TESTIMONY OF THE LOUISIANA COMMISSIONER OF INSURANCE

Before the Subcommittee on Oversight and Investigations

Committee on Energy and Commerce

United States House of Representatives

Regarding:

"Examining the Costly Failures of Obamacare's CO-OP Insurance Loans"

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James J. Donelon
Commissioner of Insurance
State of Louisiana

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Chairman Murphy, Ranking Member Degette, and Members of the Subcommittee, thank you for inviting me to testify before the Subcommittee on the issue of the Co-Op program, which will without question continue to garner headlines in the months ahead. I hope to share information that you may find useful and look forward to answering any questions you may have.

My name is Jim Donelon and I am Louisiana's elected commissioner of insurance since 2006. Prior to my election as commissioner of insurance, I served as chief deputy commissioner and executive counsel to the commissioner, and served for 19 years as a member of the Louisiana House of Representatives a significant portion of which I served as chairman of the House Insurance committee. I have been a very active member of the National Association of Insurance Commissioners, serving as president of the NAIC in 2013. I am not here today representing the NAIC, but rather the state of Louisiana as its chief insurance regulator.

The Co-Op Loan Program

Louisiana, like many states, has what many regulators might consider to be a non-competitive market for health insurance. In Louisiana, a single health insurance issuer has approximately 70% of all covered lives in all three of the fully-insured markets for major medical health insurance: individual market, small group market, and the large group market. There can be little doubt that the laws of economics are universal and fully applicable to the market for health insurance. A lack of competition can deprive consumers of choice and, potentially, value for their dollars. In addition, a single health insurance issuer having such a large market share can distort the price mechanism within other markets, not just the premium rates for health insurance. And so, it should go without saying that more competition is always better for consumers.

As a caveat, I must inform the committee that I have not shied away in the past from making my position clear: I believed in 2010 that the Affordable Care Act was not the ideal way to address the issue of affordability and accessibility for health insurance. Had I been a member of Congress, in your shoes, I would have voted against the Affordable Care Act. I have said for years that it was rushed through for reasons that all of you are aware of. Any of us who have served in a legislative body knows how hard it can be to whip votes against a clock. And the haste with which the Affordable Care Act was enacted is obvious not only from its numerous legislative fixes, but from administrative fixes that many of us have been hesitant to view as proper. Most importantly, I firmly believe that the regulation of insurance, all insurance, whether health or life or property and casualty, is best left to the individual states. Insurance markets have thrived in this country and they have done so under state regulation. State regulators and state legislatures know their states and their needs better than anyone, and they should continue to be the primary regulators and policy makers for the insurance industry.

Nevertheless, as a professional insurance regulator, it is my duty to enforce state and federal insurance laws. And despite my opposition to the enactment of the Affordable Care Act in 2010, I have endeavored to make sure that the law of the land is upheld. That's my job as an impartial regulator and my constitutional oath as an elected official. And with that in mind, let me say that the Co-Op program established under the Affordable Care Act was a well-intentioned idea. It no doubt had dual goals in mind of consumer-focused insurance companies because consumers were to be ultimately in control of the co-ops, and of increasing competition in the market for major medical health insurance.

The barriers to entry into the health insurance market are high. The start-up costs for entering that market are not easy to meet. Capital is not always plentiful or easy to come by. The destabilization of the market that has occurred in the wake of the Affordable Care Act, particularly the Market Reforms of Title I of the act, such as guaranteed issue and guaranteed renewability without medical underwriting and other rate limitations, has not made market entry look attractive. Indeed, in most states such as my own, more health insurance issuers have exited the market than have entered the market since many of the provisions of the Affordable Care Act have taken effect. For those reasons, any new entrant into the market will generally be looked at with eager eyes by an insurance regulator. The latest data from health insurance issuers bears witness to the difficulties that most insurers have had adapting to the Affordable Care Act's market reforms and limitations: more than half of health insurers suffered losses in the individual market in 2014 according to a McKinsey & Co. analysis of financial filings, despite a rise in the increase of total premium revenues over the prior year's data (2013). All of this to say: the Co-Op provision of the Affordable Care Act held promise, not only for consumers but for insurance regulators who want consumers to get more options and better value for their dollars. But the program that launched 23 start-ups did so at the worst possible time—a time when the market was in upheaval and uncertainty reigned, and to a significant extent, still does.

How the Co-Ops in operation, and those that were formerly in operation around the nation, turned out, has been a disappointment for state regulators and ultimately for consumers and tax payers. I am not here to criticize the Co-Op program, however. I am here to provide information from the perspective of a state insurance regulator who regulated Louisiana's health cooperative and who has now taken possession of the cooperative and placed into receivership, and ultimately, into liquidation. I will do so by addressing four key areas that staff and members have asked me to touch upon, and then by doing my best to answer whatever questions you may have.

1. The Demise of the Louisiana Health Cooperative, Inc.

The first issue I will give some information regarding is the failure of the Louisiana Health Cooperative, which was the second co-op to be subject to receivership activity by a state regulator following the seizure of the co-op operating in Iowa and Nebraska by my colleague and Iowa Insurance Commissioner Nick Gerhart. The Louisiana Health Cooperative was formed as a co-op under the Co-Op program of the Affordable Care Act and was licensed as a health maintenance

organization by the Louisiana Department of Insurance in May 2013, only about a year and a half away from the start of open enrollment for 2014—the first year that the market reforms of the Affordable Care Act were to take effect.

The Louisiana Health Cooperative had secured $13 million in start-up loans from CMS under the Co-Op program, and also secured millions more in solvency loans as its start-up capital. The total commitment from CMS under the Co-Op program to the Louisiana Health Cooperative was just shy of $65,800,000. From the start, the Louisiana Health Cooperative had difficulty preparing for the first open enrollment period in the fall of 2014, which was not overly surprising to us on account of the short time frame between licensing and open enrollment. At the conclusion of the open enrollment period for 2014, the Louisiana Health Cooperative had failed to meet its target enrollment, quite substantially in fact. The rates that were developed for the Louisiana Health Cooperative were designed to achieve certain economies of scale which obviously did not materialize. As a result, the Louisiana Health Cooperative suffered a $20.6 million loss in 2014, with an expense ratio of 35%, which was far out of line with the industry standard.

Furthermore, near the end of the 2014 calendar and plan year, the Louisiana Department of Insurance was alerted to the Louisiana Health Cooperative's failure to give timely notice to its enrollees that many of the existing 2014 health plans offered would not be renewed. Rather, enrollees would have to pick a new plan that would be offered by the Louisiana Health Cooperative, or the enrollees could pick a new plan offered by a different health insurance issuer. Both state and federal law requires at least 90 days notice for plan termination, which was to take effect on December 31, 2014. The Louisiana Health Cooperative, however, had failed to give notice until the first week of December 2014. Most enrollee plans were to terminate on December 31. As a result, enrollees needed to have a new plan in place for January 1. In order for anyone picking a health insurance plan through a federally-facilitated Marketplace, or Exchange, to have coverage on the firs of the month, an enrollee must pick a plan no later than the 15th day of the prior month. As such, by giving notice in the first few days of December, the Louisiana Health Cooperative had given its enrollees only about a week to pick a new health insurance plan. This failure was alarming to us.

During the same time frame, the number of consumer and health care provider complaints filed with the Louisiana Department of Insurance against the Louisiana Health Cooperative were also alarming. The Louisiana Department of Insurance has a process through which anyone, whether a consumer or a health care provider, can file a complaint with the Department of Insurance against a health insurance company, or any other insurer or licensed entity for that matter. Despite having approximately 2-3% of the total market share with its 12,000-15,000 enrollees, the Louisiana Health Cooperative was the target of 27 percent of all complaints received by the Louisiana Department of Insurance against health insurance issuers operating in the same markets in state of Louisiana. These two alarming issues, taken together, compelled state regulators to initiate a full on-site market conduct and financial examination of the Louisiana Health Cooperative beginning in March 2015, following internal preparations and analysis.

Later that same month, March of this year, the Louisiana Department of Insurance had determined that the Louisiana Health Cooperative had triggered several provisions of the state's Hazardous Financial Condition Regulation. The Louisiana Health Cooperative was informed of this on March 30, and was instructed to disclose its current business plan along with financial projections. By May, it was obvious that the Louisiana Health Cooperative had continued to suffer losses in the first quarter of 2015, but had balance sheets showing that the company still had minimum financial reserves required by law. That projection was based upon assumptions regarding monies that were to be received by the company from the premium stabilization programs of the Affordable Care Act, which you are hopefully familiar with—the Transitional Reinsurance Program, the Risk Corridor Program, and the Risk Adjustment Program. On June 30, 2015, after announcements by CMS, it was clear that the Louisiana Health Cooperative was to receive less money from two of these programs than it had projected. In fact, between the two programs, the Louisiana Health Cooperative would have to pay out a total of approximately $5.3 million. This unexpected payable produced a severe strain on the company's balance sheets. That day a team of regulators from the Louisiana Department of Insurance summoned senior executives from the company to a meeting the following day, July 1, 2015. At that meeting, our regulatory staff asked pointed questions about the company's viability, and suggested that the best result for enrollees would be for the Louisiana Health Cooperative to voluntarily wind down its operations over the remainder of the 2015 calendar and plan year, rather than risk insolvency in 2016 and force enrollees to find new coverage in the beginning of the 2016 plan year. Less than a week later, the board of directors voted to wind down the company's operations.

Throughout this time, the full examination of the company continued. During the course of the examination, the magnitude of the operational problems with the Louisiana Health Cooperative came fully into view. As a result, we reached the decision that in the best interests of the enrollees of the Louisiana Health Cooperative, the company needed to be placed into receivership so that the company's limited remaining resources could be conserved and be used to pay claims. We took that action on September 1, 2015. Now, the court-appointed receiver in charge of winding down the affairs of the Louisiana Health Cooperative has the unenviable task of simultaneously trying to wind down a company while trying to correct the many operational problems that contributed to its demise. The financial condition and the ability of the Louisiana Health Cooperative is of particular concern to us because in Louisiana, health maintenance organizations, "HMOs", which this company was organized as, is not subject to the Louisiana Life and Health Insurance Guaranty Association, and as a result, the company is not backed by that guaranty fund. This means that if the company cannot satisfy all of its claims liabilities, enrollees, and mostly health care providers could be stuck with unpaid bills. We are doing everything in our power to make sure that that does not happen.

2. The Relationship between the Louisiana Department of Insurance and CMS

Before I conclude my testimony, I have been asked, and assume you want to hear about the different roles of state and federal regulators that oversaw the Louisiana Health Cooperative. You have heard of the general activity of the Louisiana Department of Insurance as the company's chief

regulator. During our regulation of the Louisiana Health Cooperative, especially following the problems that the company had in giving timely notice of plan terminations to its enrollees at the end of 2014, the Louisiana Department of Insurance had constant and on-going contact with the Co-Op division of CMS, in addition to our permanent, working relationship with the Oversight Division at CMS, which was formerly headed by my colleague, Pennsylvania Insurance Commissioner Teresa Miller. The regulatory staff at the Louisiana Department of Insurance has a close, and effective working relationship with CMS. From January to June of 2015, my office was having constant conversations with officials at CMS in addition to contract examiners employed by CMS with respect to the Co-Op program. We had conference calls with CMS on a regular basis and beginning in June and July of 2015, we had multiple weekly conversations with CMS officials and sometimes daily interactions—all working together to try to determine what would be in the best interests of the company's enrollees. Regulators with CMS were candid in their assessments, shared information with us, and I do believe they viewed us as their partners in protecting consumers, which is one of our primary missions. Our examiners worked with CMS examiners, and in fact, we worked well together and reduced redundancies in the examination of the Louisiana Health Cooperative, which enabled us both to achieve a better picture of the company's operational condition faster than we might otherwise have been able to separately. The continuous contact and information sharing between CMS and the company now that it is in receivership has continued, and I believe, will continue to enable us to more efficiently and effectively wind down the company's operations.

Conclusion

In conclusion, I should like to say that the failure of the co-op in Louisiana and the failure of co-ops in other states, is not an indictment of nor a failure of competition in the market. I cannot speak to the causes of co-op failures in other states. But I can say that the co-op in my state did not fail because it was a co-op. Nor did it fail because the market was perfectly competitive. It is not. Our examination of that company has shown that it had other problems. Any company, whether a co-op under the Affordable Care Act or not, would face similar hazards in this market, especially following the destabilization to the market that the Affordable Care Act has caused. And, I say that not in the political sense, but in the undeniable sense that many of the reforms in Title I of the act have caused destabilization and unpredictability. In retrospect, perhaps it was not the ideal time to be a start-up in health insurance. To the extent that we have worked with CMS in the regulation of our Co-Op, my staff has found that the federal regulators at CMS were professional and proactive. But, as I always will before Congress, I conclude by saying that I continue to believe that the regulation of this industry is, again, best handled by state insurance commissioners.

Mr. Chairman, I did prepare a memorandum for the subcommittee and staff which I offer in support of my testimony.

With that, I conclude my testimony and would be happy to answer any questions you have.

MEMORANDUM FOR MEMBERS OF CONGRESS AND CONGRESSIONAL STAFF MEMBERS

FROM: JAMES J. DONELON, COMMISSIONER OF INSURANCE

RE: THE LOUISIANA HEALTH COOPERATIVE, INC.

This memorandum was requested by Congressional staff members in preparation for hearings to be held on November 5, 2015, by the Subcommittee on Oversight and Investigations of the House Committee on Energy & Commerce. The memorandum addresses four primary areas of concern:

1) A timeline of recent events and relative to the placement of the Louisiana Health Cooperative, Inc., (LAHC) into receivership;

2) The working relationship between the Louisiana Department of Insurance (LDI) and the Center for Medicare and Medicaid Services (CMS);

3) The operational and functional deficiencies of LAHC as viewed through complaint statistics and data; and

4) The issue of any remaining solvency loan disbursals and understandings from CMS regarding such disbursements.

This memorandum is prepared especially with regards to financial information concerning LAHC, with information that is accurate to the best of our current knowledge. Once the LDI finishes its "post-mortem" investigation into the failure of LAHC, a complete understanding of the reasons and circumstances of LAHC's failure will be possible. At the time of this memorandum, the primary concern of the LDI is to continue coverage for the approximately 15,000 enrollees of LAHC and to pay health care providers for enrollee claims.

I. Timeline of Recent Events & Receivership of LAHC

LAHC was licensed by the LDI on May 8, 2013, as a health maintenance organization (HMO) under Title 22 of the Louisiana Revised Statutes of 1950, the Louisiana Insurance Code. Under the relevant provisions of the Louisiana Insurance Code, LAHC had met the minimum qualifications, including the minimum financial requirements, to operate as an HMO in the state of Louisiana. For the sake of brevity, the timeline of events is limited to the recent period during which LAHC's financial deficiencies began to concern regulators.

The LDI experienced regulatory troubles (non-financial) with LAHC in the latter part of 2014 when the LDI discovered that LAHC had failed to give timely notice to enrollees of plan discontinuation as required by state and federal law; plan discontinuation in this

instance meant that LAHC was discontinuing certain health plans that had been sold for the 2014 plan year and were offering to replace those plans with new plans for the 2015 plan year. Although required to give enrollees 90 day notice of the discontinuation of current health plans, LAHC effectively gave enrollees just twelve days notice. The notices were sent to enrollees on December 3, 2014, informing enrollees that their health plans would be discontinued on December 31, 2014. Because enrollees must pick a new plan no later than December 15 to ensure coverage on January 1, LAHC left its members with just twelve days to pick a new health plan. On December 11, 2015, the LDI sent formal notice to LAHC that it would require LAHC to extend coverage into January on existing plans if enrollees did not select new coverage by December 15. This alarming breach of state and federal guaranteed renewability requirements, in addition to LAHC's inordinately high volume of consumer complaints then on file with the LDI, led then-Deputy Commissioner for Health Insurance Korey Harvey to request a market conduct examination of LAHC. After discussions with then-chief examiner Craig Gardner and Deputy Commissioner for Financial Solvency Caroline Brock, it was agreed that a financial and market conduct examination of LAHC would be appropriate in early 2015. After those conversations, LDI market conduct and solvency staff had internal discussions and preparations for the examination. The following timeline of events tracks those preparations.

Date	Description
2-13-15	LDI financial exam division informed LAHC about the upcoming LDI exam.
3-12-15	LDI financial exam division had an internal pre-exam meeting between all other applicable offices and divisions within the LDI to talk about LAHC and any pertinent issues. There were numerous items highlighted by the LDI Office of Health personnel related to complaints and the LDI financial analysis division personnel commented on the financial status of LAHC. LAHC had a net loss of $20.6 million in 2014, a combined ratio of 146% and an expense ratio of 35%. The expense ratio was much higher than the health industry standard which is around 12-15%.
3-16-15	LDI financial/market conduct exam commenced on-site at LAHC.
3-30-15	A Hazardous Financial Condition letter pursuant to Regulation 43 was sent to LAHC by the LDI financial analysis division. In the letter, standards A.2, A.5, A.6, A.14 and A.20 appear to have been triggered. LDI financial analysis division asked for a current business plan along with financial projections for the next two years.
4-8-15	LAHC management had a meeting with the LDI financial analysis division about the Regulation 43 letter than was sent to LAHC.
4-14-15	LAHC formally responded to the Regulation 43 letter related to Hazardous Financial Condition.

4-28-15 LDI Examiner in Charge (EIC) requested the preliminary 1st Quarter 2015 financial statements for LAHC on behalf of the LDI financial analysis division.

5-1-15 LAHC provided the preliminary 1st Quarter 2015 financial statements to the LDI on-site EIC. EIC provided the preliminary financials to the LDI analysis division as well as upper LDI Office of Financial Solvency management. From the financials, a net loss was shown of approximately $5.2 million. Capital and surplus was shown as approximately $9.1 million as of 3-30-15 compared to capital and surplus of $14.3 million at 12-31-14.

However, LAHC personnel did mention that even though they were providing these preliminary financials, LAHC was still waiting on the first quarter Incurred But Not Reported (IBNR) and the 3R (Risk Adjustment, Reinsurance and Risk Corridor) information from their independent actuaries, Buck Consultants, and that the numbers could change. The 1st Quarter Statement was not due until 5-15-15. LDI Office of Financial Solvency was trying to be proactive and access critical data sooner rather than later to see if a potential insolvency was developing.

5-11-15 LDI Office of Financial Solvency personnel had an internal discussion about LAHC and its financial status between the LDI financial analysis and financial exam divisions. The purpose for the meeting was reviewing and discussing the preliminary 1st Quarter 2015 financials provided on 5-1-15. LDI General Counsel and LDI Deputy Commissioner of Office of Health attended as well.

5-12-15 LDI Office of Financial Solvency granted an extension to LAHC to file the 2015 1st Quarter Statement by May 22, 2015.

5-14-15 LDI Office of Financial Solvency granted an extension to LAHC to file the 12-31-2014 audited financial statements by July 31, 2015.

5-19-15 LDI Office of Financial Solvency granted another extension to LAHC to file the 2015 1st Quarter Statement by May 29, 2015.

5-29-15 LAHC provided the official 1st Quarter 2015 financial statement with the LDI. From the financials, a net loss of $968,000 was reported compared to the preliminary number provided on 5-1-15 of negative $5.2 mil. The capital and surplus was $13.3 million compared to $9.1 million provided on 5-1-15. LAHC provided a detailed explanation of the differences, which were related to IBNR and the 3R receivables calculated by Buck Consultants.

May-June 2015 LDI Life & Health actuary, Chief Examiner and EIC reviewed, performed analysis and discussed the paid claims data from 1-1-15 to 5-31-15. The IBNR hindsight testing and the completion factors used to project the ultimate paid claims for LAHC was showing that the IBNR reported for

12-31-14 was understated by approximately $6 million. In other words, the LDI Life & Health actuary was going to recommend an adjustment for the exam report of approximately $6 million to the 12-31-14 claims unpaid amount reported as part of the 2014 Annual Statement.

6-30-15 LAHC was informed by CMS that the Risk Adjustment receivable for 2014 and the Reinsurance receivable for 2014 would be materially different than what LAHC was reporting to the LDI. The net difference between the two categories was an approximate negative $5.3 million that LAHC had not been expecting to pay to CMS. LAHC management believed that they would receive net positive monies from CMS instead of paying into the premium stabilization program created by the Affordable Care Act.

7-1-15 LAHC management was called to the LDI for an emergency meeting with the LDI Office of Financial Solvency related to the CMS announcement on 6-30-15 relative to the Risk Adjustment and Reinsurance receivables. LDI Office of Financial Solvency management asked if LAHC would survive given the developing circumstances. LAHC management asked for time to discuss their financial position with the LAHC Board and then a response would be provided to the LDI.

7-6-15 LDI Office of Financial Solvency sent a letter to LAHC to ask follow up questions regarding the Regulation 43 letter that was responded to by LAHC on 4-14-15.

7-7-15 The LAHC Board decided to elect to voluntarily wind down LAHC operations and to not participate on the Federal Facilitated Marketplace (FFM) for 2016.

7-21-15 LAHC management came to the LDI to discuss the voluntary wind down plan.

7-29-15 LDI issued an Administrative Supervision Order, which limited LAHC's ability to conduct major transactions and certain special transactions without notice to the LDI.

8-3-15 LAHC contract attorneys provided the LAHC wind down plan and budget to the LDI Office of Financial Solvency.

8-5-15 LDI EIC, LDI Administrative Supervisors and Deloitte consultants representing CMS provided LAHC with a document as a response to LAHC's wind down plan submitted on 8-3-15. All parties wanted more in-depth responses than were submitted with the original wind down plan.

8-10-15 LDI EIC visited Group Resources, Inc., LAHC's TPA in Duluth, GA to review the TPA operations related to claims handling and member services. A Deloitte representative accompanied the LDI EIC on the trip.

August 2015 Numerous meetings were held between LAHC management, LDI personnel and CMS representatives (Deloitte). The meetings were related to the plan of action of winding down the operations and the financial projections concerning having enough cash to pay claims and other obligations.

In addition, discussions were held regarding converting the $13 million loan from a liability to a surplus note, and if LAHC would receive the other $9.25 million under the CMS loan agreement.

8-26-15 CMS notified LAHC management that LAHC's request to obtain additional monies under the loan agreement was denied. Also, the $13 million start-up loan was not going to be converted from a liability to a surplus note.

8-28-15 LAHC provided the LDI Office of Financial Solvency with a revised and more in-depth wind down plan than what was provided on 8-3-15. The plan was shared with CMS and Deloitte representatives, all of whom determined that LAHC should not continue to operate under its management.

9-1-15 LDI obtained a signed Receivership Order from the 19th Judicial District Court in Baton Rouge, LA, under which LAHC's management was terminated and LAHC was placed into the possession of the Commissioner of Insurance through the court-appointed receiver.

II. Working Relationship between the LDI and CMS

Prior to the state and federal guaranteed renewability violations detailed in Section I above the Co-Op Division of CMS regularly reached out to the LDI through its Office of Health Insurance to inquire if there were any state regulatory issues with LAHC that CMS should know about or could assist in resolving. Because of the close working relationship between state and federal regulators at CMS both in the Co-Op Division as well as in the Enforcement Division, the LDI was able to obtain immediate assistance from CMS when resolving the guaranteed renewability violations in December 2014. As the LDI geared up for its full examination of LAHC, the LDI made CMS aware of the impending examination and the two agencies agreed to share any pertinent information that might lead to examination determinations or results. From January through June 2015, the LDI and CMS held conference calls at least once a month to discuss both market conduct and financial examination results. By July 2015, the LDI, CMS, and CMS contract examiners, were holding conference calls at least twice per week and were communicating regularly via e-mail in between conference calls. Once LAHC was placed into receivership, LDI staff slightly reduced its participation in the twice weekly conference calls with CMS that are now lead by LAHC's receiver, Mr. Billy Bostick. The LDI regulatory staff continues to regard the CMS regulatory staff as consummate, professional regulators, and in the performance of their duties, they partnered with LDI regulators in the mission of enforcing the relevant provisions of the Affordable Care Act and protecting consumers.

III. Complaints against LAHC

A. Complaint Data from the LDI

Complaint data against LAHC has two primary sources: the LDI and LAHC. The LDI accepts consumer complaints of all kinds against any entity that it regulates (insurers, agents/brokers, third-party administrators, self-insured funds, etc., etc.) and processes those complaints in a manner aimed at resolving the complaint. Prior to a reorganization of the LDI in July 2015, all complaints against LAHC were handled by staff of the Office of Health Insurance, and since reorganization all complaints are processed by the Office of Consumer Services. Regardless of the date of a complaint or which office processed the complaint, all complaints are processed and tracked in the same manner. Under certain circumstances, including volume or repeated subjects, complaints may lead the LDI to commence either a market conduct exam or a financial exam of an insurer, or both.

LAHC was the subject of an inordinately high amount of consumer complaints to the LDI from January 1, 2014 through July 1, 2015. During that time frame, of the six major health insurers writing major medical business, LAHC was the target of 221 complaints, 27 percent of all consumer complaints despite having 1-3% of total market share of the individual and small group markets combined. No other insurer had achieved so great a disparity between market share and complaints during that time frame.

The primary reasons for the filing of consumer complaints with the LDI against LAHC since July 1, 2014 include:

1) Complaints by health care providers that claims for payment have not been made or not been made timely;

2) Complaints by enrollees of LAHC that the enrollees received termination notices for failure to remit premiums despite enrollees having remitted premiums and those premiums having been deposited into LAHC accounts;

3) Complaints by enrollees or their health care providers that prior authorization requests are not adjudicated timely;

4) Complaints by enrollees that they did not receive insurance cards and other enrollment materials following enrollment;

5) Particularly following the placement of LAHC into receivership, enrollees have complained that health care providers have refused to continue treatment of enrollees, although the court-appointed receiver has significantly ameliorated provider concerns and substantially reduced outstanding unpaid claims.

The five most frequent complaint issues recounted above all derive primarily from functional and operational deficiencies at LAHC that are linked to its operational management and its third-party administrator (TPA). LAHC engaged the services of a TPA that had limited experience with individual market health insurance administration, which is substantially different to administer than group health insurance. Additionally, the

TPA was unprepared for the volume of this vastly different administration required for individual market policies. Few health insurers process health claims through paper forms; most health claims are electronically transmitted from health care providers to insurers or their TPAs. However, approximately 80 percent of health claims from providers LAHC were received on paper forms per LAHC instructions to providers. This is not in line with widespread industry practice, nor was the practice by LAHC's TPA of manually adjudicating all claims. These two practices made it virtually certain that few claims by health care providers would be adjudicated and paid within the timeframe required by state law, which is a maximum of 45 days for non-electronic claims. Failure to timely pay claims subjected LAHC to statutorily-mandated interest payments to providers of 12 percent per annum. The LDI has the statutory authority and responsibility to regulate insurers with respect to Louisiana's prompt payment of health care provider statutes.

B. Complaint Data from LAHC

Separate and apart from complaints received by the LDI, LAHC also receives complaints from its enrollees and health care providers directly and from the federally-facilitated Marketplace (FFM) through its Health Insurance Casework System (HICS). The single largest reason for complaints since January 1, 2015, is issuer enrollment or disenrollment complaints, which constitute approximately 65% of all complaints received by LAHC. There is an enormous misalignment of data between CMS and LAHC's TPA, in addition to a lack of communication between the FFM technology and LAHC's technology as utilized by LAHC's TPA. The enrollment/disenrollment problems include members who allegedly enrolled but cannot be found in electronic systems, renewal failures, errors on CMS-created tax records, and other less frequent issues.

The primary reasons for enrollee complaints filed with LAHC directly and through HICS since January 1, 2015 include:

1) Complaints from enrollees that they have not been properly or timely enrolled;

2) Complaints from enrollees that they have paid their premiums but have not had coverage initiated;

3) Requests in the form of complaints from enrollees to have their coverage reinstated after wrongful termination;

4) Requests from enrollees to have their coverage terminated; and

5) Complaints from enrollees that their advanced premium tax credit was not properly calculated.

In addition to complaints from enrollees, LAHC separately tracks and processes complaints from health care providers. Since January 1, 2015, LAHC has received nearly 1,000 calls from health care providers. Despite the large number of calls, most calls centered on two primary issues:

1) Provider disputes (unprocessed claims; delayed prior authorizations; and claims re-pricing); and

2) Provider network issues (provider confusion over changes in LAHC's leased network of health care providers; issues over participating and non-participating provider status; confusion on where to submit claims, etc.).

IV. Financial Snapshot of LAHC and Future Solvency Loan Disbursements

Filed 2014 financial statements for LAHC in February 2015 based on information received from LAHC's consulting actuaries showed a net loss of ($20,665,020). This information also included a projected receivable through the Risk Adjustment Program of $2,799,840, the Risk Corridor Program of $2,112,537 and the Transitional Reinsurance Program of $4,948,537.

Monthly financial statements showing a loss of ($1,753,498.83) for January 2015 and a loss of ($161,311) for February 2015 were prepared for the LDI.

Shortly thereafter, LAHC received revised information from consulting actuaries for unpaid claims liability, projected commercial and Transitional Reinsurance, Risk Adjustment, Risk Corridor and terminal claims liability. This information included a projected increased amount to be received for Risk Adjustment, Risk Corridor and Reinsurance. LAHC increased Risk Adjustment receivables by $1,055,170 and increased Risk Corridor receivables by $2,082,662. LAHC also increased Reinsurance receivables by $1,444,506 for a total increase in receivables of $4,582,338. This resulted in a net income for the month of March 2015 in the amount of $946,600.

April 2015 financial statements showed a loss of ($1,160,575).

May 2015 financial statements showed a loss of ($879,639).

On June 30, 2015, LAHC received the actual numbers for Transitional Reinsurance and the Risk Adjustment Program. The report showed a receivable for Transitional Reinsurance in the amount of $9,878,052.34, which was a net increase of approximately $4,785,009. Risk Adjustment showed a payment due in the amount of ($7,493,608.15). This resulted in a difference of ($10,293,448.15) as of June 20, 2015. LAHC also received revised 2015 projected numbers from its consulting actuaries for the Risk Adjustment payable amount of ($5,800,413), Risk Corridor receivables in the amount of $4,389,192 and Reinsurance receivables in the amount of $1,713,666 which resulted in a total net loss for June 2015 in the amount of ($11,168,463.47).

July 2015 saw an increased claims expense and a decreased Advanced Premium Tax Credit (APTC) received due to decreasing paid membership which resulted in a total net loss for July 2015 in the amount of ($4,187,950).

August 2015 saw an increased claims expense and more decreased APTC received as well as an increased IBNR projection by CMS Consultants which resulted in

an increase of IBNR of $4,835,318. These differences resulted in a net loss for August 2015 in the amount of ($10,786,621).

In September 2015, LAHC received notification that the Risk Corridor receivables would be paid at 12.6% of expected receivables. With this information LAHC made the adjustment to reduce the Risk Corridor receivables to 12.6% of the amount expected for 2014 and removed the expected receivables for 2015. This resulted in a net decrease to Risk Corridor receivables of ($8,364,134) for both years. That change resulted in a net loss for September 2015 in the amount of ($7,270,740) for a Year to Date loss of ($36,422,199).

Billy Bostick, the court-appointed receiver of LAHC, had conversations with CMS officials on September 1, 2015. During those conversations, Mr. Bostick inquired if the remaining $9,250,000 in solvency loans committed to LAHC could be disbursed in order to satisfy LAHC obligations. In that conversation, officials with CMS assured Mr. Bostick that if a final disbursement were needed to satisfy obligations, the disbursement would be made. However, CMS would not agree to put that commitment in writing.

In addition to conversations with Mr. Bostick, CMS made several representations during the month of August to LDI Deputy Commissioner for Financial Solvency Caroline Brock that a disbursement could be made to satisfy LAHC obligations. Particularly, in one conversation in late August 2015 with officials of CMS, CMS made clear representations to LDI staff, including Ms. Brock, Deputy Commissioner for Health, Life, & Annuity Korey Harvey, and then-chief examiner Craig Gardner, that CMS would not disburse any remaining solvency loans if LAHC's present management remained in place. Due to LAHC's deteriorating financial condition and the lack of confidence that both the LDI and CMS had in LAHC's management, this conditioned representation provided the final impetus for the LDI to terminate its administrative supervision of LAHC and to formally commence receivership of LAHC.

Mr. Bostick intends to formally request disbursement of the remaining $9.25 million of solvency loans no later than November 2, 2015.