Bill Eggbeer

a race against time

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The survival of CO-OPs in the health insurance marketplaces may depend on CMS’s willingness to make changes to its risk/premium stabilization programs, collectively known as the “Three R’s.”

One of the primary aims of the Affordable Care Act (ACA), in addition to expanding coverage to the uninsured, was to transform the nation’s insurance markets. This goal was to be achieved through the creation of health insurance marketplaces that would provide individuals and small businesses with alternative products priced more affordably than plans sold by established insurance companies. The opening of the federal and state marketplaces, the individual mandate, premium subsidies, and the availability of start-up and solvency loans for new state-level health plans, called consumer-operated and oriented plans (CO-OPs), allowed many new carriers to enter the market rapidly.

During the 2014 open-enrollment period, about 25 percent of the 282 carriers offering health plans on the exchanges were new entrants. About 17 percent had prior insurance experience but no such experience in the individual markets where they were offering plans, and 10 percent had no insurance experience at all, according to a September 2015 report by McKinsey & Company. The report also notes that in the 2015 open enrollment period, 333 insurance carriers competed, with some 28 percent new to their state’s individual insurance market. A similar number of carriers will be competing in the 2016 market as competed in the 2015 market: The report notes that 14 new carriers will enter the individual market and 10 will leave.

The most idealistic of the new health insurers have been the not-for-profit CO-OPs established by section 1322 of the ACA, which were designed to be a consumer-friendly counterbalance in markets typically dominated by Blue Cross Blue Shield and/or other commercial giants such as United, Aetna, and Cigna. CMS provided $2.4 billion in start-up and solvency loans for

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CO-OPs, of which 25 were launched in 23 states. Unlike some new provider-sponsored narrow-network plans, which focus on more local markets, the majority of the CO-OPs offered statewide plans.

The good news has been that, despite the botched 2014 open-enrollment period, the CO-OPs launched under the ACA had enrolled 400,000 members at the end of the period, and 1 million by the end of 2015 open enrollment. CO-OPs are providing new products to consumers on the health insurance marketplaces, and in several states have provided the only statewide alternative to a single commercial carrier. A McKinsey & Company analysis of 2014 product offerings on the marketplaces indicated that “among new entrants, CO-OPs emerged as price leaders, offering 37 percent of lowest-priced products in the 22 states where CO-OPs are present.”

The widely reported bad news has been that CO-OPs and provider-sponsored start-ups have been disappearing from the market. In an article in the Nov. 3 issue of The Washington Post, staff writer Amy Goldstein reports that more than half had closed or withdrawn from the marketplaces for 2016. The failures leave the Centers for Medicare & Medicaid Services (CMS) with nearly $1 billion in start-up and solvency loans that may never be repaid. More than 740,000 people will need to find new coverage.

Experts feel that the marketplaces will not be sustainable until 75 percent of the eligible population has coverage. Yet according to projections released in October by the U.S. Department of Health & Human Services (HHS), only 10 million people are expected to have coverage in 2016—not many more than the 9.9 million who had coverage in 2015. Given this lack of growth, many carriers will feel pressure to raise prices to cover the medical loss shortfall incurred in 2015. The closing of many CO-OPs will exacerbate this problem by removing competition from the market.

**Why the Health Insurance Marketplaces Are Hostile to Start-Ups**

Most incumbents and new entrants lost money in the health insurance marketplaces in 2014. A total of $3.5 billion in individual-market losses (on and off the exchanges) were reported, with 68 percent of all carriers losing money, according to the previously cited report by McKinsey & Company. The market is highly dynamic and is affecting large Blue Cross Blue Shield Plans as well as CO-OPs and start-ups. Blue Cross Blue Shield of North Carolina lost $125 million in its first year of operation on the exchange; Blue Cross Blue Shield of New Mexico pulled out of the exchange entirely when the state insurance commissioner denied its request for a roughly 50 percent rate hike.

Ironically, a number of the early failures have been among the most successful plans in gaining new membership. The Iowa-Nebraska CO-OP, which had more than 120,000 members and enjoyed the support of three Republican senators, became insolvent in early 2015 and shut down. In September, New York’s Department of Financial Services ordered Health Republic Insurance Company of New York, a CO-OP that had enrolled 200,000 members, to end its policies by Dec. 31—and in early November, the state agency announced it would be in the best interest of consumers to accelerate the CO-OP’s closure to Nov. 30. October saw a number of closings, starting with the Kentucky Health CO-OP, which had outperformed its rivals on the Kentucky exchange and enrolled 51,000 members. Tennessee, Colorado, and Michigan followed suit.

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with Michigan closing after the 2016 enrollment period opened. The Nevada and Louisiana CO-OPs had closed earlier.

The Kentucky program, like most CO-OPs, priced its premiums low to attract new patients, enrolling 75 percent of the people who sought coverage on the state exchange. It had pared its losses to $4 million this year, down from $50 million the year before during its start-up, and received approval for a 20 percent rate hike. However, the CO-OP’s budget was dependent on getting more funding from the CMS risk-corridor program, which is designed to limit insurance issuers’ losses (and gains) for a three-year period in the individual and small group marketplace.

The risk corridors program, according to CO-OP leaders, has played a major role in start-up closures. Insurers had asked CMS for $2.87 billion to cover start-up losses for 2014, but CMS received only $362 million in payments from insurers under the risk-sharing formula, and lacked the authority to transfer funds from other sources to make up the difference. As a result, Kentucky decided it had to close down after requesting $77 million and finding it was to receive only $9.7 million “In the plainest of language, things came up short of where they need to be,” said Glenn Jennings, the Kentucky CO-OP’s acting CEO.

The various CO-OP closures could have much broader ripple effects than just disrupting insurance for more than 700,000 CO-OP plan members. In an article in the Oct. 10 issue of The Washington Post, Goldstein points to research indicating that insurance premiums in states where CO-OPs operated were 9 percent lower than premiums in other states. This edge may be lost.

**“Three R’s” Program Viewed as Threat to Survival of CO-OPs and Start-Ups**

The steep losses recorded by new insurers can be attributed in part to the fact that some programs had to pay high rates for hospital and physician services, and pricing was more difficult for them because they lacked the volume of historical claims data that established plans have. Some also priced premiums at or below breakeven to gain market share and then quickly saw their medical costs overwhelm their premiums and reserves due to pent-up demand.

But the main cause of the current failures, according to Martin Hickey, MD, CEO of the New Mexico Health Connections CO-OP and chairman of the Board of the National Alliance of State Health CO-OPs, is the requirement for payment transfers under CMS’s three-pronged risk/premium stabilization program. The so-called “Three R’s Program” was created under the ACA to help start-up plans through their vulnerable first years of operation, and to stabilize premiums inside and outside the marketplaces. The “Three R’s” are as follows.

**Reinsurance.** The three-year Transitional Reinsurance Program was established to provide funding from 2014 to 2016 for all insurance issuers to cover high-cost claims from about $45,000 to $250,000. It has been viewed as being helpful to CO-OPs and start-ups, but expires in 2017 and will leave a hole in some CO-OP budgets that may require price increases to fill.

**Risk adjustment.** The Risk-Adjustment Program—the only permanent program among the Three R’s—provides payments to health insurance issuers that disproportionately attract higher-risk populations, such as individuals with chronic conditions. It transfers funds from plans with relatively lower-risk enrollees to plans with relatively higher-risk enrollees to protect against adverse selection according to a federal risk adjustment methodology similar to the year-end risk adjustment provided for Medicare Advantage.
plans. Although this provision was intended to stabilize the market, it has been most beneficial to large, established plans. Because many of the new plans had no access to historical diagnoses, and because only diagnosis and not cost was part of the risk-adjustment formula, they have had to contribute payments of as much as 50 percent of their premiums to a risk-adjustment pool that has been paid largely to big commercial carriers, such as UnitedHealthcare and some Blue Cross plans, which have done a good job in combining historical diagnosis data with documentation and coding of their patients’ illnesses. New plans, of course, do not have previous claims.

**Risk corridors.** The Temporary Risk Corridors Program was created to protect against inaccurate rate-setting by sharing gains and losses between CMS and qualified health plans. Under the risk and gain-sharing formula, CMS agrees to pay a portion of insurers’ losses if their claims and quality improvement costs exceed a certain targeted amount. If the insurers in the marketplaces spend less than a targeted amount for claims and quality improvements, they pay the government a percentage of the difference. However, Congress passed legislation this year mandating that this program be budget-neutral, prohibiting CMS from transferring funds from other sources to make risk corridor payments in excess of the funds paid in by the more profitable carriers. As noted previously, the $2.87 billion in risk corridor request for losses far exceeded the $362 million collected from insurers. As a result, CMS announced in a letter to the CO-OPs on Oct. 1 it would be able to fund only 12.6 percent of the losses requested, triggering the closure of those CO-OPs that had been counting on more relief.

Some observers believe that if the government had made greater risk corridor payments, it would have simply provided CO-OPs and other start-ups a longer runway to sell coverage at unsustainable prices. Hickey and other disagree.

“CMS’s failure to fix the ‘Three R’s’ makes the market toxic for all start-ups and CO-OPs in particular,” Hickey says. “We are in a race against time to get things turned around.”

**CMS Leadership Required**

The survival of the remaining CO-OPs, and quite possibly other provider-sponsored start-ups, will require more aggressive leadership from CMS, which seems surprisingly unconcerned, given the high stakes. True, CMS has allowed a few CO-OPs to convert their short-term start-up loans to long-term solvency loans, which provides some financial relief, but this solution does little to provide the capital CO-OPs need to grow. Moreover, CMS still requires the CO-OPs to maintain risk-based capital reserves equal to 500 percent of their outstanding claims, which far exceeds many state standards.

“The reality of this business is it’s just tough,” says Kevin Counihan, director and marketplace CEO for CMS’s Center for Consumer Information and Insurance Oversight, quoted in Goldstein’s Oct. 10 Post article. Counihan, who is charged with overseeing the federal marketplace, also said, “On balance, the CO-OPs are working. Are they working uniformly? No.”

The CO-OPs see it differently. A coalition of approximately 40 CO-OPs, other start-up insurers, and new-benefits providers are forming a coalition to consider legal action to try and change the “Three R’s” provisions of the ACA that they say threaten their survival. “If the risk-adjustment formula continues without change,” says Martin Hickey, “it is going to wipe us all out.”

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**About the author**

**Bill Eggbeer, MBA,** is managing director, BDC Advisors, LLC, Miami, and a member of HFMA’s Maryland Chapter (Bill.eggbeer@bdcadvisors.com).

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n. BDC Advisors Interview with Martin Hickey, Oct. 14, 2015.