

16 of 23 ACA CO-OPs Closed (Part One of a Two-Part Series)

The *Consumer Operated and Oriented Plans* (CO-OPs) created under the *Patient Protection and Affordable Care Act* (ACA), which were designed to lower costs for consumers and increase competition within health insurance markets,¹ have been fraught with issues. Currently, more than two-thirds of the 23 CO-OP health insurance providers created since 2010 are no longer operational, with only seven remaining to date.² Healthcare experts believed that certain features of CO-OPs, such as requirements for reinvesting profits into their plans to further decrease premiums, would allow CO-OPs the opportunity to increase competition within healthcare markets by offering consumers an alternative to commercial insurers.³ However, numerous factors, both legislative and market-based, have prevented satisfaction of this goal, including: insufficient premium revenues; competition from larger, more established health insurers; and, the risk corridor shortfall.⁴ Many of these factors stemmed from extensive changes to the framework of the CO-OP program after the ratification of the ACA, casting doubt on arguments by various commentators that such failures are directly attributable to the ACA.⁵

This two-part *Health Capital Topics* series will examine the current status of the CO-OP program and its impact on ACA efforts to increase access to healthcare for millions of Americans. The first installment of this two-part series will describe the CO-OP model and discuss the numerous factors that have contributed to many of these plans suffering financial losses and/or ceasing operations. The second installment of this series will discuss the implications of the struggles of the CO-OPs on the health insurance market and how, if at all, these closures reflect on the ACA's efforts to improve access to, and competition in, the health insurance market.

Section 1322 of the ACA established the CO-OP Program,⁶ which supports the creation of federally funded,⁷ non-profit health insurance issuers⁸ owned by its members, whom elect a board of directors, a majority of which must also be members of the CO-OP.⁹ Under the ACA, the specific purpose of the CO-OP Program is to “foster the creation of qualified nonprofit health insurance issuers”¹⁰ tasked with “offer[ing] competitive health plans in the individual and small group markets.”¹¹ As state-licensed health insurance carriers, CO-OPs may sell health insurance plans on the health

insurance exchanges or on the open market, offering coverage to *individuals, small groups*, and, depending on the state, *large groups*.¹² If offering insurance to *large groups*, defined as covering more than 100 people,¹³ CO-OPs are limited to having “no more than a third” of its policies in the large group market.¹⁴ In the absence of shareholders, the profits generated by the CO-OP are “reinvested in the plan to lower premiums or improve benefits”¹⁵ as a means to improve consumer access to comprehensive, affordable health insurance policies. Of the 147 CO-OP Program applications submitted, the *Centers for Medicare and Medicaid Services* (CMS) selected 24 applicants to receive federal loans and establish CO-OP plans¹⁶

The implementation of the CO-OP Program has been marked by numerous changes since the program's creation under the ACA. First, on April 15, 2011, Congress, which initially approved \$6 billion in start-up loans for the program, passed the *Department of Defense and Full-Year Continuing Appropriations Act*, which reduced the total allocation of funds to the program to \$2.4 billion.¹⁷ Second, the *American Taxpayer Relief Act of 2012* cancelled the original funding made available to create new CO-OPs, eliminating the possibility of establishing new CO-OPs after the initial 24 successful applicants.¹⁸ Third, in 2013, Vermont's insurance commissioner denied a license to the state's CO-OP before the plan began selling its health insurance product, which reduced the number of active CO-OPs to 23 in 2014.¹⁹ Finally, the *U.S. Department of Health and Human Services* (HHS) issued a final rule in March 2014 indicating its intention to implement the risk corridors program, a price stabilization instrument created within the ACA that paid a subsidy to health insurers who inaccurately priced their health insurance offerings on the exchanges,²⁰ “in a budget neutral manner,”²¹ decreasing the availability of funds to be paid out under this program.

These changes contributed to a rocky roll-out for the CO-OPs. The 23 remaining CO-OPs enrolled 400,000 people in the 2014 open enrollment period, and, by the end of the 2015 open enrollment period, more than one million beneficiaries had enrolled in a CO-OP program.²² Despite the increase in enrollees, HHS “found that 19 of the 23 CO-OPs had exceeded their 2014 calendar year projected losses as reported in the loan award

*application feasibility studies.*²³ The CO-OPs reported combined losses of approximately \$376 million in calendar year 2014²⁴ and, to date, the CO-OPs have lost approximately \$1.55 billion.²⁵ As of July 2016, 16 CO-OPs have closed in Arizona, Colorado, Connecticut, Illinois, Iowa/Nebraska, Kentucky, Louisiana, Michigan, Nevada, New York, Ohio, Oregon (2), South Carolina, Tennessee, and Utah.²⁶ Of the seven remaining CO-OPs, which cover approximately 350,000 individuals,²⁷ the majority of them are proposing “*steep premium increases*” for the 2017 enrollment period.²⁸

A December 2015 report by the Commonwealth Fund lists seven factors that may have contributed to the CO-OP shutdowns, including:

- (1) “*Critical health plan functions;*”
- (2) “*Marketing;*”
- (3) “*Benefit design;*”
- (4) “*Pricing Strategies;*”
- (5) “*High vs. low enrollment;*”
- (6) “*The ACA’s premium stabilization programs;*” and,
- (7) “*Adjusting to market conditions.*”²⁹

In particular, implementation of the ACA’s “*premium stabilization*” programs, which are provisions designed to help alleviate the risk and uncertainty associated with entering into the health insurance market and setting premium prices, negatively influenced the financial stability of many CO-OPs.³⁰ First, the implementation of the *risk corridor program* in a “*budget neutral*” manner created a revenue shortfall to fund the program, which prevented many health insurers from receiving payments that may have stabilized their operations. Specifically, HHS stated that, out of the \$2.87 billion in submitted risk corridor requests, only \$362 million has been raised through charges from insurance issuers to pay requests.³¹ Due to this shortfall, HHS advised that the agency would only be able to pay one out of every eight dollars requested to be paid under the program.³² This decision by HHS disproportionately impacted CO-OPs, because many of these organizations lacked a large capital base

or diverse revenue streams to overcome such losses.³³ Second, the *risk adjustment program*, which works to reduce the incentives for insurers to avoid enrolling sicker than average individuals,³⁴ burdened some CO-OPs with healthier patient pools relative to other insurers, as the program required them to make payments to other, larger insurers with less healthy patient pools.³⁵

Outside of the legislative structure of the program, CO-OPs also had the challenge of determining the initial and subsequent prices of their products and services.³⁶ Due to limited historical claims data from which to determine actuarially appropriate premium costs, the pricing strategy chosen by many CO-OPs often depended on the pricing strategy of larger insurance providers, such as *Blue Cross Blue Shield (BCBS)*, and, if the strategy chosen was not competitive with the plans of larger insurers, the CO-OP generally achieved lower enrollment.³⁷ Additionally, CO-OPs that offered platinum level plans attracted sicker enrollees because the lower out-of-pocket costs associated with these plans were more appealing to enrollees with significant health needs;³⁸ inappropriate pricing of these plans led CO-OPs who made this mistake to suffer losses due to being forced to pay more for treatment than total revenue received from premiums. Finally, enrollment figures for CO-OPs were widely dispersed, which contributed to the closure of many CO-OPs that experienced lower than anticipated enrollment.³⁹ Over half of the CO-OPs failed to meet their enrollment goals for 2014 and 2015, and some plans were unable to generate enough revenue to cover their fixed costs.⁴⁰

Since the 2010 passage of the ACA, the number of operational CO-OPs has drastically decreased, calling into question the viability of the program. The legislative and market-based factors attributed to the struggles of these CO-OPs may have directly, or indirectly, caused the difficulties and failures of many CO-OPs.⁴¹ The final article of this *Health Capital Topics* two-part series will discuss the implications of the CO-OP closures on the health insurance market and how these closures impact the ACA’s efforts to improve access to, and competition in, the health insurance market.

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