DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

*Administrator*
Washington, DC 20201

FEB 13 2013

The Honorable Tom Coburn, M.D.
United States Senate
Washington, DC 20510

Dear Senator Coburn, M.D.:

Thank you for your letter regarding the Consumer Operated and Oriented Plan (CO-OP) Program authorized by Section 1322 of the Affordable Care Act. Secretary Sebelius asked me to respond on her behalf.

The CO-OP Program has provided low-interest loans to eligible private, nonprofit groups to help establish and maintain new health plans. CO-OPs are directed by their customers and designed to offer individuals and small businesses additional affordable, consumer-friendly, high-quality health insurance options. Starting January 1, 2014, CO-OPs will offer health plans through Affordable Insurance Exchanges, the new, competitive health care marketplaces in each state. In addition to offering health plans through an Exchange, CO-OPs may also offer health plans outside of an Exchange.

In implementing the CO-OP program, we are working to provide consumers with more meaningful choices in the health insurance market. Competition and choice are important tools in making health care more affordable and improving the quality of care. As noted by the American Medical Association and others, health insurance markets are increasingly concentrated, leaving consumers and health care providers with fewer choices. The result can be higher prices and lower quality for consumers. Market concentration and the amount of capital necessary to satisfy state solvency standards create significant barriers to entry for new insurance companies.

Congress appropriated $3.4 billion to implement section 1322 of the Affordable Care Act. To date, nearly $2.0 billion has been awarded to nonprofit entities in 24 states, while 90 percent of the unobligated balance of funds was rescinded as of the date of enactment of the American Taxpayer Relief Act of 2012. Although the Centers for Medicare & Medicaid Services (CMS) no longer has the authority to make loans to new borrowers, CMS will continue to provide assistance and oversight to existing CO-OPs as they work to achieve program milestones and receive licensure from their respective state Departments of Insurance.

The CO-OP program provides start-up and solvency loans to help create new health insurance companies that will give more choices and control to consumers, promote competition, provide new private models of care delivery and improve quality in the health insurance market. CO-

OPs are required to be private, nonprofit organizations and use all excess revenue to reduce premiums, improve benefits, or invest in programs that improve quality of care. Funding priority has been given to organizations that could demonstrate financial viability and the ability to provide better coordination of care and use of integrated care that will enhance chronic disease management, emphasize prevention, improve transitions between care settings, and reduce hospitalizations. Because CO-OPs are not bound to legacy systems, they are positioned to establish newer, more efficient administrative operations, saving administrative expenses and creating incentives for their competitors to do the same.

Start-up disbursements must be repaid within 5 years and solvency disbursements must be repaid within 15 years. In order to prevent fraud, waste and abuse, CO-OPs have extensive reporting requirements, and CMS has implemented a range of controls and methods to monitor and assess the performance of all loan recipients, as set forth in the CO-OP Final Rule, the Funding Opportunity Announcement (FOA), and the loan agreement.

The framework for implementing the CO-OP Program has been based on the recommendations submitted by a Government Accountability Office-appointed federal Advisory Committee (GAO-appointed Advisory Committee). The GAO-appointed Advisory Committee was required by section 1322 of the Affordable Care Act to advise the Secretary of Health and Human Services regarding the award of CO-OP loans. The Committee issued a final report in April 2011, and the major elements of how CO-OPs have been selected, awarded loans, and monitored are based on the GAO-appointed Advisory Committee Report. The final report is included as Attachment A.

The CO-OP application review process has been rigorous, objective, and independent to ensure the financial strength and sustainability of CO-OPs. An extensive two-tiered review process has been established to review the loan applications, and Deloitte Consulting, LLP has been retained to administer the external review. In addition to verifying eligibility, Deloitte has used a team of insurance experts, actuaries, business plan and financial experts, market analysts, delivery system experts, and former state insurance regulators to evaluate each element of the application. These elements include, but have not been limited to, the business plan, enrollment strategy, management qualifications and health plan experience, and feasibility study in each application. The Deloitte recommendations were then sent to the CMS review committee, which has been led by insurance experts and an actuary who are not on the CO-OP program staff.

To date, 24 CO-OPs have been selected under the review process to receive loan funds. These CO-OPs are being established in every major region of the country, in states including Oregon, New Mexico, Montana, Iowa, Nebraska, Wisconsin, Maine, New York, New Jersey, South Carolina, Nevada, Michigan, Connecticut, Arizona, Kentucky, Vermont, Ohio, Louisiana, Tennessee, Utah, Massachusetts, Colorado, Maryland and Illinois. CO-OPs have been sponsored by a variety of organizations including, for example, small business groups, primary care associations, and community health centers.

All loan awardees demonstrated broad community support and financial viability. In addition, loan awardees offer improved care delivery systems such as: the use of patient-centered medical homes, chronic disease management, reliance on evidence-based medicine and evaluation of

outcomes, coordination of care between settings to reduce hospital readmissions, bundling of payments to providers to improve outcomes and reduce costs, and reliance on networks that include integrated care systems. All CO-OPs will transition to consumer control of the CO-OP once enrollment of members begins.

The GAO-appointed Advisory Committee acknowledged that CO-OPs face challenges. Many state insurance markets, particularly the individual markets, are highly concentrated, which allows dominant insurers substantial pricing flexibility over their smaller competitors. Consistent with the GAO-appointed Advisory Committee recommendations, the CO-OP awardees demonstrated relationships with providers, an ability to use lean administrative systems, and innovative ways of providing care to constrain costs, all of which will lead to competitive premiums. We expect that these factors, combined with CO-OP community support and member-focus, will attract market share and enable CO-OPs to have a competitive impact on insurance markets.

A number of independent analyses have discussed the strong potential for CO-OPs to succeed and to leverage both market and quality of care innovations that will benefit the American people. For example, the GAO-appointed Advisory Committee observed in its final report that the CO-OP program combined with the competition created by the Exchanges would enable CO-OPs to build enrollment and stability.

A study in April 2012 performed by the Commonwealth Fund[1] noted their "potential to provide new health care coverage options to individuals and small businesses, especially in noncompetitive markets." It particularly noted their ability to be viable over time and be attractive to consumers "because the CO-OP founders understand that to thrive they must provide a new, affordable coverage alternative, one meeting the health needs of individuals and working with providers to develop new payment and delivery systems.... [T]hese CO-OP founders and HHS, as the main financier, have a clear-eyed view of the risks and obstacles that lie in front of them. They know that they cannot rely on the current models used in the health insurance industry and, with the typical spirit of U.S. entrepreneurialism, are developing business plans that use innovative methods to ensure that CO-OPs succeed." An article in the Harvard Business Review[2] highlighted the belief that "CO-OPs can play a significant role in fostering higher quality of care, greater cost efficiency, and broader access throughout the U.S. health system."

Importantly, the Affordable Care Act requires CO-OPs to be licensed under state law, as any new issuer must be licensed. As a result of this licensing requirement, CO-OPs are subject to the regulatory scrutiny and oversight of state departments of insurance, whose foremost mission is to ensure the financial stability of issuers in their states to protect the consumers in these markets. All new market entrants, as well as existing issuers, are required to maintain solvency capital at

[1] Innovative Strategies to Help Affordable Consumer Operated and Oriented Plans (CO-OPs) Compete in New Insurance Marketplaces, April 13, 2012: http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2012/Apr/1591_Gardiner_innovative_strategies_help_coops.pdf

[2] Sabeti, Heerad. The For-Benefit Enterprise, November 2011. Harvard Business Review: http://hbr.org/2011/11/the-for-benefit-enterprise/ar/1/

specified levels. CMS works with individual loan recipients and state regulators to structure solvency loans in a manner that satisfies state law and state solvency regulators. In addition to financial stability, the state regulatory framework governing insurance companies requires prompt payment of providers and network adequacy. Because of the effectiveness of state financial oversight, it is rare for licensed insurers to become insolvent.

In addition to state regulation, CO-OPs are extensively monitored by CMS for compliance with their loan agreements and program policies. CO-OPs must comply with and facilitate any monitoring or oversight conducted by CMS, which includes bi-weekly performance reviews, quarterly reports, regular audits, site visits, and corrective actions. The full extent of CO-OP monitoring is described in the FOA, which is included as Attachment B.

Your letter suggests that 35 to 40 percent of CO-OP loans will not be repaid. The estimate that you refer to is known as the loan subsidy rate, a general budget assumption factor used in all federal loan programs (e.g. utilities, agriculture, rural housing, and disaster relief) that takes into account many factors, including interest rate, term of financing, and default assumptions. The loan subsidy rate is approved by the Office of Management and Budget (OMB) and calculated using OMB's standard credit subsidy calculator and a credit subsidy model developed by CMS. The loan subsidy rate reflects features such as flexible repayment schedules which will help CO-OPs succeed in their mission and repay their loans.

The calculation of the loan subsidy rate includes several factors. Funds appropriated for CO-OPs are loaned to these new, nonprofit entities at interest rates below Treasury market rates, which accounts for almost half of the projected subsidy rate of 43.21 percent that was included in the President's 2013 budget. The use of below market interest rates is common for such loan programs and will facilitate the establishment of CO-OPs by meeting the startup and solvency capital requirements necessary for market entry by 2014.

Another factor contributing to the subsidy rate is the assumed "default rate." It is important to note that default does not mean insolvency or plan failure; default is defined as scheduled principal and interest not received on time. In fact, delayed repayment may be a sign of growth, as state regulators often require licensed issuers to hold additional reserves if they plan to expand enrollment. For example, CMS and the borrower may need to negotiate a new repayment schedule because enrollment numbers were higher than anticipated and state licensure and solvency requirements dictate larger reserve requirements; however, the CO-OP could continue to operate successfully while paying loans back at a modified schedule. This possibility is explicitly anticipated in section 1322(b)(3) of the Affordable Care Act, which states that loans shall be repaid within five and fifteen years, " ... taking into consideration any appropriate State reserve requirements, solvency regulations and requisite surplus note arrangements ... "

The use of an OMB-approved credit subsidy rate in accordance with OMB Circular A-11 and the Federal Credit Reform Act appropriately constrains the size of the total program loan portfolio and limits the expected cost to the federal government for the program to the amount appropriated for section 1322 of the Affordable Care Act. Further, the simultaneous regulation of approved CO-OPs by the state Departments of Insurance and CMS provides effective monitoring and active mitigation of the risks to taxpayers, policyholders, and the overall insurance market is minimal.

We believe that CO-OPs offer an important option to Americans buying insurance in the individual and small business markets. For small businesses and individuals, CO-OPs will provide a new choice and opportunity for payers and consumers to work together to create coverage and care that is both more efficient and higher-quality. CO-OPs offer the potential to make private insurance markets work better and in ways that will constrain long-term costs. We look forward to working with your office to ensure that CO-OPs succeed in robust and responsible ways.

Sincerely,

Marilyn Tavenner

Marilyn Tavenner
Acting Administrator

Enclosures