and I guess I would just point out for the record, New York State absolutely aggressively expanded Medicaid, actively promoted ObamaCare, probably more so than most any other State in the country, and the hearing today is recognizing the failure of a CO-OP that was oversubscribed -- not undersubscribed -- and cost the taxpayers over $250 million, which is almost 25 percent. So I don't know that some of these other comments would accurately portray the problem. I'll just go back to the products were underpriced from day one, and if you underprice your product, there will be a price to pay.

So, Ms. Cohen, my worry now about loss York and the loss of $250 million plus -- Dr. Cohen, sorry -- that it appeared that the New York CO-OP was in distress right from the beginning, lost over $35 million in the first year. I'm assuming you're aware that there was an additional loan of $91 million after they lost 35 million, so could you speak to what that rationale was that the taxpayers now lost another

$91 million?

Dr. Cohen. Sure. As we looked at the CO-OP program over the first few years, I think you have heard a lot about the early years having uncertainty. We're still in that. We're only in the second year of the program in terms of folks facing a number of challenges. When any CO-OP approached us with any additional requests for funds, we evaluated that on an individual basis as we did even the startup of any one of these companies. We looked at their financial health at that time, their projection of where they were going to go, how they intended to get to a place of good standing, again, to say that we want to be good stewards of taxpayer dollars and want to be sure that if we are going to be further investing in a company, that we are going to be seeing those dollars. So we can only look at the information we have on hand at that time. At that time, our independent expert panel who reviews these felt that a further investment in New York, in the New York CO-OP, was the right decision. And we moved forward with that investment. And as we do all -- we continue oversight and information, and facts on the ground change, and we make different decisions as we move forward.

Mr. Collins. With that said, I would appreciate if you could provide the committee with the analysis that you indicate did occur that after losing $35 million in their first year, I have to presume that analysis would include such things as the difference in the, I

would hope, much higher rates charged in 2015? Let me just start with that. They lost a lot of money in 2014, based on rates that weren't adequate to cover losses. Were the rates substantially increased the next year, like 20 percent or more?

Dr. Cohen. It's important to remember that CMS shares in partnership the oversight responsibility here, but the responsibility for rate setting is done at the State level in the New York Department of Insurance, or DFS, in New York is the one primarily responsible for saying, are these rates adequate to cover the expenses?

Mr. Collins. And was that done?

Dr. Cohen. So they do their own rate review in New York. As you know, New York also runs its own exchange. So from our perspective at CMS, we do do oversight in terms of the financial stability of the program, according actually with how OIG recommended our additional enhanced oversight. But the rates themselves are set by New York, by the company, and then approved by the State Department of Insurance.

Mr. Collins. So do you know much the rates were increased for 2015?

Dr. Cohen. I don't have off the top of my head, but I know that they did request and were granted a rate increase for 2015.

Mr. Collins. I think it's just important to note again that it's a little concerning that CMS is making a $91 million loan based on what sounds like an analysis done by the New York State Department of

Insurance, which ultimately was proven, by the fact that they're now shutting down, to have been totally bogus. So if you could share that information back with the committee, I think we could learn something from that.

Dr. Cohen. I would be happy to provide that.

Mr. Collins. I certainly appreciate that.

And Ms. Jarmon, my office will be sending you a letter to ask for even a more thorough investigation of what happened in New York State and what we may learn from the failures of the New York state CO-OP, and again thank you for that.

And, with that, I would recognize Ranking Member DeGette for 5 minutes.

Mr. DeGette. Thank you so much, Mr. Chairman.

I want to thank our witnesses for coming today, and I want to start with the risk-mitigation mechanisms in the law, which we commonly refer to as the three Rs, as I mentioned earlier. Those were designed to promote competition and ensure stability in the insurance marketplace. Is that correct, Dr. Cohen?

Dr. Cohen. That's right.

Mr. DeGette. And yet some would argue that those programs are what have led to the insolvency of the CO-OPs. I don't really understand how programs that were designed to help the CO-OPs could wind up hurting them. Let me go into that a little bit. The risk

adjustment program is designed to transfer funds from lower risk programs to higher risk programs. Is that correct, Dr. Cohen?

Dr. Cohen. The risk adjustment program is designed to again make sure that companies are taking care of the people who really need the care, those that are sick, and making sure they're not just cherry picking the healthy folks but really offering coverage to anyone who walks through the door.

Mr. DeGette. What that does then is it transfers money then from lower risk plans, where there aren't so many severely sick people, to higher risk plans. Right?

Dr. Cohen. That's right.

Mr. DeGette. Given that, how is it that the CO-OPs wound up owing money to big insurance companies through the risk adjustment program?

Dr. Cohen. Right. So the risk adjustment program is not based on size. It's agnostic to size, but as you point out, what it's really looking at the math formulas focused on the total risk and the health of the population.

Mr. DeGette. So there was nothing in the statute to target not for profit or profit?

Dr. Cohen. No. It's agnostic as to --

Mr. DeGette. Was that the intention of the program. Do you know?

Mr. DeGette. It was intended to be a risk program for all of the

insurers that participated in the marketplace.

Mr. DeGette. Now, the risk corridor program also ended up not coming through to the CO-OPs as we learned very painfully in Colorado in the last couple of weeks, and some State insurance commissioners, including mine, made management decisions based on the CO-OP's inability to deal with losses, so I want to ask you some questions about that. The 2015 CR/Omnibus legislation made it so insurer payments into the risk corridor program are the only source of funding to reimburse claims, effectively making the program budget neutral. Is that correct, Dr. Cohen?

Dr. Cohen. It is a mathematical formula that decides the proration rates or the ins and outs of that program, but yes, you're correct.

Mr. DeGette. I'm correct. Thank you. Now, in July of 2015, couple months ago, CMS reiterated to State insurance commissioners that they, quote, "anticipate that risk corridor corrections will be sufficient to pay for all risk corridor payments." Is that correct, Dr. Cohen?

Dr. Cohen. That's correct.

Mr. DeGette. And yet just a few weeks ago, CMS revealed it would only be able to pay 13 percent of the reimbursements that the CO-OPs are owed. Is that correct?

Dr. Cohen. That's right.

Mr. DeGette. So why is that?

Dr. Cohen. As I mentioned, that formula is based on information that we got from the issuers themselves. That was not information that CMS had prior to actually the month of September. Originally, that data came in, as you may know, over the course of the month of July, and it was actually so messy we needed issuers to resubmit it.

Mr. DeGette. But see, here's the problem. In July, you're saying it's going to be sufficient to cover all risk corridor payments, and then, in October, you're saying, oh, it's only 13 percent. So irrespective of whether you had the data, you had CO-OPs like the one in my State with 83,000 people in it, who were relying on that. I guess it was bad information.

Dr. Cohen. I think it's important to remember that the risk corridor is one of three, ours as you mention, and in the reinsurance program, we actually paid 25 percent more than we thought we would be able to pay. Again --

Mr. DeGette. But, again, if you have a CO-OP that's on the edge, that didn't solve that problem. I'm running out of time. I just want to ask you a couple of questions. Do you think that you can do anything to give more certainty to this program without statutory changes? Yes or no?

Dr. Cohen. Could we give more certainty to the program?

Mr. DeGette. Can you make changes that would give more certainty

to these CO-OPs so they could stay in business without statutory changes?

Dr. Cohen. I think we are always looking for opportunities.

Mr. DeGette. If you can supplement your responses by giving us the ideas. Do you believe that there are statutory changes that Congress could pass to give more certainty?

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[1:33 p.m.]

Dr. Cohen. I think that there are opportunities, yes, for --

Ms. DeGette. And that would be helpful if you would supplement that too.

Thank you very much, Mr. Chairman.

Mr. Collins. Yes. I thank the ranking member for her comments.

We'll now turn to Dr. Buschon for 5 minutes.

Mr. Buschon. Thank you, Mr. Chairman.

And I thank the witnesses for being here.

So, Dr. Cohen, who ultimately made the decision to give out $91 million to New York, as was said; $66 million to Minutemen Health; $65 million to Kentucky Health CO-OP? I can go on, but three of -- there's a few more, but three of the six that I have listed here failed. So I want to know the person that made the decision to give them the money.

Ms. Cohen. So we had a very rigorous process with an outside --

Mr. Buschon. Here's the thing. I know you've already described your process. I understand you have outside people that look at all the data. But what I want to know is someone put their signature on the loan from CMS and said: We're giving them this money. Who did that?

Ms. Cohen. I don't know who signed the loan agreements, but I can get back to you --

Mr. Buschon. Was it you?

Ms. Cohen. It wasn't me, sir.

Mr. Buschon. I didn't expect it would be.

Ms. Cohen. I can let you know and --

Mr. Buschon. Yeah, I'm sure we won't -- I'm sure you'll have every intention of doing that, but I can tell you as a Member of Congress with experience asking these questions that I'll never find the answer to that because no one's going to take that responsibility, and I understand that. But do you know if it was a political appointee or a full-time CMS staff?

Ms. Cohen. I don't know who signed the loan agreements, but, again, you know, I can talk more about the process that we went through in terms of evaluating the information that we had understanding the --

Mr. Buschon. Yeah, I understand.

Ms. Cohen. But we can get you that information.

Mr. Buschon. Dr. Cohen, you also testified before Ways and Means, and they asked when CMS knew the CO-OPs would fail. And it says you didn't really give a clear answer. So I'm going to ask it. When did CMS know these CO-OPs would fail?

Ms. Cohen. We have been doing oversight of the CO-OP program since its inception. And each circumstance is very unique. And there

were different periods of time where we had information in front of us. When we knew folks were potentially going down the wrong path, we put folks in enhanced oversight, on corrective action plans, and as information presented itself, again, we took action. We really are still in the very early stages of this program. And I think from the discussion today you could see that we have taken our oversight responsibilities very seriously. We do feel like we are trying to be the best stewards of taxpayer dollars as possible.

Mr. Buschon. Can I ask -- I am going to run out of time. Is there political pressure to keep these CO-OPs alive?

Ms. Cohen. Sir, I would say we are trying to do our best job possible to make sure that consumers can know that if they go to the marketplace now and want to sign you for the CO-OP, that they are strong and stable. And that, you know, we have done a tough job here. I think if there was another way that we could have arrived here, we would have. But we've been doing a tough -- some tough work. Again --

Mr. Buschon. Okay. That doesn't answer the question, but I understand that.

Why do we need the three Rs?

Ms. Cohen. So --

Mr. Buschon. Because, you know, like I think Mr. Collins pointed out, if I was going to start a business out there somewhere, I wouldn't rely on the three Rs to make sure that if something didn't work out,

I all of a sudden got a check from the Federal Government. So just fundamentally I get it, but, I mean, first of all, answer this question real quickly: CMS has always said they intended the risk corridor Program to be budget neutral. Is that correct?

Ms. Cohen. So all of the three R programs --

Mr. Buschon. No. That question specifically. Did CMS always intend for the risk corridor to be --

Ms. Cohen. I don't know if always. I would have to get back to you on that. I don't know if --

Mr. Buschon. Okay. Because that's what it says here on my paper.

Ms. Cohen. I don't know if that wasn't something --

Mr. Buschon. So then you can go into why we need the three Rs in the first place. And I may know that may -- I understand you didn't make these decisions, but you're here and so --

Ms. Cohen. Happy to answer. So the programs were based on our experience with the Medicare part D program, the drug program in Medicare that had those three similar programs. As you stand up any new market, there is uncertainty. We've been hearing about a lot of that uncertainty earlier today. And so, again, those programs, one, we wanted to make sure that sick people weren't somehow not covered by the insurance. We want those folks to be covered. The reinsurance program specifically was to cover the cost of any high-cost enrollees

very -- in early years. We know there may have been pent-up demand as --

Mr. Buschon. So it's basically -- I mean, at the end of the day, it's basically to capitalize the business. Right? So that they have the capital to get off the ground.

Ms. Cohen. I think it's to keep premiums stable for consumers --

Mr. Buschon. Okay. And following up on what Ms. DeGette said, I mean, you thought earlier in the year that you were going to be able to make the payments, and then you found out in October that you couldn't. And what was -- what is the -- I mean, basically what's the reason for that?

Ms. Cohen. It -- honestly, it's the math formula. It's the way the data came in from the issuers. And, you know, that's the way the math worked out. And so we, you know, we were able to pay at 12 percent, which is the dollars coming in, dollars going out. And, you know, that's the way we move forward for this program. We've always said that we will take from next year's collections and pay back to this year. It is a 3-year temporary program.

Mr. Buschon. Okay. Thank you.

And I yield back.

Mr. Collins. Thank the gentleman for his questions.

Now recognize Mr. Yarmuth for 5 minutes.

Mr. Yarmuth. Thank you very much, Mr. Chairman. Welcome to the

witnesses.

I can help Dr. Buschon out a little bit on the background of the CO-OPs. One of the things, the problems, we faced when we were drafting legislation was that in certain States, the availability of private insurance was limited to one provider. Or I think, in Alabama, there was Blue Cross Blue Shield dominated over 90 percent of the market. And in many States, that was the situation -- maybe not that high. But the idea was to create competition, and the only way you could do it was to create a new entity. We chose CO-OPs as a nonprofit. And the idea was that you could that way create the kind of price competition that was meaningful.

But we knew, and we knew in Kentucky when the CO-OP was established -- and I talked with them many times as they were getting started -- that they had no idea what kind of an insured population they were going to have. They didn't know what the age was going to be. They had no data to predict that. They didn't know how many would enroll. They didn't know how many would have never had any healthcare, so automatically once they became insured, they would have a rush of care. They would try to get tests and because they -- or treat things that they had never been able to treat before or whether they were going to get people who had had medical care but just lost their insurance. So the unpredictability of it was certainly the rationale for that. And, you know, I'm really proud of the experience with ACA in Kentucky.

We have led the country in the reduction and in the amount of uninsured. More than 50 percent of our previously uninsured are now covered, more than 520,000 people a State of 4.4 million. And in my district alone, in Louisville, we've reduced the uninsured rate by 81 percent, an astounding accomplishment. And more importantly than that, I think, is that every day I'm hearing from people who have -- now have insurance and had a family member or a neighbor or friend whose life has been saved because they had insurance that they otherwise wouldn't have. And I could talk about that for a long time.

But the focus of this hearing is on the CO-OPs. And I want to try and set the record straight about what happened with Kentucky.

Ms. Jarmon, unlike most of the CO-OPs reviewed by your office, is it your understanding that the Kentucky Health Cooperative had far higher enrollment than expected, nearly double their original projections?

Ms. Jarmon. We actually have a chart in our report on the enrollment projections as of 2014, and for Kentucky, yes, it was like 183 percent. So that was -- right. It was one of the few that was --

Mr. Yarmuth. And is it your understanding that a very high percentage of those enrollees were much sicker or used -- utilized much more care than -- and therefore were more expensive to ensure than the general population?

Ms. Jarmon. I don't have that --

Mr. Yarmuth. You don't have that information.

Well, again, that's why we established this risk corridor program and why it was so important. And that's what happened to Kentucky's CO-OP. They relied on this. Kentucky's CO-OP, as I mentioned before the earlier panel, lost $50 million in its first year. In the second -- first half of 2015 that loss had slowed down to a rate of 4 million. They were on track to make a profit in 2016, and unfortunately, when the risk corridor program was by that 87 percent, they were unable to continue.

Dr. Cohen, is it your understanding that had Congress not capped the payments for the risk corridor program, that Kentucky Health Cooperative would still be open for business?

Ms. Cohen. No. I think that there were a number of factors that contributed. Obviously, that was one of the last and certainly we have heard was an important factor for them. But, you know, you have to know that there were many factors, as we've been talking about all along in terms of the uncertainty and the challenges for the CO-OP program.

Mr. Yarmuth. And as I mentioned before, that having been said, is it your understanding that even without the CO-OP, Kentucky residents will still have more health insurers to choose from in 2016 than they had --

Ms. Cohen. Yes.

Mr. Yarmuth. -- in prior years?

Ms. Cohen. Yes very exciting.

Mr. Yarmuth. Yep. So, again, I think I could talk for a long time about the success of the Affordable Care Act in Kentucky. We're a much healthier State because of it. And I know somebody threw around a figure that maybe the approval rating of the Affordable Care Act is down near 20 percent. In Kentucky, it's well over 50 percent.

Ms. Cohen. And I'll give you a new number that the CDC just put out today for a new reduction in the uninsured rate to 9 percent historic. So I appreciate your leadership on that.

Mr. Yarmuth. Thank you, Dr. Cohen.

I yield back, Mr. Chairman.

Ms. DeGette. Mr. Chairman, can I take a moment of personal privilege?

Mr. Collins. Yes. Absolutely.

Ms. DeGette. You might have noticed this is not one of the new Members of Congress here. This is a dear, dear friend of mine and Chairman Upton's, Max. And Max has been helping us with our 21st Century Cures bill. Most of the staff and members have met him. Last night, Max was very honored to receive an award at the Every Life Foundation for Rare Diseases, Rare Voice Awards gala reception. And also Chairman Upton and I received awards, but Max is the one. He's why we're doing this. So thanks for letting me --

Mr. Collins. Oh, no. Thank you. And we all welcome Max. When

I look back to the unanimous vote out of our committee on 21st Century Cures, I can tell you Max whipped more than one vote.

Ms. DeGette. Max is our secret weapon.

Mr. Collins. We may be looking at a future majority whip here sitting next to us.

With that, I'd like to recognize Mrs. Blackburn for 5 minutes.

Mrs. Blackburn. Thank you so much.

And thank you for our witnesses and for your patience today. We appreciate it.

I'm sorry that Mr. Yarmuth left. You know, I think it's important to note in Kentucky, when Tennessee had TennCare, a lot of Kentucky residents were coming into the State to try to get healthcare. And the Kentucky CO-OP did close. And the Kentucky approval rating of the ObamaCare products that are in the marketplace is really quite low, as was evidenced in that State this week.

Ms. Cohen, I want to come to you. I had Commissioner McPeak here. I don't know, were you in the room for the first panel?

Ms. Cohen. I was.

Mrs. Blackburn. Okay. I'm really concerned about what has happened with taxpayers and the liability there with what took place with the loans and then the solvency grants. And we all should be concerned with that. That is not your money to give away. It is taxpayer money. And this is just money down the hole it appears because

this didn't work. And to go in here and hear from the CO-OPs that they now have these loan conversion options and that these startup loans classified as assets rather than debt, and I don't see how you get there. I mean, doesn't that type loan conversion really give a false picture of what is going on in that CO-OP? Is that not a falsehood?

Ms. Cohen. So, you know, when talking about those conversions, which is what some of the CO-OPs have approached CMS with, we evaluated each of those on an individual basis. And I think you heard Ms. McPeak mention that in that case that was not the right step forward. And we did not go --

Mrs. Blackburn. To have suggested that, is that not giving an inappropriate picture of the financial stability of that CO-OP?

Ms. Cohen. So that was a request by the CO-OP to CMS. We did evaluate whether or not that was the right --

Mrs. Blackburn. So you looked at whether they could call debt an asset.

Ms. Jarmon, let me ask you. In the business world, the private business world, I think if you did that, you'd be accused of fraud, if you started re-characterizing your debts as assets and putting them on your balance sheet as an asset. I mean, I have just never even heard of somebody saying that the Federal Government would approve such a process. How do you all view that?

Ms. Jarmon. I believe that came out in guidance in July of this

year. So it was after we had done our work. We will be looking at it, but --

Mrs. Blackburn. You're going to go back in and review that?

Ms. Jarmon. Yes, we will look at it as part of our followup. It was part --

Mrs. Blackburn. Well, we will appreciate getting that. Is that not an odd business practice? I've never seen this type characterization viewed as being a standard operating procedure.

Ms. Jarmon. It appears unusual. Right.

Mrs. Blackburn. It does appear unusual. And I think that it leads us, Ms. Cohen, to wonder if there are other unusual business practices that are surrounding the stability of the CO-OPs or the lack of stability of the CO-OPs and the entire lack of stability of the Affordable Care Act programs. This is highly unusual.

Vermont Health CO-OP, $33 million in Federal loans had been awarded to the Vermont Health CO-OP. How much, if any, of the money for the Vermont Health CO-OP has been or will be returned to the Federal Treasury?

Ms. Cohen. We work aggressively, if we are winding down any CO-OP, to return funds back to the taxpayer.

Mrs. Blackburn. How much has been returned?

Ms. Cohen. I don't have the number --

Mrs. Blackburn. Would you get that number for us?

Ms. Cohen. I will do what I can.

Mrs. Blackburn. When money is awarded and then they don't get the license to stand up the CO-OP, every penny of that ought to be coming back to the Federal Treasury. And I think you know that.

Ms. Cohen. We work aggressively to recover the loan funds in --

Mrs. Blackburn. I can imagine what the IRS would say if people would: Well, you know, we're going to work to get that money back to you, IRS. We're really working on it.

So we want to see that that comes back. Because I think it is inconceivable that the taxpayers are going to be held responsible for this.

And when should we expect that money? What's your timeline for getting that money back in?

Ms. Cohen. So we're working through that process right now. I don't have --

Mrs. Blackburn. So you've got all this money out here. Ms. Cohen, listen to yourself. You got all this money out here. It is being wasted. Half of your CO-OPs are insolvent, and you've got this re-characterization process going to take your debts and make them appear to be assets. That is highly unusual. And you want to sit here and say: Well, we're looking at it?

When are you doing it? Are you continuing to meet on it every week? Do you have a timeline for coming up with getting this money

back? Is it a top priority?

Ms. Cohen. So my team --

Mrs. Blackburn. Yes. Please read the note that's been passed to you.

Ms. Cohen. So we got all of the money back from Vermont, which -- I would say the rest of the CO-OPs that we've been working with over the last several months, obviously, are still in business. They continue to provide coverage for consumers until the end of the year. And then we'll work through the process at that point in accordance with the loan agreement to recover funds for the taxpayer.

Mrs. Blackburn. Okay. So there is something in process. Thank you.

Ms. Cohen. Thank you.

Mrs. Blackburn. And if you will continue to provide that type of information for us, that is what we need to know, the specifics. It does not help us in doing our due diligence and being certain that people have coverage, it does not help us if you come into a hearing and you cannot say: This is where we are, exactly where we are, and what we're going to do. It is helpful when Ms. Jarmon says: This happened after our July review, and then we're come going to come back in and we're going to look at this very unusual business practice and have a recommendation for you. That's the kind of thing that is helpful.

I am way over my time. I yield back.

Mr. Collins. That's okay. We are missing a lot of our members. So we'll actually maybe ask a few more questions, you know, to dig down a little bit deeper.

And, again, I'd like to kind of just set the stage. All of us up here agree we need to be good stewards of taxpayer money. And that's the purpose of this hearing. Learning from what's happened the last 2 years, and losses have occurred, it sounds like a few CO-OPs are doing okay. You know, half of them failed. There's lessons to be learned here. And I think the purpose of this hearing and our requests for more information will be: How can we take all of that and hopefully not continue to lose taxpayer money?

But, Ms. Jarmon, there is a yes for OIG that the loan agreements, as I understand it, between CMS and the CO-OPs do have provisions in them, enforcement provisions, and I just wondered, could you, you know, explain what some of those provisions might be. And then a very direct question would be, to the best of your knowledge, and then I'll go to Dr. Cohen, have we taken any of these enforcement measures against any CO-OPs?

Ms. Jarmon. Right. The loan agreements do allow -- there's an option to terminate the loan agreements which would require the CO-OP to forfeit all unused loan funds. And there's also within the loan agreement and the funding opportunity, there's the issue of the

enhanced opportunity plans and corrective action plans, which CMS has actually put several of the CO-OPs under enhanced plans and corrective action plans. So those are all part of the loan agreement.

Mr. Collins. Have we terminated -- has CMS terminated any loan agreements?

Ms. Jarmon. I'm not aware.

Dr. Cohen. So we have terminated the loan agreements for those 12 CO-OPs that you have heard that are shutting down. So we have terminated all of those, and we will --

Mr. Collins. Did we get any money back?

Ms. Cohen. So that is the process -- so let me clarify, and I want to make sure for the record I have it right. So, in Vermont, we did get the vast majority of the money. There was some funding that was used in their startup funds that was not recovered. On a go-forward basis, we are making sure that consumers have coverage through the end of the year. These entities will be operating through the end of the year. And at that time, we will do a run-out of claims and understand the financial health of the organization and then use all of our ability with the terms of the loan agreement to recover --

Mr. Collins. Now, but that's not the case in New York. They're not running -- it's my understanding that -- the CO-OP in New York, which lost $250 million in fact is shutting down in 2 weeks' time. So that doesn't --

Ms. Cohen. That's right.

Mr. Collins. -- line up with what your testimony just was.

Ms. Cohen. That is right. So that is why we are doing so much of the hard work right now before this open enrollment period started on November 1 to make sure we understood the financial health of any one of these CO-OPs, is because we want consumers to be confident that there wouldn't be a midyear closure of any one of these CO-OPs.

In the case of New York, we went to wind them down and terminate their loan agreement back in the September timeframe when we sent in our audit team after we even decided to wind them down. We went and found out that their financial situation was even more dire than we understood it to be when we made the decision to wind them down, and that is why we are in this unfortunate situation. I will say that the folks in New York, the Governor's Office, the Department of Insurance, has jumped on this problem and is working it very aggressively to make sure consumers have a smooth transition. And this is exactly why we're doing all of this tough work right now so this doesn't happen in other places.

Mr. Collins. You know, just I purchased a lot of distressed companies in my private sector career. And let me tell you, a bank who then loans money in many cases in what you might call workout or asset-based lending agreements, there's literally daily and weekly reports. And you are under a magnifying glass until that bank who has

money at risk is confident that they're going to be able to be paid back. And it, quite frankly, sounds as though CMS has accepted a lot of information at face value, has not dug very deeply into those details to say: Okay, 2 months later, we're totally shocked the finances are much worse. If somebody was really watching a $250 million loan, day by day and week by week, I don't think you would wake up 2 months later you would have found out 2 months earlier, and maybe we would have lost $200 million instead of $250 million. I think there's lessons learned in that, you know, when you're stewards -- good stewards of taxpayer money, the taxpayers expect a level of scrutiny just at least consistent with what big banks do when they make loans. And, in fact, you could argue maybe it should even be more than that.

So my last few seconds here, another question, I know that there's going to be outstanding claims, as these CO-OPs are shutting down, including New York. Who pays -- I mean, I'm assuming there's no money. Who's going to pay those claims?

Ms. Cohen. So, as I said, the CO-OPs continue to wind down over the course of this year, and they do have funding that --

Mr. Collins. So like take New York. Is there enough money in --

Ms. Cohen. So New York is a different circumstance where they need to wind down by November 30 and then run out those claims after --

Mr. Collins. And they'll have enough money to pay all those?

Mr. Collins. So one of the big things that we did in partnership

with the State Department of Insurance is make sure that they go into receivership. And by doing that, we are able to have better control over their finances and the claims payout as well as --

Mr. Collins. Do you feel as though there will be enough money to out. If there's not, is the government going to make -- you know, the provider, that -- now there's no money. Who has -- how do they get paid?

Ms. Cohen. So we're working -- and as you said, it's a day-by-day type of situation. We're watching very closely to make sure we can --

Mr. Collins. Could there be more taxpayer moneys having to go in as this is wound down?

Ms. Cohen. So our first primary goal is to protect the consumer and the --

Mr. Collins. It should be. Right.

Ms. Cohen. -- and the taxpayer. And so we're going to do everything possible to make sure that we can have a smooth transition. That's a partnership between ourselves and the New York State Department of Insurance. We're working collaboratively in that process to make sure that that --

Mr. Collins. Well, and we would encourage you to continue to do that. And thank you for your testimony.

I'd like to see if Ranking Member DeGette has a few follow-on questions.

Ms. DeGette. Thank you, Mr. Chairman. I just want to -- I want to go back to something that Mr. Morrison said in the previous panel. When we set up the insurance CO-OPs under the ACA, we set them up to help give people who were sicker, who were poorer, who had less of a choice, a choice of an insurance plan. And as we all know quite clearly, the CO-OPs don't have a lot of the same benefits as private insurance companies. They don't have the kind of capitalization from other products and so on. Wouldn't that be a fair statement, Dr. Cohen?

Ms. Cohen. Yes. They face a number of those challenges.

Ms. DeGette. Right. And so when you're -- so when you're -- when you're just starting up some CO-OPs, it's not like you're a private company saying: Okay. Let's offer this new product and we can -- and if it takes us a few years, we can do that. So I really think that the comparison of the CO-OPs to a private business is a little unfair. And that's why I think we set up these three Rs, to try to help the CO-OPs get established and then the concept, Dr. Cohen, was that they would become self-sufficient and they would be able to sustain their business model. Is that right?

Dr. Cohen. I think that those programs were set up to help the entire market transition, CO-OPs amongst them.

Ms. DeGette. Okay. And so I guess I was a little concerned when I heard you say earlier that you were reviewing all of the States' situations on an individual basis. I'm -- and here's why. When

you're -- and I saw this from my end being in Congress where my State thinks in July that the money's going to be sufficient for risk corridor payments. Then they hear in October that, no, that's not going to happen. And they have a real degree of uncertainty with how CMS is viewing that State CO-OP, whether it's -- how they're viewing their capitalization, how they're viewing their viability. And they don't know day to day whether they're going to be able to offer a product in open enrollment period that starts on November 1. So the concern that a lot of us have is where you don't have some kind of a bright line rule, the uncertainty in those States is really contributing to instability in the whole insurance market in those States. I assume you understand those points I'm making.

Ms. Cohen. Absolutely.

Ms. DeGette. And so I'm hoping that you and your staff would be willing to continue to meet with our committee staff on both sides of the aisle to help us figure out how we can help you get some certainty so that we don't have situations where States like New York and Colorado are suddenly going out of business just a few weeks before the open enrollment period, the other providers, including private insurance companies, are scrambling to try to figure out how to absorb this, and the 83,000 people in Colorado, I'm sure it was -- I don't know how many it was in New York, but, you know, this is affecting real lives. And I know you realize that, but I think it would be really helpful if we

could get much more clear standards going forward.

Ms. Cohen. Understand.

Ms. DeGette. Thank you, Mr. Chairman.

I yield back.

Mr. Collins. Thank you. And it was 155,000 in New York.

As we conclude this hearing. I would ask Dr. Cohen if we could get a commitment out of CMS to provide that analysis that resulted in the CMS awarding additional funds to New York's CO-OP and some others the end of 2014.

Ms. Cohen. I will work with the staff to get it confirmed.

[The information follows:]

******** COMMITTEE INSERT ********

Mr. Collins. Thank you. And also if you could commit that CMS will provide us any CO-OP corrective action plans that may exist. I mean, as you've done this analysis, could you forward those to the committee?

Ms. Cohen. I'll have to look and see. Some of those are market-sensitive. But I will -- we will do our best to get what we can to the committee.

[The information follows:]

******** COMMITTEE INSERT ********

Mr. Collins. I thank you for that. And then also I'd like to enter into the record a Wall Street Journal article that does have a quote from CMS that risk corridors were intended to be budget neutral. And I'd ask unanimous consent to enter this into the record.

So moved.

[The information follows:]

******** COMMITTEE INSERT ********

Mr. Collins. As we conclude our hearing, again, I want to, first of all, also say that we would ask unanimous consent that members' written opening statements be introduced into the record.

And, without objection, those documents will be entered into the record.

And I'd like to thank our two witnesses for your comments, as we all want to work together to, again, be good stewards of taxpayer money.

And I would like to remind members they have 10 business days to submit questions for the record. And I ask that the witnesses all agree to respond promptly to those questions.

And, with that, this meeting is adjourned.

[Whereupon, at 2:03 p.m., the subcommittee was adjourned.]