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The CoOpportunity Liquidation and the Future of Affordable Care Act CO-OPs



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The CoOpportunity Liquidation

It's official; on March 2, 2015, Judge Arthur Gamble of the Iowa District Court in Polk County entered a final order of liquidation[1] (the ''Order'') for CoOpportunity Health, Inc. (''CoOpportunity''), a Consumer Operated and Oriented Plan (''CO-OP'') established under the Affordable Care Act (''ACA'') that has sold health insurance on the Iowa and Nebraska Exchanges. This order responded to a January 29, 2015 petition[2] filed by Nick Gerhart, the Iowa Commissioner of Insurance (the ''Commissioner''), seeking to liquidate CoOpportunity. The liquidation closely follows the rehabilitation order with respect to CoOpportunity in December 2014.

As a result of the Order, the Commissioner has assumed control of CoOpportunity under the general supervision of the Iowa District Court in Polk County in order to liquidate CoOpportunity. CoOpportunity did not oppose the petition for liquidation or the Order. Accordingly, CoOpportunity's operations will be wound down under the supervision of the Commissioner, and responsibility for paying claims of CoOpportunity's providers will transition to the health insurance guaranty associations in Iowa and Nebraska.

The guaranty associations provide only limited benefits, regardless of the extent of claims made by a particular insured. In both Iowa and Nebraska, coverage for policyholders of a liquidated insurer is limited to $500,000 per person. That means there may not be coverage for medical expenses of CoOpportunity members which exceed this limit but which were not paid prior to the rehabilitation of CoOpportunity.

One of the major contributors to CoOpportunity's rapid financial deterioration was the decision by Congress to scale back funding for the risk corridors under the ACA in the Consolidated and Further Continuing Appropriations Act of 2015.

The liquidation of CoOpportunity came on the heels of deteriorating year-end 2014 financial results for CoOpportunity. Between November 30 and December 31, 2014, the amount of cash and invested assets held by CoOpportunity declined by approximately $15 million, to approximately $13 million at year end. Additionally, the Commissioner's petition for liquidation noted that CoOpportunity had been unable to obtain any additional operating funds, from the Federal Government or otherwise. Critically, the Centers for Medicare and

[1] *Available at* http://www.iid.state.ia.us/node/10274752.
[2] *Available at* http://www.iid.state.ia.us/sites/default/files/press_release/2015/01/29/petition_pdf_11438.pdf.

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Medicaid Services (''CMS'') indicated in mid-December of 2014 that it would not be providing additional capital or operating support for CoOpportunity.

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The Commissioner's petition for liquidation revealed the extent to which CoOpportunity relied on such risk corridor payments for its continuing solvency; CoOpportunity estimated that the potential impact to its balance sheet of the reduction of risk corridor payments to be over $60 million. The risk corridor payment was almost as large as the other two 3R payments from CMS—reinsurance and risk stabilization—combined, from which CoOpportunity expected to receive approximately $75 million.

CoOpportunity's accounts receivable from CMS (after the reduction in risk corridor payments), combined with CoOpportunity's other assets, gave it total current assets of approximately $102 million, well below current liabilities, which include incurred but not reported claims (IBNR) of over $150 million (in both cases as of December 31, 2014).

The rehabilitation and subsequent liquidation of CoOpportunity gave individuals covered by its policies the opportunity to change carriers in the Exchange during open enrollment (through February 15). Additionally, a special enrollment period exclusively for CoOpportunity members is currently open; that period runs from February 16 to April 29 in order to give former CoOpportunity members every chance to enroll in new ACA-compliant coverage through the Iowa or Nebraska exchange. Individuals who enroll during this special enrollment period will face a one or two-month gap (for new enrollments in March or April, respectively) in advance premium tax credits and cost-sharing reductions. Additionally, premium, co-payment and coinsurance paid to CoOpportunity in 2015 will not carry over to members' new plans. All CoOpportunity coverage will be cancelled on August 31, 2015, regardless of whether the insured has secured new coverage or not. Brokers, agents and providers have until December 15, 2015 to submit proofs of claim against CoOpportunity in liquidation.

CO-OPs' Troubled Financial Performance

There are 23 CO-OPs in the United States, all established under the ACA. So far, only CoOpportunity has been subject to formal rehabilitation and liquidation proceedings, but CoOpportunity's financial troubles are not unique. The financial results for other CO-OPs raise questions regarding their financial stability as well.

A recent AM Best Briefing[3] indicated that only one of the 23 CO-OPs established under the ACA—Maine Community Health Options—reported both favorable underwriting and net income at the end of the third quarter in 2014. Every other CO-OP, including CoOpportunity, reported both underwriting and net losses. As of September 30, 2014, the aggregate underwriting loss for these 22 CO-OPs was more than $243 million.

At the same time, the total amount of surplus notes outstanding (including those issued by CoOpportunity) increased by $320 million between March 31 and September 30, 2014, indicating a substantial increase, given that just over $1 billion of such surplus notes were outstanding in total as of September 30. These surplus notes were issued to CMS by CO-OPs and are a special type of debt issued pursuant to, and governed by, state insurance law. Surplus notes are debt, but the face value of surplus notes is treated as surplus for insurance accounting purposes, which means that surplus notes are frequently used to provide capital support to an insurer, as they are used in this context. Insurers that issue surplus notes cannot repay principal or interest without approval from their domestic insurance regulator, which approval is generally conditioned on the repayment not posing a threat to the financial condition of the insurer.

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A.M. Best noted that each of the CO-OPs, including CoOpportunity, had a ratio of surplus notes outstanding to capital and surplus of greater than 100%, a potentially worrisome indicator of continuing financial stress. More ominously, A.M. Best noted that, as of September 30, 2014, two plans (Community Health Alliance Mutual Insurance Company (TN) and Meritus Mutual Health Partners (AZ)) had a ratio of surplus notes outstanding to capital and surplus of over 700%, and four others had a ratio over 300%. These ratios are not simple indicators of financial risk, however; CoOpportunity had a relatively low (as compared to other CO-OPs) ratio of 174% just months before it was placed into rehabilitation.

Sen. Charles Grassley, R-Iowa, has expressed concerns about CMS' management of start-up loans to and surplus notes issued by CO-OPs (unlike surplus notes, which are treated as surplus for accounting purposes and are subject to state insurance laws, start-up loans are traditional debt and were made by CMS on favorable terms). Grassley told A.M. Best that he was ''concerned that even though CoOpportunity's funding shortages were well known for at least six months, CMS apparently did not tell the CO-OP or IID (Iowa Insurance Department) that it would not receive additional funding'' from CMS.[4]

If CoOpportunity had known it would not receive additional loans from CMS, the CO-OP potentially could have taken steps to secure other financing or otherwise protect its surplus. Grassley raised these criticisms in a Senate hearing regarding CMS's role in the CO-OP program conducted on February 4, 2015. There may well be additional hearings or pressure on CMS from Grass-

[3] *Available at* http://www3.ambest.com/ambv/bestnews/PressContent.aspx?altsrc=14&refnum=22103.

[4] Jeff Jeffrey, ''US Senator Launches Investigation Into Collapse of CoOpportunity Health,'' *BestWeek Insurance Newsletter* (January 26, 2015).

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ley or from other legislators representing Iowa or Nebraska in the future.

In its briefing, A.M. Best also reported that CoOpportunity and 10 other CO-OPs had booked accrued retrospective premiums, overwhelmingly related to risk corridor payments. Three of these CO-OPs chose to nonadmit the accrued retrospective premiums, which likely indicates that the relevant CO-OPs have substantial doubts about eventually receiving risk corridor payments. A.M. Best indicated that it was ''concerned about the financial viability of'' several of these CO-OPs. However, CMS told CNBC that CMS was ''not aware of any immediate financial threat'' to any CO-OP other than CoOpportunity.[5]

Sources of Additional Capital for CO-OPs

While CoOpportunity was placed in rehabilitation and subsequently in liquidation, other CO-OPs have taken steps to bolster their financial stability. The Tennessee CO-OP, Community Health Alliance, announced that it was freezing 2015 plan enrollment as a ''preventative measure to support the long-term viability of'' the CO-OP, after substantial enrollee growth during open enrollment for the 2015 plan year.

Martin Hickey, CEO of New Mexico Health Connections, the New Mexico CO-OP, who serves as Chairman of the National Alliance of State Health Co-Ops, told A.M. Best's *BestWeek* that he believed ''other Co-ops should be able to weather the storm.'' He noted that CoOpportunity was the only CO-OP that was required by its state regulator (Iowa) to enroll significant numbers of members who would have been eligible for Medicaid if Iowa had accepted the ACA Medicaid expansion funds.[6]

Despite the potential financial challenges facing the 22 remaining CO-OPs, they continue to enroll growing numbers of members on the state and federal operated Exchanges. HealthyCT, the Connecticut CO-OP, grew its market share from 3% to almost 20% of the Connecticut Marketplace enrollment, and the Maine CO-OP continues to be the largest insurer on that state's Exchange. As the CO-OPs increase their total member enrollment, they may need to seek additional sources of capital for growth and stability. It appears unlikely that further financing from CMS will be forthcoming; accordingly, the private sector will be critical to any future capital growth of the remaining 22 CO-OPs.

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Debt and equity are the standard means by which an entity can raise additional capital, but neither debt nor equity appear to be viable options for the CO-OPs over the medium term. Given their non-profit status, CO-OPs are very unlikely to be able to structure any equity investments as a means to seek additional capital, even if willing investors could be located.

Debt financing does not appear to be substantially more plausible. CMS's loan agreements with the CO-OPs impose substantial restrictions on the uses of CO-OP surplus while CMS loans are outstanding; surplus may only be used to repay CMS loans, ''to lower premiums, to improve benefits, to meet State Reserve Requirements, to accommodate reasonable and sufficient reserves for enrollment growth, financial stability, and stable coverage for [the CO-OP's] members, or for other programs intended to improve the quality of health care'' for CO-OP members. CO-OPs accordingly cannot use surplus to pay interest to other debtors, which makes any debt unlikely during the term of the start-up loans or surplus notes.

Additionally, the loan agreements prohibit CO-OPs from issuing or incurring new indebtedness without the prior written consent of CMS, and cannot create or grant any mortgage, security interest, lien or other encumbrance upon its assets that is of equal or higher priority than the existing CMS loans without the express, advance written consent of CMS. Even if CMS were to grant such consent, each CO-OP would also need consent from its domestic insurance regulator for the issuance of additional debt given that the solvency loans from CMS have been structured as surplus notes under state insurance law. Any new debt financing would be on junior terms, subject to state regulatory approval prior to any repayment, and unlikely to pay principal or interest for over a decade. There is good reason to be skeptical of any plan involving CO-OPs raising capital through the use of debt.

Additionally, the provisions of the CO-OPs' loan agreements with CMS make joint ventures, mergers and acquisitions unlikely sources of capital. The consumer control provisions of the ACA and additional requirements imposed in the loan agreements make a viable joint venture with a for-profit entity unlikely, as consumers must retain voting control of the direction of the CO-OP, and the CO-OP must be operated ''with a strong consumer focus . . . .''[7] The CMS loan agreements also prohibit a CO-OP from converting to or selling to a for-profit or non-consumer operated entity ''at any time after receiving a Loan (including after full repayment of the Loans).'' This prohibition means that a CO-OP could only merge with or be acquired by another consumer-operated entity. Any such merger or acquisition would also be subject to state insurance regulatory approval.

While most outside investors will be unable to provide capital to CO-OPs as debt or equity, and joint ventures, mergers and acquisitions are also restricted by the ACA provisions applicable to CO-OPs and the terms of each CO-OP's loan agreements with CMS, there is one potential form of financial support which could improve the financial condition of a CO-OP. One or more substantial health care providers interested in the continued viability of a particular CO-OP in a state could negotiate reductions in the fees charged to the CO-OP for member care at such provider(s), perhaps in ex-

[5] Dan Mangan, ''Obamacare co-ops try to swim—not sink—as red ink persists,'' *CNBC.com* (January 26, 2015) (*available at* http://www.cnbc.com/id/102364418).

[6] *BestWeek*, note 4 above.

[7] Patient Protection and Affordable Care Act § 1322(c)(3), *codified at* 42 U.S.C. 18042(c)(3).

change for a narrow provider network commitment from the CO-OP. This would have the practical effect of reducing claim expenses for the CO-OP, thereby bolstering the CO-OP's financial condition without requiring additional capital or surplus.

This method of financial support has a number of advantages; first, it is flexible, and could be reduced or eliminated if the CO-OP achieved profitability on its own. Second, it is not subject to the restrictions on debt and equity outlined above, and does not require the consent of CMS. Third, it aligns the interests of the CO-OP and providers in achieving more effective care at lower cost. However, the structure of this type of arrangement could place the CO-OP's financial stability in the hands of a non-affiliated provider.

Given the financial challenges facing many CO-OPs and the limited options for seeking additional capital in the future, it remains to be seen whether there will be additional rehabilitations or liquidations of CO-OPs in the future. Alternatively, despite the challenges, the remaining 22 CO-OPs may achieve financial and operational stability and fulfill the role that the ACA envisioned for them in enhancing competition in the health insurance marketplace and providing meaningful choices for Exchange consumers.

The outcome will depend on any additional changes to the 3R's in Washington, CO-OPs' experience with the 2015 plan year, and the potential for new partnerships with providers in the future.

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