JAMES J. DONELON, COMMISSIONER OF INSURANCE FOR THE STATE OF OF LOUISIANA, IN HIS CAPACITY AS REHABILITATOR OF LOUISIANA HEALTH COOPERATIVE, INC.	:	SUIT NO. 651,069, SECTION. 22
Versus	:	19TH JUDICIAL DISTRICT COURT
TERRY S. SHILLING, GEORGE G. CROMER, WARNER L. THOMAS, IV, WILLIAM A. OLIVER, CHARLES D. CALVI, PATRICK C. POWERS, CGI TECHNOLOGIES AND SOLUTIONS, INC., GROUP RESOURCES INCORPORATED, BEAM PARTNERS, LLC, AND TRAVELERS CASUALTY AND SURETY COMPANY OF AMERICA	:	PARISH OF EAST BATON ROUGE
	:	STATE OF LOUISIANA

TERRY SHILLING'S
PEREMPTORY EXCEPTION OF PRESCRIPTION

NOW COMES, through undersigned counsel, Terry Shilling, who respectfully excepts to Plaintiff's Petition and First Supplemental, Amending and Restated Petition for Damages and Request for Jury Trial (the "First Amended Petition") on the grounds of prescription.[1] As more fully shown in the Memorandum in Support of this Exception, Plaintiff brings only one claim against Mr. Shilling for alleged breach of fiduciary duty. On the face of the First Amended Petition, and as the evidence will confirm, Mr. Shilling ceased service as an officer and/or director of Louisiana Health Cooperative, Inc. in July of 2013. This lawsuit was filed more than three years later, after peremption had accrued. Plaintiff has not, and cannot, advance any theory to hold Mr. Shilling liable for alleged breaches of duty committed by his successors. Further, under the facts alleged in the First Amended Petition, the doctrine of "continuing tort" does not apply to suspend the peremptive period, and neither "adverse domination" nor *contra non valentem* can apply as a matter of law.

In accordance with Uniform Rule, District Courts 9.8, Mr. Shilling advises that this case is not set for trial and that testimony and other evidence may be offered at the hearing in support of this Exception.

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[1] Further, by separate pleading filed contemporaneously herewith, Defendant, Terry Shilling, also excepts to the Petition and the First Amended Petition on the following grounds: Peremptory Exceptions of No Right of Action and No Cause of Action and Dilatory Exception of Vagueness and Ambiguity of the Petition.

WHEREFORE, Terry Shilling prays that, after due proceedings are had, this Exception be sustained and that all claims asserted against him in Plaintiff's First Supplemental, Amending and Restated Petition for Damages and Request for Jury Trial be dismissed with prejudice and for such other and further relief as is appropriate under the circumstances.

Respectfully submitted,

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Ellie T. Schilling, 33358
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Attorneys for Terry Shilling

CERTIFICATE OF SERVICE

I hereby certify that a copy of the above and foregoing has been served on all counsel of record by e-mail, this 22nd day of February, 2017.

THOMAS McEACHIN

JAMES J. DONELON, COMMISSIONER OF INSURANCE FOR THE STATE OF OF LOUISIANA, IN HIS CAPACITY AS REHABILITATOR OF LOUISIANA HEALTH COOPERATIVE, INC.	:	SUIT NO. 651,069, SECTION. 22
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	:	STATE OF LOUISIANA

ORDER

The foregoing Peremptory Exception of Prescription filed by Defendant, Terry S. Shilling, having been considered;

IT IS ORDERED that Plaintiff, James J. Donelon, Commissioner of Insurance for the State of Louisiana, appear and show cause, if he can, on the _____ day of _____ 2017 at ___:___ o'clock ___.m. why the Exception should not be sustained and all claims against Mr. Shilling dismissed with prejudice as prayed for therein.

Baton Rouge, Louisiana this _____ day of February, 2017.

_____
JUDGE

PLEASE SERVE:

James J. Donelon
Through his counsel of record:
J.E. Cullens, Jr.
Edward J. Walters, Jr.
Darrel J. Papillion
David Abboud Thomas
Jennifer Wise Moroux
Walters, Papillion, Thomas, Cullens, LLC
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JAMES J. DONELON, COMMISSIONER OF INSURANCE FOR THE STATE OF OF LOUISIANA, IN HIS CAPACITY AS REHABILITATOR OF LOUISIANA HEALTH COOPERATIVE, INC.	:	SUIT NO. 651,069, SECTION. 22
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	:	STATE OF LOUISIANA

MEMORANDUM IN SUPPORT OF TERRY SHILLING'S
PEREMPTORY EXCEPTION OF PRESCRIPTION

Defendant, Terry Shilling, through undersigned counsel, respectfully submits this Memorandum in Support of his Peremptory Exception of Prescription in response to plaintiff's First Supplemental, Amending and Restated Petition for Damages and Request for Jury Trial (the "First Amended Petition"). Plaintiff asserts only one count against Mr. Shilling, claiming he breached a fiduciary duty. This claim is subject to a liberative prescription of one year for acts of negligence or gross negligence and two years for intentional torts. La. Rev. Stat. § 12:1502. Prescription commences from the date of the act. The claims against Mr. Shilling are prescribed because he no longer served as an officer or director of Louisiana Health Cooperative, Inc. ("LAHC") by July of 2013, and this lawsuit was not filed within three years thereof. Accordingly, all claims against Mr. Shilling should be dismissed with prejudice.

FACTS

The Petition in this matter was filed on August 31, 2016 and was amended on November 28, 2016. It alleges that Louisiana Health Cooperative, Inc. ("LAHC") was organized in 2011 in accordance with the Patient Protection and Affordable Care Act (the "ACA"). *See* First Amended Petition, ¶17. Plaintiff alleges that Terry Shilling was the CEO, President and/or a Director of LAHC from 2011 until "approximately 2013." *Id.*, ¶10(a). In fact, Mr. Shilling ceased acting as an officer or director in July of 2013, more than three years prior to the filing of the Petition. Mr.

Shilling's resignation was accepted by LAHC's Board of Directors on July 9, 2013. *See* July 9, 2013 Minutes of the Board of Director's Meeting, attached hereto as Exh. "1." At the same time, the Board elected Greg Cromer as CEO. *Id.* LAHC entered an employment agreement on June 24, 2013 with Mr. Cromer confirming his employment as CEO of LAHC effective July 8, 2013. *See* Exh. "2," attached hereto. LAHC also issued a News Release on July 8, 2013 announcing Mr. Cromer's appointment as LAHC's new CEO. *See* Exh. "3," attached hereto.

The Petition alleges that LAHC failed due to alleged acts of gross mismanagement and negligence by defendants, including Mr. Shilling and other officers and directors who succeeded him. *Id.*, ¶¶ 25-36. Plaintiff alleges that LAHC stopped doing business by July of 2015 and was placed in rehabilitation by the Louisiana Department of Insurance in September 2015. *Id.*, ¶ 21. Plaintiff alleges that a Petition for Rehabilitation was filed and an Order of Rehabilitation entered on September 1, 2015. *Id.*, ¶ 7. Plaintiff further alleges that the Order of Rehabilitation became permanent and LAHC placed into rehabilitation under the control of the Commissioner on September 21, 2015. *Id.*

The Petition, as amended, contains five counts. Only one count, Count 1 for Breach of Fiduciary Duty, is asserted against Mr. Shilling and the other individual former officers and directors of LAHC. Plaintiff seeks damages including, among other things, all losses of LAHC, lost profits, and "disgorgement of all excessive salaries, bonuses, profits, benefits, and other compensation inappropriately obtained by" defendants. *Id.*, ¶ 38.

Plaintiff unsuccessfully attempts to plead around prescription by vaguely alleging that the individual defendants "adversely dominated" LAHC and "effectively concealed the bases for the causes of action." *Id.*, ¶ 139. Plaintiff contends that as a result it did not know of the causes of action until after the Receiver began his investigations in the rehabilitation matter. *Id.* No specific facts are supplied by Plaintiff to support these allegations. The evidence is to the contrary. A March, 2016 congressional report states that:

> CMS [Centers for Medicare & Medicaid Services] learned in December 2014, through routine communication with the CO-OP [LAHC] and the Louisiana Department of Insurance (LDI), **that LDI was preparing to notify the CO-OP that it had been found in a condition that would render continuance of its business hazardous to policyholders, creditors, or others**. CMS had previously noted certain risks with the CO-OP's finances.

See p. 23, March, 2016 Report to Congressional Requesters regarding "Federal Oversight, Premiums, and Enrollment for Consumer Operated and Oriented Plans in 2015," attached as Exh. "4" (emphasis added). Thus, it is apparent that Plaintiff began its investigations and was aware of the financial problems and difficulties that allegedly give rise to his purported causes of action long before the commencement of rehabilitation in September, 2015.

Plaintiff also alleges that the defendants' activities constitute "continuing torts" beginning in 2011 and continuing until LAHC was placed in rehabilitation. *Id.*, ¶ 140. Thus, Plaintiff contends, the applicable limitation and prescriptive periods "did not commence as to Plaintiff until shortly before LAHC was placed into Receivership, at the earliest." *Id.*, ¶ 141. Plaintiff also claims the benefit of suspension under La. Rev. Stat. § 22:2008(B), which applies to rehabilitation actions. *Id.*, ¶ 142.

The breach of fiduciary claim asserted against Mr. Shilling is prescribed and should be dismissed. As shown below, continuing tort does not suspend the running of prescription in this matter as the First Amended Petition is devoid of any allegations of concerted action or conspiracy among the several individual defendants who all served during different time periods. Moreover, even if La. Rev. Stat. § 22:2008(B) applies, it does not revive claims which were already prescribed when the rehabilitation proceeding commenced. Further, Plaintiff's theories of adverse domination and concealment cannot suspend prescription as a matter of law.

LAW AND ARGUMENT

I. APPLICABLE LEGAL STANDARDS.

A. Exception of Prescription, Generally.

Liberative prescription is a means of "barring of actions as a result of inaction for a period of time." La. Civ. Code art. 3447. Prescription is interrupted by the filing of suit in a court of competent jurisdiction and venue. La. Civ. Code art. 3462. The character of the plaintiff's action as described in the petition determines which prescriptive period is applicable to the action. *Starns v. Emmons*, 538 So.2d 275, 277 (La. 1989); *Wonycott v. So. Business Machines, Inc.*, 595 So. 2d 723, 725 (La. App. 5 Cir. 1992).

"When an exception of prescription is filed, ordinarily, the burden of proof is on the party pleading prescription." *Eastin v. Entergy Corp.*, 03-1030 (La. 2/6/04); 865 So. 2d 49, 54; *citing Lima v. Schmidt*, 595 So. 2d 624, 628 (La. 1992). "However, if prescription is evident on the face of the pleadings, as it is in the instant case, the burden shifts to the plaintiff to show the action has not prescribed." *Id.*; *see also Campo v. Correa*, 01-2707, p.7 (La. 6/21/02); 828 So. 2d 502, 508; *Primus v. Touro Infirmary*, 05-0662 p.2 (La. App. 4 Cir. 1/25/06); 925 So. 2d 609, 610.

At the trial of a peremptory exception of prescription, "evidence may be introduced to support or controvert any of the objections pleaded, when the grounds thereof do not appear from the petition." *Denoux v. Vessel Mgmt. Servs., Inc.*, 07-2143 (La. 5/21/08); 983 So. 2d 84, 88 (*quoting* La. Code Civ. Proc. art. 931). "In the absence of evidence, the exception of prescription must be decided on the facts alleged in the petition, which are accepted as true." *Id.*

B. Applicable Prescriptive Periods.

The time within which to bring actions against "any officer, director, shareholder, member, manager, general partner, limited partner, managing partner, or other person similarly situated" of a Louisiana business organization is limited by La. Rev. Stat. § 12:1502. The statute provides, in relevant part:

> C. No action for damages against any person described in Subsection A of this Section for an unlawful distribution, return of an unlawful distribution, or **for breach of fiduciary duty, including without limitation an action for gross negligence**, but excluding any action covered by the provisions of Subsection D of this Section, **shall be brought unless it is filed in a court of competent jurisdiction and proper venue within one year from the date of the alleged act, omission, or neglect, or within one year from the date that the alleged act, omission, or neglect is discovered or should have been discovered**, but in no event shall an action covered by the provisions of this Subsection be brought more than three years from the date of the alleged act, omission, or neglect.
>
> D. No action for damages against any person listed in Subsection A of this Section for **intentional tortious misconduct**, or for an intentional breach of a duty of loyalty, or for an intentional unlawful distribution, or for acts or omissions in bad faith, or involving fraud, or a knowing and intentional violation of law, **shall be brought unless it is filed in a court of competent jurisdiction and proper venue within two years from the date of the alleged act or omission, or within two years from the date the alleged act or omission is discovered or should have been discovered**, but in no event shall an action covered by the provisions of this Subsection be brought more than three years from the date of the alleged act or

omission.

> E. The time limitations provided in this Section **shall not be subject to suspension on any grounds or interruption except by timely suit filed in a court of competent jurisdiction and proper venue**.

La. Rev. Stat. §§ 12:1502(C), (D), (E) (emphasis added).

II. THE CLAIMS AGAINST MR. SHILLING ARE PRESCRIBED.

The First Amended Petition alleges gross negligence and intentional breaches of fiduciary duty. The former are governed by a one-year prescriptive period, and the latter by a two year prescriptive period. Because Mr. Shilling ceased being an officer or director of LAHC by July 8, 2013, LAHC had, at most, one year thereafter, or by July 8, 2014, to assert claims for breaches of fiduciary duty arising from negligence or gross negligence and two years, or by July 8, 2015, to assert claims for intentional tortious conduct. Even if Plaintiff was not aware of the alleged facts giving rise to his claims until December, 2014, he had to commence this action no later than three years from July 8, 2013, or at least by July 8, 2016. As the Petition was not filed until August 31, 2016, more than three years after Mr. Shilling was no longer an officer or director of LAHC, the claims against him are prescribed.

A. La. Rev. Stat. § 22:2008(B) Does Not Revive Prescribed Claims.

Plaintiff argues that prescription was suspended by La. Rev. Stat. § 22:2008, which provides in relevant part:

> B. Notwithstanding any law to the contrary**, the filing of a suit by the commissioner of insurance seeking an order of conservation or rehabilitation shall suspend the running of prescription and peremption as to all claims in favor of the subject insurer during the pendency of such proceeding**. The filing of a suit by the commissioner of insurance seeking an order of liquidation shall interrupt the running of prescription and peremption as to such claims from the date of the filing of such proceeding for a period of two years, if an order of liquidation is granted.

La. Rev. Stat. § 22:2008(B).[1] Here, the petition for rehabilitation of LAHC was not filed until September 1, 2015. *See* First Amended Petition, ¶7.

On its face, § 22:2008(B) conflicts with § 12:1502(E) in that it allows for suspension by a

1 Unlike interruption, the "[s]uspension of prescription constitutes a temporary halt to its running." *LeBreton v. Rabito*, 97-2221 (La. 7/8/98); 714 So. 2d 1226, 1229. "After the cause for the suspension ends, the prescriptive time begins running and the time which precede[d] the suspension is added to the time which follows it to compose the necessary period; only the period of the suspension is deducted." *Id.* (internal citations and quotations omitted).

means other than the filing of suit for breach of fiduciary duty, which § 12:1502(E) forbids. However, the resolution of this conflict is not necessary. It is clear that § 22:2008(B), even if applicable, could not revive claims which were already prescribed when the petition for rehabilitation was filed. Once accrued, the abandonment of the rights derived from the accrual of prescription can only be obtained through renunciation. La. Civ. Code art. 3449, 3450; *Smith v. McKeller*, 638 So. 2d 1192, 1197 (La. App. 1 Cir. 1994) ("to be effective, renunciation of accrued prescription must be unequivocal and takes place only when the intent to renounce is clear, direct, absolute and manifested by words or actions of the party in whose favor prescription has run") (internal quotations and citations omitted).

Thus, as the claims against Mr. Shilling for negligent or intentional breaches of fiduciary duty were prescribed by July of 2015, the filing of a petition for rehabilitation in August of 2015 has no effect on prescription.

B. Prescription Is Not Suspended Under the Continuing Tort Doctrine.

1. Continuing Tort, Generally.

"The 'continuing tort' doctrine provides an exception to the general rule of prescription." *Jones v. State ex rel. Dep't of Corr.*, 13-0482 (La. App. 1 Cir. 11/1/13); 2013 WL 5918755, *2; *writ denied*, 13-2783 (La. 2/14/14); 132 So.3d 965.

> When tortious conduct and resulting damages are of a continuing nature, prescription does not begin until the conduct causing the damages is abated. The 'continuing tort' doctrine **applies only when continuous conduct causes continuing damages**, and it is the continuing nature of the alleged conduct that has the dual effect of rendering such conduct tortious and of delaying the commencement of prescription.

Id. (*citing Bustamento v. Tucker*, 607 So. 2d 532, 538–539 (La. 1992)).

"Louisiana jurisprudence draws a distinction between damages caused by continuous, and those caused by discontinuous, operating causes." *Hogg v. Chevron USA, Inc.*, 09-2632 (La. 7/6/10); 45 So.3d 991, 1002–03.

> When the operating cause of the injury is continuous, giving rise to successive damages, prescription begins to run from the day the damage was completed and the owner acquired, or should have acquired, knowledge of the damage. *See South Central Bell Telephone Co. v. Texaco, Inc.*, 418 So. 2d 531 (La. 1982), and cases cited therein. **When the operating cause of the injury is discontinuous, there is a multiplicity of causes of action and of**

> **corresponding prescriptive periods. Prescription is completed as to each injury, and the corresponding action is barred**, upon the passage of one year from the day the owner acquired, or should have acquired, knowledge of the damage. See A.N. Yiannopoulos, Predial Servitudes, § 63 (1982).

Id. at 1003 (emphasis added). "When a defendant's damage-causing act is completed, the existence of continuing damages to a plaintiff, even progressively worsening damages, does not present successive causes of action accruing because of a continuing tort." *In re Med. Review Panel for Claim of Moses*, 00-2643 (La. 5/25/01); 788 So. 2d 1173, 1183.

In the context of the breach of a duty, the Louisiana Supreme Court further explains: "A continuing tort is occasioned by continual unlawful acts and for there to be a continuing tort there must be a continuing duty owed to the plaintiff and a continuing breach of that duty by the defendant." *Crump v. Sabine River Auth.*, 98-2326 (La. 6/29/99, 10), 737 So. 2d 720, 728–29 (emphasis added). Thus, prescription commences when the duty ends or when breach of the duty ends. *Id.*

2. Any Duty Mr. Shilling Owed Ended When He Ceased Being an Officer and Director and Was Not "Continuous" Beyond that Time.

In *Wooley v. Lucksinger*, 06-1140 (La. App. 1 Cir. 12/30/08); 14 So.3d 311, 462, *aff'd in part, rev'd in part on other grounds*, 09-0571 (La. 4/1/11); 61 So.3d 507, the First Circuit held that the § 12:1502 "is a hybrid liberative prescriptive statute." Although the statute states that it is not subject to suspension, the First Circuit concluded that the suspensive doctrine of continuing tort could apply under the facts of that case.[2] Those facts, however, are different from those alleged by LAHC in several important ways.

There, various receivers brought claims against related failed HMOs. The petition alleged that the companies "had overlapping officers and directors who ran the operations of those entities in a coordinated, co-dependent and intertwined manner." *Id.* at 463 (emphasis added). It alleged that the directors and officers engaged in "a persistent and ongoing kiting scheme among AmCareCo and its subsidiaries." *Id.* at 465. It alleged that "the insolvent business enterprise was kept alive for a little over three years through what amounted to a Ponzi scheme." *Id.* It

2 The Fourth Circuit holds that continuing tort cannot apply as a matter of law to toll prescription under § 12:1502. *See Suhren v. Gibert*, 10-0767 (La. App. 4 Cir. 1/12/11); 55 So.3d 941, 946–47 (holding "the time limitations contained within this statute do not allow for plaintiffs…to levy claims under the continuous tort doctrine").

alleged the directors and officers engaged in a "conspiracy" and "scheme" to operate the insolvent HMOs and conceal the insolvency, as well as acts of "aiding and abetting" the various breaches of each other. *Id.* at 465-66 (emphasis added). Plaintiffs alleged that as a result, the defendants' wrongful conduct constitutes a continuing tort beginning in May 1999 and continuing until shortly before the companies entered receivership. *Id.* at 466.

The appellate court held:

> Pursuant to the continuing tort doctrine, a prescriptive period cannot begin to run as long as the operative tortious behavior continues and this behavior continues to cause damage. **There must be a continuous duty owed to the plaintiff and a continuing breach of that duty by the defendant**. Prescription does not commence for a continuing tort until the last act occurs or the conduct is abated.

Id. (*citing Bustamento,* 607 So. 2d at 539 and 542–43; *Miller v. Conagra, Inc.,* 07–0747, pp. 6–7 (La. App. 3 Cir. 12/5/07); 970 So. 2d 1268, 1273; F. Maraist & T. Galligan, Louisiana Tort Law, § 10.04(5), pp. 10-16 to 10-17 (2d ed.2007)). The appellate court found that, under the facts alleged, there was a continuous duty and a continuous breach of that duty. *Id.* at 466-67.

Here, conversely, the First Amended Petition is completely devoid of any allegations of concerted action, or a conspiracy, or scheme among the individual defendants which would suspend prescription as in *Wooley*. Rather, the First Amended Petition alleges "a multiplicity of causes of action and of corresponding prescriptive periods." *Hogg,* 45 So.3d at 1003. Plaintiff's claims do not arise from a single "continuing duty owed to the plaintiff" or from "a continuing breach of that duty by" a single defendant or group of solidarily bound conspirators. *Crump,* 737 So. 2d at 728–29. Rather, Plaintiff's alleged claims arise from the purported breaches of alleged multiple duties owed by multiple defendants at various times, many of which were after Mr. Shilling no longer owed a fiduciary duty to LAHC as an officer or director.[3] Plaintiff has not, and cannot, advance any theory by which Mr. Shilling can be held liable for the tortious acts of his

[3] For example, plaintiff complains that the individual defendants rolled out LAHC in 2014 when it was not prepared to do business; failed to negotiate an acceptable agreement with GRI, which became Third Party Administrator in March 2014; failed to oversee GRI; failed to protect health information, which was improperly released in 2014; failed to prevent misuse of company credit cards in October/November of 2013; and imprudently switched from Verity Healthnet, LLC to Primary Healthcare Systems in mid-2014. *See* First Amended Petition, ¶¶ 24-35. All of these acts occurred after Mr. Shilling ceased being an officer or director of LAHC and no longer owed a fiduciary duty to LAHC in that capacity.

successors.[4] Continuing tort simply does not apply here.

C. Prescription is Not Suspended by Alleged "Adverse Domination" or "Concealment."

Plaintiff urges that prescription was also suspended on the grounds of alleged "adverse domination" or unspecified acts of "concealment." *See* First Amended Petition, ¶ 139 ("Plaintiff shows that LAHC was adversely dominated by the Defendants named herein, who effectively concealed the basis for the causes of action stated herein"). Thus, plaintiff contends that it could not have known of the claims until after LAHC was placed in rehabilitation. *Id.* Other than this single, conclusory paragraph, the First Amended Petition contains no particular allegations of concealment or adverse domination. This theory is also without merit.

As explained by one court:

> The doctrine of adverse domination has long been a part of federal common law, and it acts to preserve claims that would otherwise have been time-barred. The doctrine tolls the running of a statute of limitations during periods **when the named defendants formed a majority of an institution's board of directors**. This theory is based on the recognition that the institution can act only through its board of directors, and a defendant-controlled board is unlikely to authorize a suit against its individual members. Thus, the doctrine preserves the viability of cases against the board members until the alleged malefactors were no longer in control of the board.

F.D.I.C. v. Caplan, 874 F. Supp. 741, 745 (W.D. La. 1995) (*citing FDIC v. Dawson,* 4 F.3d 1303, 1308 (5th Cir. 1994) (applying Texas law)) (emphasis added). Here, Plaintiff has certainly not alleged that a majority of the board of LAHC dominated or controlled LAHC. Plaintiff has not even named a majority of the board members as defendants.

"As yet, Louisiana courts have not formally recognized the doctrine of adverse domination." *Id.*[5] In Louisiana, "[t]here is no prescription other than that established by legislation." La. Civ. Code art. 3457. "Adverse domination" is not a part of Louisiana law and

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[4] Because the individual defendants are not solidary obligors, Mr. Shilling "shall not be liable for more than his degree of fault and shall not be solidarily liable with any other person for damages attributable to the fault of such other person, including the person suffering injury, death, or loss, regardless of such other person's insolvency, ability to pay, degree of fault, immunity by statute or otherwise, including but not limited to immunity as provided in R.S. 23:1032, or that the other person's identity is not known or reasonably ascertainable." La. Civ. Code art. 2324(B) (emphasis added).

[5] The undersigned was unable to find any Louisiana case applying the doctrine of adverse domination to suspend prescription on a breach of fiduciary duty claim against officers and directors under La. Rev. Stat. § 12:1502.

does not apply here. Moreover, although in some circumstances Louisiana courts do apply other suspensive doctrines that are similar to adverse domination, including *contra non valentem agere nulla currit,* they have no application as to claims governed by La. Rev. Stat. § 12:1502.[6] *Contra non valentem* incorporates, among other things, the concealment doctrine. *Wimberly v. Gatch,* 635 So. 2d 206, 211 (La. 1994) (holding prescription is suspended where "the debtor himself has done some act effectually to prevent the creditor from availing himself of his cause of action").

However, the courts that have considered whether *contra non valentem* can suspend the running of the prescriptive periods under La. Rev. Stat. § 12:1502, have concluded that it cannot apply. In *Robert v. Robert Mgmt. Co., LLC,* 14-0822 (La. App. 4 Cir. 2/11/15); 164 So.3d 922, 934, *writ denied,* 15-0541 (La. 5/22/15); 170 So.3d 984, the appellate court held that suspension under *contra non valentum* is inapplicable under "the express wording of La. R.S. 12:1502 E," which "specifically prohibits the application of the judicially-created doctrine under the facts and circumstances presented in this case."

Accordingly, prescription was not suspended by any alleged adverse domination or concealment. The claims against Mr. Shilling are prescribed and should be dismissed with prejudice.

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[6] *Caplan*, notably, was decided before the enactment of La. Rev. Stat. § 12:1502, which went into effect on June 28, 2001. Thus, although the *Caplan* court considered whether prescription of a breach of fiduciary duty claim against a corporate officer could be suspended by *contra non valentem*, this doctrine cannot suspend prescription under La. Rev. Stat. § 12:1502(E).

CONCLUSION

For the foregoing reasons, the Peremptory Exception of Prescription submitted by defendant, Terry Shilling, should be sustained. All claims against Mr. Shilling should be dismissed with prejudice.

Respectfully submitted,

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Attorneys for Terry Shilling

CERTIFICATE OF SERVICE

I hereby certify that a copy of the above and foregoing has been served on all counsel of record by e-mail, this 22nd day of February, 2017.

THOMAS McEACHIN

LOUISIANA HEALTH COOPERATIVE
BOARD OF DIRECTORS MEETING
JULY 9, 2013 – 2-3:30PM CDT

BOARD ACTIONS NEEDED					
AGENDA ITEM	ACTION NEEDED	CMS Review?	PRESENTER	AUTHOR	ATTACHMENT?
1. Approval of Minutes	Approval	No	Thomas	Shilling	
2. Election of Officers	Approval	No	Shilling	Bayham	
3. Financial Statements	Approval	No	Shilling	Sidener	Yes
4. Rest of Year Forecast	Review	No	Shilling	Sidener	Yes
5. Compliance /Credentialing	Approval	No	Shilling	Fisk	1
6. Board Level Policies	Approval	No	Shilling	Robin/Alan	
7. Delegated Activities	Approval	Yes	Shilling	Various	HI, Connection, etc.
8. Mississippi Expansion	Approval	Yes	Shilling	Hartnett	Task List
9. Status Updates Below	Review	No	Shilling	Various	Yes
10. Future Meeting Schedule	Approval	No	Thomas	Shilling	No
11. Adjournment					

STATUS UPDATES					
ITEM	ACTION NEEDED	CMS Review?	PRESENTER	AUTHOR	ATTACHMENT?
1. House Oversight Requests	Status	No		Fisk	Yes
2. Bingham Agreement / Bill	Status	No	Shilling	Fisk	Yes
3. First NBC Line of Credit	Status	Yes	Shilling	Sidener	No
4. NCQA Survey	Status	No	Shilling	Bayham	Yes
5. Board Subcommittees	Status	No	Shilling	Bayham	Yes
6. HMO License	Status	No	Shilling	Gentry	No
7. Rates and Products	Status	In Process	Shilling	Hartnett	Yes
8. Network Discussion	Status	No	Shilling	Bayham	Yes
9. CMS Milestones	Status	No	Shilling	Gentry	Yes
10. Marketing and Outreach	Status	No	Shilling	McHaney	Yes

LOUISIANA HEALTH COOPERATIVE
BOARD OF DIRECTORS MEETING
JULY 9, 2013 – 2-3:30PM CDT

ATTACHMENT 1
Changes to the Compliance Plan, Credentialing Plan, Execution of Provider Agreements

RESOLVED, that the approved Compliance Plan is hereby amended to adopt the following changes:

- 1
- 2
- 3
- [[once the changes to the compliance plan are finalized, we add them here]]

2. RESOLVED that the attached LAHC Credentialing Plan is hereby adopted.

3. RESOLVED, that the Board recognizes the LAHC Loan Agreement with CMS requires the Board to monitor network development and provider agreements, hereby delegates its approval of individual hospital agreements, individual and group practitioner agreements and other individual and group provider contracts to the Chief Executive Officer, Chief Financial Officer, or the Vice President for Network Development.

Louisiana Health Cooperative
Minutes of the Board of Directors' Meeting
July 9, 2013

Members Attending:	Members Attending: Thomas, Oliver, Hulefeld, November			
Guests Present:	Guests: Cromer, Shilling			
AGENDA ITEM	***ACTION TAKEN***	***MOTION***	***Moved:***	***Seconded:***
Minutes of 5/23/2013	**Approved**	Minutes of the May 23, 2013 Board Meeting were reviewed and approved	Oliver	Hulefeld
Election of Officers	**Accepted**	Acceptance of the following changes in LAHC Board of Directors Membership and Executive Leadership: - Resignation of Warner Thomas as Chair - Resignation of William Oliver as Secretary - Resignation of Scott Posecai as Treasurer - Resignation of Terry Shilling as Interim CEO - Resignation of Deborah Sidener as Interim CFO - Election of William Oliver as Chair of the Board - Election of Peter November as Secretary of the Board - Election of Greg Cromer as CEO - Election of Charles Gleason as CFO and Treasurer All resignations and elections are effective as of the close of 7/9/13 meeting	Hulefeld	Thomas
Financial Statements	**Approved**	Financial Statements at 5/2013 approved as presented	Oliver	Hulefeld

Louisiana Health Cooperative
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July 9, 2013

Compliance / Credentialing	**Approved**	Approval of the following Changes to the Compliance Plan, Credentialing Plan, Execution of Provider Agreements: 1) The Section entitled "Anonymous Reporting" is deleted in its entirety and replaced with…(see Attachment A05) 2) That the LAHC Credentialing Plan is hereby adopted 3) That the Board recognizes the LAHC Loan Agreement with CMS requires the Board to monitor network development and provider agreements, hereby delegates its approval of individual hospital agreements, individual and group practitioner agreements and other individual and group provider contracts to the Chief Executive Officer, Chief Financial Officer, or the Vice President for Network Development	Oliver	November
Delegated Activities / Contracts	**Approved**	Approval to proceed with contracting with the following delegated entities: - Health Integrated (for Medical Management Services) - The Connection (for Call Center Services) - Avtex (CRM software) - Private Exchange	Hulefeld	November
Mississippi Expansion	**Approved**	Approval to proceed with the filing of the Expansion Funding Request on 7/15/13 to include Rating Areas 4 and 5 in the Gulf Coast Region of Mississippi.	November	Hulefeld
Meeting Schedule	**TBD**			
Status Updates	The Board reviewed the activities of LAHC listed on the agenda			
Board Requests	The Board requested the following actions of LAHC management - List of Bank accounts including CD's as of 6/30 (Debby, Chuck) - Compensation of Board members (Greg, NASHCO Information) - Review Bylaws to confirm CFO can be treasurer of LAHC (Robin) - Understanding of bylaws relating to nominating committee (Robin write up) - Follow up regarding next meeting (Rene)			
Adjournment	**3:30 PM**			

Louisiana Health Cooperative
Minutes of the Board of Directors' Meeting
July 9, 2013

EMPLOYMENT AGREEMENT

THIS EMPLOYMENT AGREEMENT ("Agreement"), dated as of 6-24-2013, 2013, is made by and between the **Louisiana Health Cooperative, Inc.**, a Louisiana not-for-profit corporation with a current mailing address of 3445 North Causeway Boulevard, Suite 800, Metairie, Louisiana 70002 ("LAHC") and George G. Cromer, an individual currently residing at 308 Margon Court, Slidell, Louisiana 70458 ("Cromer").

WITNESSETH:

WHEREAS, LAHC wishes to employ Cromer as Chief Executive Officer ("CEO") of LAHC, and Cromer wishes to serve in that capacity, subject to the terms and conditions of this Agreement;

WHEREAS, both LAHC and Cromer desire to set forth their respective rights and obligations in this Agreement; and

WHEREAS, this Agreement has been duly approved and its execution has been duly authorized by the Board of Directors of LAHC ("Board" or "LAHC Board");

NOW, THEREFORE, in consideration of the mutual promises, covenants, and conditions contained herein, and other valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

1. **Term**. Pursuant to the terms and conditions herein, Cromer's employment with LAHC will commence on or about 7-8, 2013, contingent upon prior approval of this Agreement by the Centers for Medicare and Medicaid Services ("CMS"), and shall continue until terminated by either party in accordance with Paragraph 9 of this Agreement. This is an at-will employment agreement for an indefinite period.

2. **Position and Duties**. During the Term of this Agreement, Cromer will serve as the CEO of LAHC. He will serve in such capacity as determined by the Board and will perform such reasonable responsibilities and duties commensurate with such position. Cromer's duties and responsibilities are generally described in the position description attached hereto as Exhibit A (which may be modified and supplemented at any time by mutual agreement of Cromer and the Board). In addition, within 36 months of beginning work, Cromer shall be expected to complete a Masters-level business related degree in a course of study approved by the Board.

3. **Outside Activities**. Cromer shall devote his entire professional and business time and efforts to the diligent and faithful performance of his duties to LAHC, and shall not be employed or engaged in any other professional or business activity, whether or not such business or professional activity is pursued for gain, profit or other pecuniary advantage, unless LAHC consents thereto in writing; provided that Cromer may engage in voluntary activities involving municipal, charitable, religious, and similar types of organizations to the extent such activities do not inhibit or prohibit the performance of his duties under this Agreement or conflict with the business of LAHC. LAHC hereby consents to Cromer continuing to serve as an elected state official.

EXHIBIT
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4. **Compensation**. Cromer shall be paid a salary at the annual rate of Two Hundred Thirty Five Thousand Dollars ($235,000.00), less standard deductions and withholdings as required by law and/or as directed by Cromer. Thereafter, any increases to the salary shall be within the sole discretion of the Board. Cromer will be paid in accordance with LAHC's normal payroll procedure. Cromer shall also be eligible for bonus compensation, based on LAHC's achievement of stated objectives under the direction of Cromer and for a retention payment as described in Exhibit A. A description of the bonus compensation amount and objectives is included in Exhibit A hereto.

5. **Expense Reimbursement**. Cromer will be reimbursed for reasonable expenses incurred in connection with his pursuit of LAHC business in accordance with LAHC's reimbursement policies, as amended from time to time. Cromer will have access to a LAHC business credit card to support payments of any reimbursable expense.

6. **Travel and Office Expenses.** LAHC will reimburse Cromer for travel expenses incurred in performing his duties as CEO. For in-state travel Cromer shall be paid a car allowance as described in Exhibit B in lieu of mileage reimbursement. For other travel expense Cromer must present receipts documenting such expenses to LAHC before reimbursement is provided. This expense reimbursement is separate from Cromer's regular compensation, as provided for in Paragraph 4 of this Agreement, and will not be considered for purposes of determining future increases in Cromer's compensation, if any.

7. **Benefits**. Cromer will receive the benefit package detailed in the CEO Benefit Summary attached hereto as Exhibit B. These benefits will be subject to and provided in accordance with the terms, conditions, and overall administration of any applicable benefit plan, policy, and arrangement, which may be amended from time to time.

8. **Representations and Warranties**. Cromer represents, warrants, and covenants to LAHC that he is free to enter into this Agreement and provide the services contemplated hereunder and the engagement hereunder does not conflict with or violate, and will not be restricted by, any pre-existing business relationship or agreement to which Cromer is a party or otherwise is bound.

9. **Termination**. Either party may terminate this Agreement, with or without cause, by providing the other party with 60 days prior written notice, except that LAHC may terminate this Agreement immediately, with or without cause and without prior notice, by providing Cromer with: (1) written notice of the immediate termination of this Agreement; and (2) continued payment of his then-current salary, less deductions for withholdings required by law and less other deductions authorized by Cromer, for a period of 180 days. If LAHC exercises the 60-day notice of termination LAHC will continue to pay Cromer his then-current salary, less deductions for withholdings required by law and other deductions authorized by Cromer for a period of 180 days beyond the end of the 60-day notice.

10. **Confidentiality**

(a) General. Cromer acknowledges that LAHC considers all information disclosed to him during his employment to be confidential, including information received from third parties ("Confidential Information"). Confidential Information shall include trade secrets, technical information and specifications, business information, personnel information, financial information, business systems, computer software and documentation, development plans and data, written, printed, oral or otherwise. All materials or works developed by Cromer shall be deemed to be Confidential Information. Failure to mark any materials embodying Confidential Information as confidential shall not affect its status as Confidential Information under the terms of this Agreement. Notwithstanding the foregoing or any other term or provision herein, Confidential Information shall not include any information which at the time of disclosure by Cromer (i) was already in the public domain, or (ii) was already generally available to the public through no act, omission, or fault of Cromer.

(b) Nondisclosure. Cromer shall not, directly or indirectly, disclose Confidential Information to any person or give any person access to Confidential Information who is not an employee of LAHC without prior written consent of the Board, except for disclosures to LAHC employees or agents, which are reasonably necessary in order to carry out LAHC business. Cromer shall not remove any copyright or other notice or legend on any materials received or accessed in connection with his provision of services as CEO of LAHC.

(c) Non-Use. Cromer shall use the Confidential Information only for the purposes of rendering services to LAHC. Cromer shall not make any use of the Confidential Information to develop any plans or products for his own account or for any other person or entity.

(d) Termination. Upon termination of Cromer's employment or upon LAHC's demand, whichever is earlier, Cromer shall return any and all materials containing Confidential Information (including any copies or reproductions thereof) in his possession (or under his control) to LAHC.

(e) Injunctive Relief. Cromer acknowledges that the use or disclosure of the Confidential Information in a manner inconsistent with this Agreement will cause irreparable damage to LAHC, and that LAHC shall be entitled to equitable and injunctive relief to prevent the unauthorized use or disclosure, and to such damages as are occasioned by such unauthorized use or disclosure, including reasonable attorneys' fees.

11. **Non-competition; Non-Inducement; Non-Solicitation**. During the term of Cromer's employment and for a period of one (1) year following the termination of his employment (for whatever reason), whether initiated by LAHC or Cromer or otherwise, Cromer will not directly or indirectly, either as principal, agent, employee, consultant, officer, director, stockholder, lender or in any other capacity:

(a) Engage in or have a financial interest in any Competitive Business; provided, however, that nothing contained herein shall preclude Cromer from purchasing or owning less than two percent (2%) of the stock or other securities of any company with securities traded on a nationally recognized securities exchange; or

(b) For the purpose of benefitting any party other than LAHC, contact or otherwise solicit, or attempt to solicit, any employee, leased employee, consultant, independent contractor, or agent of LAHC, with the intention or effect of encouraging such party to terminate or modify his or his employment, engagement, agency, or other relationship, as applicable, with LAHC; or

(c) Contact or otherwise solicit, or attempt to solicit, any clients, customers, prospects, suppliers, vendors, licensors or licensees, franchisors or franchisees of LAHC with the intention or effect of encouraging such party to terminate or reduce the volume of its business with LAHC or to place elsewhere any portion of its business which could be served by LAHC.

For the purposes hereof, a business will be deemed competitive with the business of LAHC or in competition with LAHC (a "Competitive Business") if it substantially involves or supports the offering of health coverage to residents of or businesses located in the State of Louisiana or conducts business or offers coverage through the Louisiana Health Benefit Exchange or its successor.

Cromer acknowledges and agrees that enforcement of the terms of this Agreement is necessary for the purpose of ensuring the preservation, protection and continuity of the business, trade secrets, and goodwill of LAHC and that, in furtherance of such purpose, the prohibition against competition and solicitation imposed by this paragraph 11 is narrow, reasonable, and fair. Cromer further acknowledges and agrees that, given his experience, knowledge and skills, substantial opportunities for work as an employee or independent contractor outside of the areas restricted by this Agreement are and will remain available to him. If any part of this paragraph 11 is determined by a court of competent jurisdiction to be unreasonable in duration, geographic area, or scope, then this Agreement is intended to and shall extend only for such period of time, in such area, and with respect to such activities as are determined to be reasonable, and that all other portions of this Agreement shall remain in full force and effect.

12. **Limitation on Payments**. Notwithstanding the foregoing or any other provision of this Agreement to the contrary, if tax counsel selected by LAHC and acceptable to Cromer determines that any portion of any payment under this Agreement would constitute an "excess benefit," then the payments to be made to Cromer under this Agreement shall be reduced (but not below zero) such that the value of the aggregate payments that Cromer is entitled to receive under this Agreement and any other agreement or plan or program of LAHC shall be one dollar ($1.00) less than the maximum amount of payments which Cromer may receive without becoming subject to the tax imposed by Section 4958 of the Internal Revenue Code of 1986, as amended.

13. **Dispute Resolution**. Except for violations of paragraphs 10 or 11, upon demand of either party, any controversy between the parties or claim by one party against the other arising out of or relating to this Agreement, or a breach hereof, shall be settled by arbitration conducted in accordance with the arbitration rules of the American Health Lawyers' Association. The parties shall be bound by the decision of the arbitrator(s). Judgment upon the award rendered by the arbitrator(s) may be entered in a court in accordance with paragraph 19 of this Agreement. The arbitrator(s) shall be bound by applicable agreements and Louisiana statutes, regulations and rules of procedure and the arbitrator(s) should permit reasonable discovery, issue subpoenas, decide arbitrability issues, preserve order and privacy in the hearings, rule on evidentiary matters, determine the close of the hearing and the procedures for post-hearing submissions, and issue an award resolving the submitted dispute. The arbitrator(s) shall also have authority to rule on motions to dismiss and motions for summary judgment, pursuant to the standards set forth in the Federal Rules of Civil Procedure and/or applicable Louisiana state law. The arbitrator(s) shall be able to apply substantive law as well as the law that allocates burdens of proof. The arbitration shall take place in Louisiana. The prevailing party shall be reimbursed for its costs of arbitration by the losing party but prevailing party will not be reimbursed for its attorney's fees.

14. **LAHC Property**. On or before the last day of Cromer's employment, in addition to all Confidential Information, Cromer agrees to return to LAHC all other LAHC documents (and all copies thereof) and property that Cromer has had in his possession at any time, including, but not limited to, computers, cellular phones, keys and key cards. Cromer acknowledges that any possession or use of LAHC property following the termination of employment for any reason is unauthorized unless he has the express written permission of the Board.

15. **Successors and Assigns**. This Agreement shall be binding upon, and inure to the benefit of, the parties hereto and their respective successors, assigns, heirs and personal representatives, provided that Cromer may not assign this Agreement nor any rights or benefits hereunder.

16. **Waiver**. The failure to insist upon strict compliance with any of the terms, covenants or conditions herein contained shall not be deemed a waiver of such terms, covenants or conditions hereof, nor shall any waiver or relinquishment of any right at any one or more times be deemed a waiver or relinquishment of such right at any other time or times.

17. **Amendment**. This Agreement may not be modified or amended, or any term or provision hereof waived or discharged, except by a written instrument signed by the party against which such amendment, modification, waiver, or discharge is sought to be enforced.

18. **Survival**. The provisions of paragraphs 10, 11 and 13 shall survive the termination of this Agreement.

19. **Governing Law; Jurisdiction**. This Agreement and the rights and obligations of the parties hereunder shall be governed by and construed according to the laws of the State of Louisiana without giving effect to choice or conflict of law provisions. The parties hereby submit to the exclusive jurisdiction of the state and federal courts sitting in the State of Louisiana in any action or proceeding arising out of or relating to this Agreement.

20. **Severability**. If any provision of this Agreement is or becomes invalid, illegal or unenforceable in any respect under any law, the validity, legality and enforceability of the remaining provisions hereof shall not in any way be affected or impaired.

21. **Entire Agreement**. This Agreement, including Exhibits A and B, contains the entire agreement between the parties in respect of its subject matter and supersedes any and all prior or contemporaneous agreements, whether oral or written, with respect thereto. This Agreement may only be amended, modified, or changed by written agreement signed by the parties.

IN WITNESS WHEREOF: the parties hereto have executed this Agreement as of the _____ day of _____, 2013.

Louisiana Health Cooperative, Inc.

Warner Thomas
Chair, LAHC Board of Directors

George G. Cromer, Individually

Exhibit A

Position Description and Bonus Compensation

Position Description: The position description may be updated from time to time by mutual agreement between the LAHC Board and Cromer.

Purpose for the Position:
Working through Vice Presidents, and in concert with the priorities and policies of the LAHC Board of Directors, the Chief Executive has responsibility for achievement of the Objectives of the LAHC Organization.
Responsibilities include relationship with Board of Directors, Planning, Management and Organizational Development, Policy, Controls, Product Development, Growth and Solvency, Member Engagement and Focus.

Duties and Responsibilities:
- Maintains close relationship with Board of Directors: Communications with Board, Reports by CEO and Functional Heads and standards of performance.
- Planning -- overall LAHC strategy (in concert with Strategic Initiatives of the Board of Directors, Strategic Plan and Operational Plan).
- Organizational Development -- organizational chart, job descriptions, and authority levels.
- Management recruitment and development -- succession planning, in-house training, outside training, promotion from within, human resource plan, new positions and active recruiting.
- Policy -- Board of Director Policies, LAHC-wide policies, and management input and review.
- Standards of performance and performance reviews and improvement plans.
- Operational Controls -- monthly reports, quarterly reviews and supplemental action programs.
- Management morale -- involvement in planning, salary discussions, access to CEO and management turnover.
- Product development -- overall strategy, quarterly priority meetings, status reports, new products and development expense.
- Compliance with laws and regulations.
- Community relations -- Government Relations, Public Relations and community participation.
- Profitability and growth: solvency objectives, results compared to peers, membership growth objectives, market share and profitability by product line.

Bonus Compensation:
On an annual basis starting with the 2013 calendar year, Cromer will develop, and the LAHC Board will in good faith approve a list of objectives and timelines for LAHC, and Cromer will be eligible for bonus compensation based upon LAHC's achievement of such objectives by the stated timelines. The initial set of objectives will be for achievement between the initial date of employment and December 31, 2013 and any payment for these objectives shall be prorated for 2013. Cromer will present such objectives for approval by the LAHC Board on or before August 1, 2013. In any full calendar year, Cromer will be eligible for bonus compensation up to twenty percent (20%) of his then-current total annual compensation based on full achievement of the stated goals as determined by the Board. Such objectives must be reviewed with and

approved by the LAHC Board by December 31 of the year preceding the year covered by the objectives. Cromer's bonus compensation shall be prorated at a lower percentage as determined by the Board if LAHC achieves some but not all of the stated goals by the stated timelines. The Board will annually determine the goals and associated timelines and present the same to Cromer in a separate written document. Such document will be acknowledged and signed by the Board Chair and Cromer and shall be expressly incorporated herein by terms to such effect as stated therein.

Retention Payment:

In addition to his regular compensation and any Bonus Compensation determined in accordance with this Exhibit A, Cromer shall be entitled to accrue an amount equal to twenty five thousand dollars ($25,000) for that year of service (the "Retention Payment"). Cromer shall be entitled to collect each Retention Payment if still employed at the end of the third anniversary from the date such Retention Payment was accrued. If Cromer is not employed by LAHC on the third anniversary of his accrual date for any Retention Payment, Cromer shall not be entitled to that Retention Payment. For example, if Cromer's date of hire were June 1st, 2013, then on June 1st, 2013, Cromer would accrue his 2013 Retention Payment. Cromer will be eligible to collect his 2013 Retention Payment on June 1, 2016.

Exhibit B

Employment Benefits

As CEO of LAHC, Cromer will be entitled to the benefits set forth below. These benefits will be subject to and provided in accordance with the terms, conditions, and overall administration of any applicable benefit plan, policy, and arrangement, which may be amended from time to time at the sole discretion of the Board. Cromer acknowledges these benefits will be available to him to the same extent they are generally offered to all employees of LAHC and further defined in additional detail based on discussions with the LAHC Board.

- Paid Time Off (i.e. CTO, Vacation, and Sick Leave)

- Holiday

- Health Insurance

- Dental Insurance

- Retirement

- Group Life Insurance

- Disability Insurance

In addition, Cromer shall be entitled to the following benefits based on the additional responsibilities and requirements of his position. These benefits are not generally offered to all employees of LAHC.

- Use of a Company credit card for work-related fuel expenses.

NEWS RELEASE

LOUISIANA HEALTH COOPERATIVE

FOR IMMEDIATE RELEASE:
Monday, July 8, 2013

Contact:
Jim Pittman
Office: 504-383-7460
jpittman@mylahc.org

Louisiana Health Cooperative Announces Chief Executive Officer

Metairie, LA – Louisiana Health Cooperative, Inc. (LAHC), is pleased to announce the selection of Greg Cromer as the new Chief Executive Officer (CEO).

Cromer was born and raised in Bogalusa, LA and brings to LAHC extensive knowledge of the health insurance industry and leadership on the state level. Currently Cromer serves as State Representative for District 90, the Slidell-area.

"We are a non-profit company," said Cromer, "focusing on members and not profits. We are poised to serve the entire state of Louisiana by offering guaranteed issue, quality health insurance. No one will be turned down or rated-up for pre-existing health conditions. LAHC is a tremendous asset to our state."

LAHC was selected by the *U.S. Department of Health and Human Services (HHS)* on September 28, 2012 to create and operate a Consumer Oriented and Operated Plan, or "CO-OP" statewide. As Louisiana's first non-profit health insurance CO-OP, LAHC plans to provide a variety of health insurance options for individuals and employers statewide with coverage starting January 1, 2014.

Member enrollment, beginning October 1, 2013, will coincide with the availability of the Federal Health Insurance Marketplace, a website where individuals can shop for and purchase health insurance. Authorized by the *Affordable Care Act*, the Marketplace will allow eligible low and moderate income individuals to receive financial assistance with premiums, deductibles and co-insurance costs. According to Cromer, "The best thing that can happen in the marketplace is that we bring more consumers and more providers into the market to create additional competition and expanded choices for the consumer." In addition to the Marketplace, LAHC benefit plans will also be available through a network of brokers.

NEWS RELEASE

"We feel that we can provide as good or better service than the current leaders in the market, "Cromer said, "our aim is to be extremely competitive with any other carrier currently in that market."

Cromer graduated from Bogalusa High School and earned a bachelor's degree in Industrial Management from Southeastern Louisiana University. In the Louisiana Legislature, Cromer serves as the Chairman of the House Insurance Committee, which has oversight on legislation pertaining to public and private insurance systems including life, health, employment, property and casualty insurance.

LAHC was started based on the central principle that cooperatives are non-profits and consumer-governed. LAHC is one of 24 health insurance CO-OPs nationwide focusing on developing programs intended to improve the quality of health care delivered to members, such as:

- preventive programs offering early health screenings;
- focusing on health outcomes based on sound clinical evidence;
- ongoing measurement and comparison of performance to clinical quality standards;
- a comprehensive medical network;
- coordinated care programs;
- opportunities for members to participate in their care.

For more information on Louisiana Health Cooperative (LAHC), contact Jim Pittman at (504) 383-7460 or jpittman@myLAHC.org. More information on the Affordable Care Act, Marketplaces and CO-OPs, is online at www.HealthCare.gov.

Linked **Connect with us on** **@LAHealthCOOP on**

###

United States Government Accountability Office

Report to Congressional Requesters

March 2016

PRIVATE HEALTH INSURANCE

Federal Oversight, Premiums, and Enrollment for Consumer Operated and Oriented Plans in 2015

EXHIBIT
4

GAO-16-326

March 2016

PRIVATE HEALTH INSURANCE

Federal Oversight, Premiums, and Enrollment for Consumer Operated and Oriented Plans in 2015

GAO Highlights

Highlights of GAO-16-326, a report to congressional requesters

Why GAO Did This Study

The Patient Protection and Affordable Care Act established the CO-OP program and provided loans that helped create 23 CO-OPs to offer qualified health plans to individuals and small employers. While the program seeks to increase competition and improve accountability to members, questions have arisen about their long-term sustainability and their effects on health insurance markets, particularly as 12 CO-OPs ceased operations on or before January 1, 2016.

In April 2015, GAO issued its first report examining the status of CO-OP premiums, enrollment, and program loans in 2014 (GAO-15-304). As one CO-OP ceased operations in early 2015, GAO was asked to review the CO-OP program again. This report examines (1) how CMS monitors the CO-OPs' performance and sustainability; (2) how CO-OP premiums changed from 2014 to 2015, and in 2015, how they compared to premiums for other health plans; and (3) how CO-OP enrollment changed from 2014 to 2015, and in 2015, how it compared to projections. GAO analyzed 2014 and 2015 premium and enrollment data from CMS, states, and the National Association of Insurance Commissioners; and reviewed applicable regulations, policies, procedures, and documentation of CMS monitoring activities. GAO also interviewed CMS officials.

In commenting on a draft of this report, the Department of Health and Human Services stated its commitment to CO-OP beneficiaries and taxpayers, and provided technical comments, which GAO incorporated as appropriate.

View GAO-16-326. For more information, contact John E. Dicken at (202) 512-7114 or dickenj@gao.gov.

What GAO Found

The Centers for Medicare & Medicaid Services' (CMS) monitoring of the consumer governed, nonprofit health insurance issuers—known as consumer operated and oriented plans (CO-OPs)—evolved as the CO-OP program matured, and as 12 of the 23 CO-OPs ceased operations on or before January 1, 2016. CMS's initial monitoring activities, starting when it began to award CO-OP program loans in early 2012, focused on the CO-OPs' progress as start-up issuers and their compliance with program requirements. Since then, CMS refined and expanded its monitoring to evaluate CO-OP performance and sustainability. CMS officials use enrollment and financial data to identify CO-OPs for which actual performance differed substantially from what was expected. CMS officials also perform routine assessments of each CO-OP's risk in various areas, such as working capital and management. To evaluate and respond to financial or operational issues identified at CO-OPs, CMS formalized a framework that it called an escalation plan. Under this plan, CMS may require that a CO-OP take corrective actions or the agency may implement an enhanced oversight plan based on its evaluation of the issue. As of November 2015, CMS used its escalation plan to evaluate and respond to issues at 18 CO-OPs, including 9 of the CO-OPs that have ceased operations. CMS officials told GAO that they plan to work with states' departments of insurance to continue monitoring CO-OPs that have ceased operations to the extent possible in order to minimize any negative impact on members and, if possible, recover loans made through the program.

GAO found that in 14 of the 20 states where CO-OPs offered health plans during both 2014 and 2015, the average CO-OP premiums for 30-year-old individuals purchasing silver health plans—the most commonly selected plan—were lower in 2015 than the average premiums for such plans in 2014. In the 23 states where CO-OPs offered health plans during 2015, the average premiums for all CO-OP health plans were lower than those for other issuers in more than 75 percent of rating areas—geographical areas established by states and used, in part, by issuers to set premium rates. Across the 23 states, average silver health plan premiums were lower for CO-OPs than other issuers in 31 percent to 100 percent of rating areas.

In addition, GAO found that the combined enrollment for the 22 CO-OPs that offered health plans in 2015 was over 1 million as of June 30, 2015, more than double the enrollment of a year earlier. More than half of these members were in CO-OPs that ceased operations. GAO also found that the combined enrollment for all 22 CO-OPs in 2015 exceeded their projections for 2015 by more than 6 percent. Of the 11 CO-OPs that have ceased operations, 6 did not meet their individual enrollment projections for 2015. Among the 11 CO-OPs that continue to operate in 2016, 4 CO-OPs had not yet reached a program benchmark of enrolling at least 25,000 members. CMS officials told GAO that exceeding this benchmark represents a level of enrollment that should better allow an issuer to cover its fixed costs; CMS officials told GAO that they are monitoring the CO-OPs' enrollment with attention to this benchmark.

Contents

Tables

Figures

Abbreviations

CMS	Centers for Medicare & Medicaid Services
CO-OP	consumer operated and oriented plan
HHS	Department of Health and Human Services
LDI	Louisiana Department of Insurance
NAIC	National Association of Insurance Commissioners
OIG	Office of Inspector General
PPACA	Patient Protection and Affordable Care Act

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

March 10, 2016

Congressional Requesters

The Patient Protection and Affordable Care Act (PPACA) established the consumer operated and oriented plan (CO-OP) program—a loan program intended to foster the creation of new, consumer-governed, nonprofit health insurance issuers, known as CO-OPs, to offer qualified health plans to individuals and small employers.[1] For this purpose, PPACA appropriated funding for the Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that administers the CO-OP program, to award loans totaling more than $2.4 billion.[2] The funding disbursed under these loans helped establish 23 CO-OPs that began offering health insurance in 2014.[3] (See appendix I for a list of the 23 CO-OPs.)

The CO-OP program is intended to enhance competition in the states' markets for health insurance sold directly to individuals and small employers—which potentially could reduce health plan premiums—while improving choice for consumers and encouraging accountability to members.[4] However, 12 CO-OPs ceased operations on or before

[1]Pub. L. No. 111-148, § 1322, 124 Stat. 163, 187-192 (Mar. 23, 2010) (codified at 42 U.S.C. § 18042). Qualified health plans are health plans certified to be offered through a health insurance exchange established under PPACA. Small group market means the health insurance market under which individuals obtain health insurance coverage through a group health plan offered by a small employer. A small employer is defined as having employed an average of 1 to 50 employees during the preceding year; however, states may apply this definition based on an average of 1 to 100 employees. See 42 U.S.C. §§ 300gg-91(e), 18024(b).

[2]The amounts awarded represent the total funding that CMS agreed to provide the CO-OPs. The CO-OPs receive some or all of this funding when disbursements are made.

[3]One additional organization in Vermont received CO-OP program loan awards, but was subsequently denied a license as a health insurance issuer by the state. As a result, CMS terminated the organization from the CO-OP program. According to CMS officials, CMS did not recover any of the start-up loan funding disbursed to that CO-OP—about $4.5 million—but did recover all solvency loan funding that had been disbursed to the CO-OP—about $10 million.

[4]Members are individuals covered under policies issued by the CO-OP. PPACA requires that governance of a CO-OP be subject to a majority vote of its members.

January 1, 2016, renewing questions previously raised about the long-term sustainability of the CO-OPs and the effects that they will ultimately have on states' health insurance markets.[5] Such questions led to our first review of the CO-OP program. In April 2015, we reported that as of January 2015, CMS disbursed more than two-thirds of the $2.4 billion in CO-OP program loans awarded. We also reported that while the average premiums for CO-OP health plans were generally lower than those for other issuers, most CO-OPs did not meet their initial enrollment projections during the first enrollment period (October 1, 2013, through March 31, 2014).[6]

Given that questions about CO-OP sustainability and their ultimate impact continue, you asked us as the first CO-OP began to cease operations in early 2015 to conduct a follow-up review of the CO-OP program. In this report, we examine the following

1. How does CMS monitor the CO-OPs' performance and sustainability?
2. How did premiums for CO-OP health plans change from 2014 to 2015, and in 2015, how did they compare to premiums for other health plans?
3. How did enrollment in CO-OP health plans change from 2014 to 2015, and in 2015, how did it compare to projections?

To examine how CMS monitors the CO-OPs' performance and sustainability, we reviewed CMS policies and procedures regarding its monitoring activities, as well as documentation from CMS related to the implementation of those activities. In particular, we reviewed

[5]Specifically, the CO-OP that offered health plans in Iowa and Nebraska ceased operations early in 2015. The 10 CO-OPs that offered health plans in Arizona, Colorado, Kentucky, Louisiana, Michigan, Nevada, New York, South Carolina, Tennessee, and Utah, as well as 1 of the 2 CO-OPs that offered health plans in Oregon, ceased operations on or before January 1, 2016. In addition, the CO-OP that offers health plans in Illinois and the CO-OP that offers health plans in Maine and New Hampshire have both frozen enrollment for 2016.

[6]See GAO, Private Health Insurance: Premiums and Enrollment for New Nonprofit Health Insurance Issuers Varied Significantly in 2014, GAO-15-304 (Washington, D.C.: April 2015). In addition, the HHS Office of Inspector General (OIG) reported in July 2015 that 2014 enrollment and profitability for the CO-OPs were below projections. See HHS OIG, Actual Enrollment and Profitability Was Lower Than Projections Made by the Consumer Operated and Oriented Plans and Might Affect Their Ability to Repay Loans Provided under the Affordable Care Act, A-05-14-00055 (Washington, D.C.: July 2015).

documentation regarding eight CO-OPs selected to reflect differences in the total amount of loan awards, the total amount of loan awards disbursed, actual enrollment in early 2015, geographic location, and the type of health insurance exchange (i.e., a federally facilitated or state-based exchange) operated in the state or states where the CO-OP offered health plans.[7] We also interviewed officials from CMS regarding the agency's oversight activities from 2013, prior to the first enrollment period, through the beginning of the open enrollment period in November 2015, including their monitoring of the 12 CO-OPs that ceased operations and other CO-OPs the agency considered at risk. We assessed CMS monitoring activities in the context of internal control standards.[8]

To examine how 2015 premiums for CO-OP health plans differed from 2014 premiums, we analyzed data regarding premiums on the health insurance exchanges of the 23 states where CO-OPs operated in 2015. This data included premium data that we obtained from CMS for the 16 states that either had a federally facilitated exchange or a federally supported state-based exchange where CO-OPs participated during the 2015 open enrollment period (November 15, 2014, through February 15, 2015). We also obtained comparable premium data from the 7 states that had state-based exchanges where CO-OPs participated. For the 20 states where CO-OPs offered health plans on an exchange during both the 2015 open enrollment period and the 2014 open enrollment period (October 1, 2013, through March 31, 2014), we calculated and compared the state-wide average CO-OP premium for silver tier health plans—the most commonly selected of the five levels of benefit coverage, including plans specified by metal level, as well as catastrophic plans—for 30-year-

[7]PPACA required the establishment in all states of health insurance exchanges—marketplaces where eligible individuals can compare and select among private insurance plans. In states electing not to establish and operate an exchange, PPACA required the federal government to establish and operate the exchange. Exchanges established and operated by the federal government are known as federally facilitated exchanges. The exchanges in states that chose to establish and operate their own exchange are known as state-based exchanges. The eight CO-OPs we selected were in Idaho and Montana, Illinois, Iowa and Nebraska, Kentucky, Maine and New Hampshire, Maryland, New Mexico, and Tennessee. We cannot generalize our observations from these eight CO-OPs to all CO-OPs.

[8]See GAO, Standards for Internal Control in the Federal Government, GAO-14-704G (Washington, D.C.: Sept. 10, 2014); and Standards for Internal Control in the Federal Government, GAO/AIMD-00-21.3.1 (Washington, D.C.: Nov. 1, 1999). Internal control is a process affected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

old individuals in 2014 and 2015.[9] To examine how 2015 premiums for CO-OP health plans compared to the premiums for other health plans in the 23 states where CO-OPs operated in 2015, we calculated and compared the average CO-OP premium with the average premium for other health plans for each rating area (geographical areas established by states and used, in part, by issuers to set premium rates) and for each health plan tier. We did this for eight different categories of policyholder: 30, 40, and 60-year-old individuals and couples, and 30 and 50-year-old couples with two children.[10]

To examine how enrollment in CO-OP health plans changed from 2014 to 2015, we obtained data from the National Association of Insurance Commissioners (NAIC) on quarterly statements dated June 30, 2015, and annual statements dated December 31, 2014, filed by each of the CO-OPs that operated in 2015.[11] We then compared enrollment as of June 30, 2014, to enrollment as of June 30, 2015, for each CO-OP. To examine how CO-OP 2015 enrollments compared to projections, we obtained from CMS estimates of projected enrollment made by each

[9]PPACA required certain categories of benefits at standardized levels of coverage specified by metal level—bronze, silver, gold, and platinum—depending on the portion of health care costs expected to be paid by the health plan. Catastrophic plans, which are available to individuals meeting certain criteria, generally provide coverage for services only after a high deductible is met. In this report, we refer to each level of coverage—catastrophic, bronze, silver, gold, and platinum—as a "tier." We focused our analyses on 2015 premiums because they were the most recently available data at the beginning of our work. We also analyzed 2016 premiums for silver tier health plans in the 13 states where CO-OPs continued to operate as of January 4, 2016. Specifically, for each state we calculated and compared the 2016 state-wide average CO-OP premium for silver tier health plans for 30-year-old individuals to the 2015 state-wide average CO-OP premium. We focused on 30-year-old individuals to facilitate comparison to the results of our April 2015 report, for which we presented the average premiums for 30-year-old individuals in detail and also noted that results for those premiums were consistent with results for premiums involving other categories of policyholders.

[10]PPACA gave states the authority to establish geographic locations by which premiums may vary, known as rating areas.

[11]The NAIC is the standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia, and five U.S. territories. As health insurance issuers, CO-OPs are required to submit quarterly and annual filings to the NAIC.

CO-OP.[12] We compared actual 2015 enrollment as of June 30, 2015, to the CO-OPs' estimates of projected enrollment.

To assess the reliability of the data we obtained from CMS on CO-OP program loans, CO-OP and other issuer premiums, and CO-OP enrollment, we performed manual and electronic testing to identify missing data and other anomalies, and interviewed agency officials to confirm our understanding of the data. To assess the reliability of the data we obtained from states on CO-OP and other issuer premiums, we performed manual and electronic testing to identify missing data and other anomalies, and followed up with state officials and incorporated corrections as necessary. To assess the reliability of the CO-OP enrollment data we obtained from NAIC, we compared NAIC data to similar data obtained from CMS for consistency. Based on these procedures, we determined that the data were sufficiently reliable for our purposes.

We conducted this performance audit from June 2015 to March 2016, in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

CO-OP Program Requirements, Loans, and Funding

PPACA established certain conditions governing participation in the CO-OP program. Specifically, PPACA defines a CO-OP as a health insurance issuer organized under state law as a nonprofit, member corporation of which the activities substantially consist of the issuance of qualified health plans in the individual and small group markets in the state where the CO-OP is licensed to issue such plans. PPACA prohibits organizations that were health insurance issuers on July 16, 2009, or sponsored by a state or local government, from participating in the

[12]Under the loan agreements, CMS requires annual enrollment projections as part of each CO-OP's business plan. CO-OPs may update business plans, including projected enrollment, on a semi-annual basis.

CO-OP program.[13] PPACA also requires that (1) governance of a CO-OP be subject to a majority vote of its members; (2) the governing documents of a CO-OP incorporate ethics and conflict of interest standards protecting against insurance industry involvement and interference; and (3) the operation of a CO-OP have a strong consumer focus, including timeliness, responsiveness, and accountability to its members.[14]

Consistent with PPACA, CMS established two types of CO-OP program loans: start-up loans and solvency loans.

- **Start-up loans** cover approved start-up costs including salaries and wages, fringe benefits, consultant costs, equipment, supplies, staff travel, and certain indirect costs. Disbursements were made according to a schedule established in the loan agreement between CMS and the loan recipient, and were contingent upon the loan recipient's achievement of program milestones. Milestones included obtaining health insurance licensure and submitting timely reporting information in the required format. Each disbursement for a start-up loan must be repaid within 5 years of the disbursement date.

- **Solvency loans** assist CO-OPs in meeting states' solvency and reserve requirements.[15] CO-OPs may request disbursements of solvency loans "as needed" to meet these requirements and obligations under their loan agreement with CMS. Reasons for a CO-OP's need for additional solvency disbursements could include enrollment growth or higher than anticipated claims from members. CO-OP requests are subject to CMS review of necessity and sufficiency. Each disbursement of a solvency loan must be repaid within 15 years of the disbursement date.

PPACA appropriated $6 billion for the CO-OP program; however, a series of subsequent laws reduced the appropriation by about 80 percent and

[13]A sponsor is an organization or individual that is involved in the development, creation, or organization of the CO-OP, or provides 40 percent or more in total funding to a CO-OP. 45 C.F.R. § 156.505. PPACA also prohibits organizations with a related entity that was a health insurance issuer on July 16, 2009, from participating in the CO-OP program.

[14]Federal regulations require the majority of a CO-OP's voting directors to be members—those covered under policies issued by the CO-OP—within a year of issuing health plans. 45 C.F.R. §§ 156.505, 156.515.

[15]PPACA prohibits the use of start-up and solvency loans for carrying on propaganda or otherwise attempting to influence legislation, or for marketing.

limited program participation. Specifically, in 2011, two separate appropriations acts rescinded $2.6 billion of the original CO-OP appropriation.[16] Additionally, in January 2013, the American Taxpayer Relief Act of 2012 rescinded $2.3 billion in unobligated CO-OP program appropriations, and as a result, about $1.1 billion of the original appropriation was available for the costs associated with the $2.4 billion in loans awarded and program administration.[17] The American Taxpayer Relief Act of 2012 transferred any remaining appropriations to a contingency fund for CMS to provide assistance and oversight to CO-OP loan awardees, which meant that no additional CO-OPs could be funded through the CO-OP program.

CO-OP Participation in States' Health Insurance Exchanges

The participation of CO-OPs in states' health insurance exchanges has varied since their establishment:

- For 2014, 22 CO-OPs offered health plans on the health insurance exchanges of 22 states.[18] One CO-OP participated in both the Iowa and the Nebraska exchanges, and two CO-OPs offered health plans on the exchange in Oregon. The CO-OP for Ohio offered plans off the exchange, but did not participate in the state's exchange.
- For 2015, 22 CO-OPs offered health plans on the exchanges of 23 states. While the Ohio CO-OP participated in the exchange for Ohio

[16]The Department of Defense and Full-Year Continuing Appropriations Act, 2011 rescinded $2.2 billion. Pub. L. No. 112-10, § 1857, 125 Stat. 38, 168 (Apr. 15, 2011). The Consolidated Appropriations Act, 2012 rescinded $400 million. Pub. L. No. 112-74, § 524,125 Stat. 786, 1115 (Dec. 23, 2011).

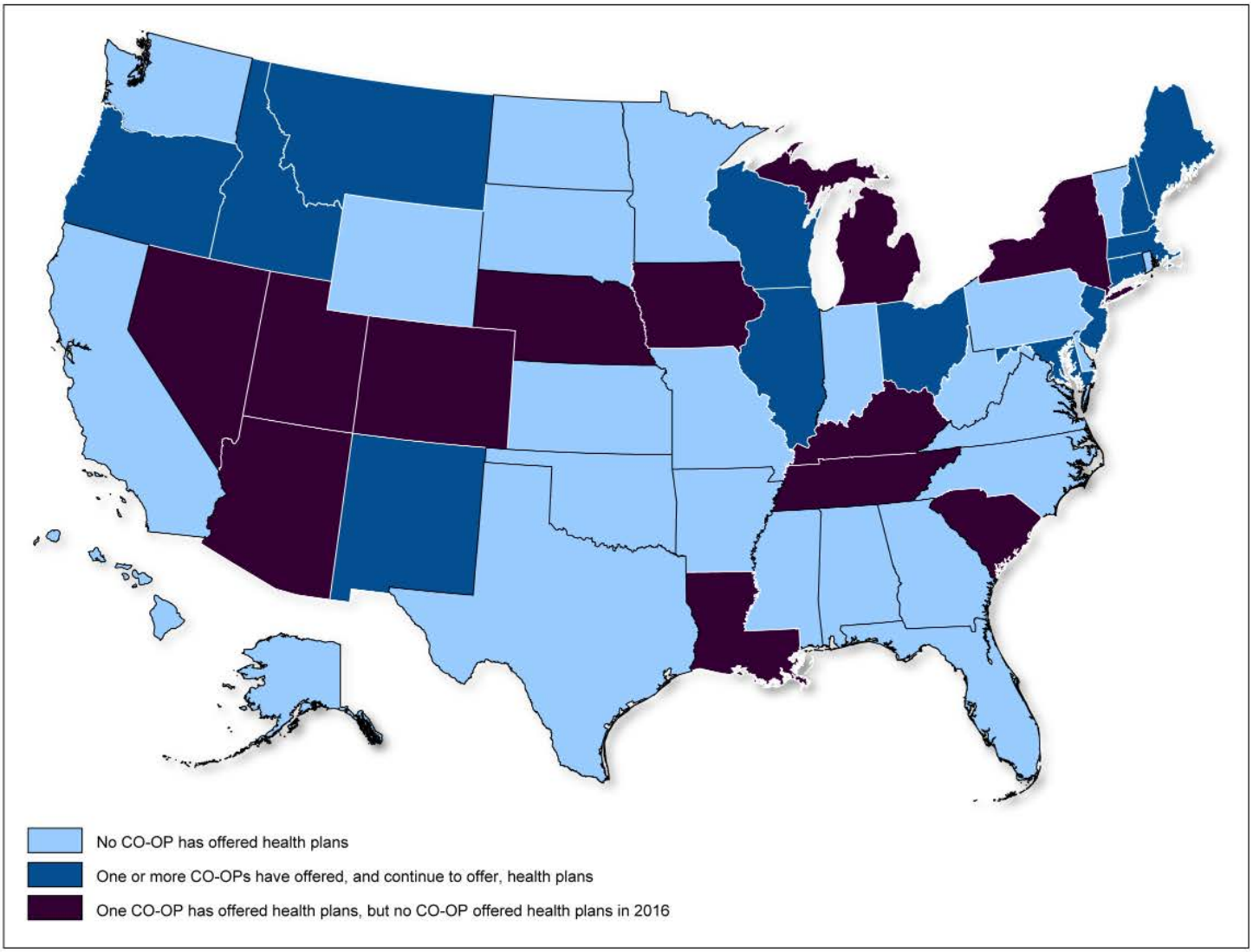
[17]Pub. L. No. 112-240, § 644, 126 Stat. 2313, 2362 (Jan. 2, 2013). The rescinded amount also reflects a $13 million reduction as part of the across-the-board cancellation of budget resources known as sequestration as ordered by the President on March 1, 2013. As a direct loan program, an appropriation is required to cover the estimated long term cost to the government—known as the credit subsidy cost—of the CO-OP program loans. Because this cost is calculated as the net present value of estimated cash flows over the life of each loan, the total amount of the CO-OP program loans awarded are greater than the appropriation amount. The difference between the appropriation and the loan awards is borrowed from the Department of Treasury and repaid with principal and interest payments by the loan recipients.

[18]CO-OP loan recipients are required to offer qualified health plans at the silver and gold metal levels in every individual market exchange that serves the geographic regions where the organization is licensed and intends to provide health care coverage. 42 C.F.R. § 156.515(c)(2).

for the first time, the CO-OP that offered plans on both the Iowa and the Nebraska exchanges withdrew from participation. In addition, the CO-OPs in Maine and Massachusetts both expanded to the New Hampshire exchange and the CO-OP from Montana expanded to the Idaho exchange.

- For 2016, 11 CO-OPs continued to offer health plans on the exchanges of 13 states as of January 4, 2016. The CO-OPs that offered health plans in Arizona, Colorado, Kentucky, Louisiana, Michigan, Nevada, New York, South Carolina, Tennessee, and Utah, and one of the CO-OPs that offered health plans in Oregon, ceased operations on or before January 1, 2016. (See fig. 1.)

Figure 1: States Where Consumer Operated and Oriented Plans (CO-OPs) Offered Health Plans in the Health Insurance Exchanges, 2014 through 2016, as of January 4, 2016



Source: GAO analysis of Centers for Medicare & Medicaid Services, CO-OP, and state data; Map Resources (map). | GAO-16-326

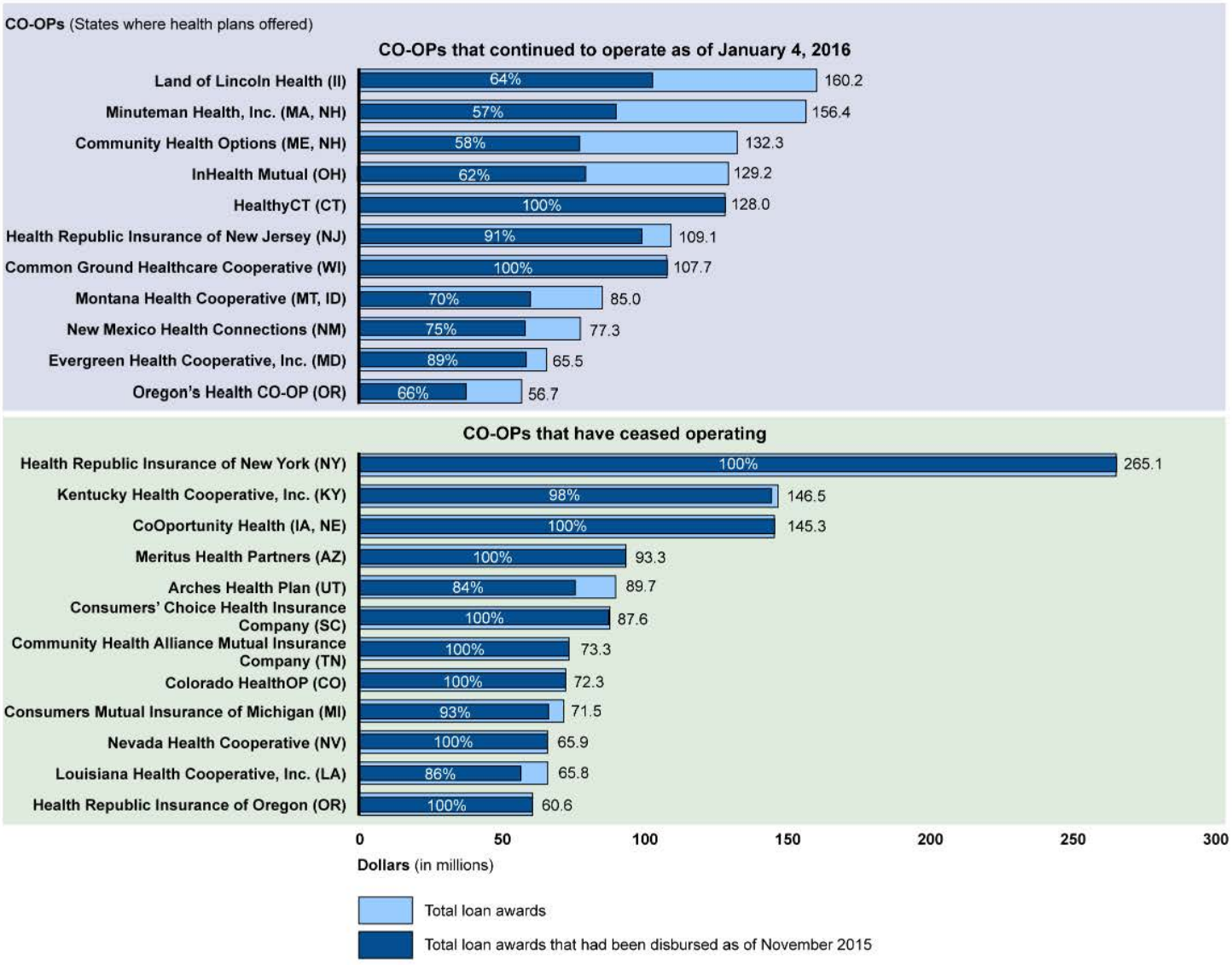
Notes: In 2014 and 2015, two CO-OPs offered health plans in Oregon. One of these CO-OPs ceased operations on January 1, 2016.

Disbursement of CO-OP Loan Awards

CMS awarded the 11 CO-OPs that continued to operate as of January 4, 2016, about $1.2 billion in combined start-up and solvency loans, and awarded about the same amount to the 12 CO-OPs that ceased operations. For the 11 CO-OPs that continued to operate, CMS disbursed, as of November 2015, about $897 million (74 percent) of the

CO-OP program loans awarded. Specifically, it disbursed 100 percent of the loans awarded to 2 CO-OPs, and from 57 percent to 91 percent of the loans awarded to the other 9 CO-OPs. This range primarily reflects differences in the percentage of solvency loan awards disbursed to each CO-OP, as disbursements of the start-up loan awards totaled nearly 100 percent. Disbursements of solvency loan awards to the 9 CO-OPs that received less than 100 percent of their awards ranged from 49 percent to 89 percent. For the 12 CO-OPs that ceased operations, CMS had disbursed 100 percent of the loan awards to 8 CO-OPs, while the percentage disbursed to the other 4 CO-OPs ranged from 84 percent to 98 percent. (See fig. 2.)

Figure 2: Total Consumer Operated and Oriented Plan (CO-OP) Loan Awards and the Percentage Disbursed, November 2015



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-326

Note: Oregon's Health CO-OP and Health Republic Insurance of Oregon both offered health plans in Oregon in 2014 and 2015. On January 1, 2016, the Health Republic Insurance of Oregon ceased operations.

Federal and State Roles Related to the CO-OP Program

CMS and state regulators have different, but complementary, roles for the CO-OP program. As the agency that administers the CO-OP program, CMS is responsible for

- interpreting statutory requirements and issuing regulations regarding CO-OP program eligibility, standards, and loan terms;
- soliciting and approving loan applications of qualified applicants;[19]
- determining loan award amounts and negotiating the related loan agreements;
- establishing and updating CO-OP program policy, procedures, and other guidance;
- approving the disbursement of loan funds to CO-OPs; and
- monitoring CO-OP financial controls and compliance with applicable statutory requirements and related regulations, loan agreements, and CO-OP program policy and guidance.

While CMS has oversight responsibilities for the CO-OP program, state regulators have primary oversight authority of the CO-OPs as health insurance issuers. This authority includes issuing and revoking licenses to offer health plans, monitoring issuers' financial solvency and market conduct, as well as reviewing and approving premium rates and policy and contract forms. CMS requires CO-OPs to report any requirements from and meetings with state regulators regarding their oversight to CMS. In addition, according to a CMS official, the agency has coordinated oversight activities with state regulators when appropriate.

[19]In July 2013, the HHS OIG reported that CMS awarded the initial start-up loans in accordance with federal requirements. See HHS OIG, The Centers for Medicare & Medicaid Services Awarded Consumer Operated and Oriented Plan Program Loans in Accordance with Federal Requirements, and Continued Oversight Is Needed, A-05-12-00043 (Washington, D.C.: July 2013).

PPACA Provisions on Health Insurance Premiums, Benefits, and Risk Mitigation Programs

PPACA established rules governing how issuers, including CO-OPs, may set premium rates. For example, while issuers may not consider gender or health status in setting premiums, issuers may consider family size, age, and tobacco use.[20] Also, issuers may vary premiums based on areas of residence. States have the authority to use counties, Metropolitan Statistical Areas, zip codes, or any combination of the three in establishing geographic locations across which premiums may vary, known as rating areas.[21] The number of rating areas per state varies, ranging from a low of 1 to a high of 67. Most states have 10 or fewer rating areas.

PPACA also requires that coverage sold include certain categories of benefits at standardized levels of coverage specified by metal level—bronze, silver, gold, and platinum. Each metal level corresponds to an actuarial value—the proportion of allowable charges that a health plan, as opposed to the consumer, is expected to pay on average.[22] Health plans within a metal level have the same actuarial value, while plans from different metal levels have different actuarial values and pay a higher or lower proportion of allowable charges. For example, a gold health plan is more generous overall than a bronze health plan. Actuarial values for health plans under PPACA range from 60 to 90 percent by metal level as follows: bronze (60 percent), silver (70 percent), gold (80 percent), or platinum (90 percent).

[20]PPACA restricts the amount by which issuers can vary premiums based on age and tobacco use. Premiums for adults aged 64 or older may not be more than 3 times the premiums of adults aged 21. The premiums for tobacco users may not be more than 1.5 times the premiums of non-tobacco users. With regard to family size, issuers may only take into account the premium rates of three covered children under the age of 21 when determining the premium for a family with four or more children.

[21]A Metropolitan Statistical Area consists of one or more counties that contain at least one core urban area with a population of 50,000 or more, as well as adjacent counties that have a high degree of social and economic integration with the urban core, as measured by commuting ties.

[22]Actuarial value measures the relative generosity of benefits covered by a health insurance plan. Under PPACA, a health insurance plan's actuarial value indicates the average share of allowable medical spending that is paid by the plan, as opposed to being paid out of pocket by the consumer. Actuarial values are calculated on an average basis for a standard population and do not predict the actual out-of-pocket costs for any individual. Amounts paid in premiums are not considered part of a health plan's actuarial value.

Issuers may also offer "catastrophic" health plans to individuals under 30 and individuals exempt from the individual mandate.[23] Catastrophic plans have actuarial values that are less than what is required to meet any of the other metal levels. Although these plans are required to cover three primary care visits and preventive services at no cost, they generally do not cover costs for other health care services until a high deductible is met.

Some PPACA provisions, such as those that prohibit issuers from considering gender and health status in setting premiums and from denying coverage based on health status, reduced issuers' ability to mitigate the risk of high-cost enrollees. To limit the increased risk that issuers could face, PPACA also established three risk mitigation programs: a permanent "risk adjustment" program and two temporary programs, "reinsurance" and "risk corridors".[24] Each of these programs uses a different mechanism intended to both improve the functioning of the health insurance markets and stabilize the premiums that issuers charge for health coverage. For example, the risk adjustment program transfers funds from issuers with lower risk enrollees to those with higher risk enrollees, and the risk corridor program transfers funds from issuers with high profits to those with high losses.[25]

[23]PPACA mandates that individuals, subject to certain exceptions, obtain health insurance coverage beginning in 2014 or pay a financial penalty—the "individual mandate." Exemptions from paying the financial penalty are granted to people based on income or other factors that prevent them from getting coverage.

[24]See Pub. L. No. 111-148, §§ 1341, 1342, 1343, and 10104(r), 124 Stat. 208, 211, 212 and 906 (codified at 42 U.S.C. §§ 18061-18063).

[25]For information on CMS's implementation of the risk mitigation programs see GAO, Patient Protection and Affordable Care Act: Despite Some Delays, CMS Has Made Progress Implementing Programs to Limit Health Insurer Risk, GAO-15-447 (Washington, D.C.: April 30, 2015).

CMS Expanded and Refined CO-OP Monitoring Activities as the Program Matured

Since it began awarding CO-OP loans, CMS's oversight has evolved from monitoring the establishment of the CO-OPs to monitoring their performance and sustainability. CMS also refined its monitoring activities by formalizing a framework for responding to issues at specific CO-OPs, and it continues to adjust its monitoring as some CO-OPs have ceased operations.

Initial CMS Monitoring Focused on CO-OPs' Progress as Start-up Issuers

CMS's initial activities to monitor the CO-OPs, starting when it began awarding CO-OP loans in early 2012, tracked their progress in becoming health insurance issuers (for example, establishing provider networks, arranging appropriate office space, and filling key management positions) and their compliance with program requirements (for example, establishing governance subject to a majority vote of its members and incorporating ethics and conflict-of-interest standards). During this initial period, CMS established two core monitoring activities to be conducted by a CMS account manager—a primary point of contact at CMS who is responsible for the day-to-day monitoring of individual CO-OPs. These two core activities were

- **Routine teleconferences with CO-OPs**. The account manager participated in routine teleconferences with key stakeholders from each CO-OP. Key CO-OP stakeholders could have, for example, included the chief executive officer, chief financial officer, chief operating officer, or the chief information officer. CMS policy initially required that these meetings take place on at least a bi-weekly basis. According to CMS officials, the frequency of these meetings varied across CO-OPs depending on the progress demonstrated by the CO-OP. Items discussed during these meetings could have, for example, included the CO-OP's implementation of its business plan or progress in achieving the milestones of its disbursement schedule, as well as any challenges, issues, concerns, and questions the CO-OP had. CMS account managers maintained documentation of these teleconferences electronically.

- **Standard reporting.** CMS required each CO-OP to submit standard reports that provide financial and other performance related information. (See table 1.) CMS account managers tracked the timely submission and completeness of each report. Reports submitted by the CO-OP were maintained electronically for CMS officials to review, as needed.

Table 1: Standard Reports that Consumer Operated and Oriented Plans (CO-OPs) Were to Submit to CMS as of April 2013

Standard report	Frequency	Description
Project plan	Monthly	Demonstrates the CO-OP's approach to implementing its strategy for competing in the health insurance exchange(s) as well as meeting CO-OP program requirements.
Evidence of milestone completion	Quarterly	Documents the CO-OP's achievement of milestones that supported a particular loan disbursement.
Financial reports	Quarterly	Provides information on the CO-OP's financial position and results of operations, including cash flows.
Progress reports	Semi-annually	Provides the status of the CO-OP's progress in meeting its project plans and completing milestones.

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) policies. | GAO-16-326

Note: CMS subsequently modified its standard reporting requirement to include enrollment data and more frequent reporting of certain financial data.

In addition, CMS hired an independent auditor to review each CO-OP's compliance with its loan agreement; key federal and state requirements, such as those related to governance of the CO-OP, the use of loan funding, types of investments; and the documentation that supported financial reporting. CMS officials stated that these reviews were completed in 2013 and 2014.

According to officials, CMS used the information obtained from these initial monitoring activities to assess loan recipients' progress in establishing start-up health insurance issuers and compliance with CO-OP program requirements. From the time loans were granted through November 2014, if there was a problem that presented a significant risk to a recipient's viability or a pattern of noncompliance with program requirements, CMS required an improvement plan. CMS policy states that an improvement plan could include (1) a corrective action plan to resolve noncompliance with program requirements or the terms and conditions of a loan agreement; (2) an enhanced oversight plan requiring stronger and more frequent CMS review of operations and financial status; (3) technical assistance to help improve performance, meet program requirements, or fulfill terms and conditions of the loan agreement; or (4) withholding of loan disbursements until milestones were achieved. According to CMS officials, the agency required improvement plans for five different CO-OPs during this time period. Officials stated that these plans generally focused on issues with meeting start-up milestones, including the CO-OP's capability to obtain licensure or comply with program requirements when establishing contractual relationships with providers or vendors for necessary services, such as information technology.

CMS Expanded and Refined CO-OP Monitoring Activities as the Program Matured

As CO-OPs began enrolling members, CMS supplemented its initial monitoring activities with additional tools to evaluate CO-OP performance and sustainability. CMS also formalized a framework for responding to financial or operational issues identified at specific CO-OPs and enhanced its reporting requirements to support the newly developed tools. CMS officials told us that they expect to monitor CO-OPs that have ceased operations to the extent possible.

CMS developed two tools that analyze enrollment and financial data, and other information collected from the CO-OPs:

Direct analysis. CMS officials developed a tool to analyze various aspects of performance, including enrollment, net income, premium revenues, claims and administrative expenses, and financial information related to risk mitigation programs and reserves. According to CMS officials, they conduct this analysis on a quarterly basis and compare the information with CO-OP projections and—when possible—to industry benchmarks. According to CMS officials, if direct analysis indicates that an individual CO-OP deviates appreciably from projections or otherwise signals a potential difficulty, then CMS officials perform additional review and analyses. CMS officials also noted that the direct analysis may, at times, be focused on particular areas of concerns. For example, during 2015, CMS looked closely at the CO-OPs' expectations related to risk mitigation programs: CMS officials monitored the extent to which each CO-OP's financial projections relied on estimated payments from risk mitigation programs. CMS officials told us that because of these analyses, they were able to identify CO-OPs that would likely face increased financial difficulties when the agency announced on October 1, 2015, that issuers eligible for payments through the risk corridor program would likely receive only a portion—12.6 percent—of the total amounts they claimed.[26] CMS officials told us that they worked with these CO-OPs to address concerns associated with these payments.

Risk assessment. CMS also developed a tool to assess risk based on data collected through its established monitoring activities. CMS officials

[26]In its announcement of 2014 risk corridor proration rates, CMS noted that issuers with high profits were expected to pay $362 million in risk corridor charges, and those with high losses had submitted claims for $2.87 billion in risk corridor payments, resulting in an anticipated 12.6 percent proration rate for the claims paid to those issuers with losses.

told us that they use this tool on a quarterly basis to assess risk across seven factors:

1. Long-term sustainability. CMS assesses risk based on whether a CO-OP expects to break even financially by 2017 and, if so, the extent to which a CO-OP expects to repay start-up loans while maintaining required reserve levels. CMS officials told us that although some viable CO-OPs might not expect to break even by 2017, they selected this date, in part, to provide a common basis for developing a risk score, because the first repayments of CO-OP loans are due in 2017.
2. Working capital. CMS assesses risk based on whether a CO-OP expects to generate net revenues from premiums, risk mitigation programs, or other funding sufficient to cover operating expenses over the next 12 months and, if not, the extent to which the CO-OP plans to rely on the disbursement of any remaining solvency loan funds.
3. Profitability. CMS assesses risk based on whether the CO-OP's performance is consistent with the projections in its business plan. This risk category does not measure current profitability.
4. Compliance with state requirements. CMS assesses risk based on whether a state department of insurance determined that a CO-OP was non-compliant with state requirements and, if so, the extent to which remedial action has been implemented. CMS also considers whether the CO-OP has had a history of non-compliance and the severity of any regulatory action taken by a department of insurance.
5. Compliance with CO-OP program requirements. CMS assesses risk based on whether the agency has determined that a CO-OP was non-compliant with CO-OP program loan terms and provisions and, if so, the extent to which the CO-OP has been responsive to CMS officials' requests. CMS also considers whether the CO-OP experienced any legal compliance issues that would affect participation in the program.
6. CO-OP management. CMS assesses risk based on whether the agency identified conflicts of interest with CO-OP management and performance concerns including high turnover, fraud, or a lack of appropriate internal controls.
7. CO-OP infrastructure issues. CMS assesses risk based on whether the agency identified concerns involving the CO-OP's key operating systems—including claims, enrollment and billing, customer service, and utilization management.

For quantitative factors included in the risk assessment, CMS officials told us they compare individual CO-OP data to benchmarks and assign a risk level (high, medium-high, medium, and low) based on the extent of deviation from the benchmarks. For qualitative factors, CMS officials told us they assign CO-OPs a risk level based on responses to a standard set of questions completed by account managers.

To help ensure the most current data are available to be used in the direct analysis and risk assessment tools, CMS enhanced certain reporting requirements associated with the core monitoring activities it previously established. While the agency continues to require routine teleconferences with CO-OPs and standard reporting, CMS enhanced its initial reporting requirements to include submission of enrollment and selected financial data on a monthly basis rather than on a quarterly basis. CMS also now requires CO-OPs to provide certain financial projections quarterly rather than annually.

To respond to issues identified at individual CO-OPs using the direct analysis and risk assessment tools, as well as its other monitoring activities, in November 2014, CMS formally established a framework, known as an escalation plan, for evaluating and responding to concerns. The identification of an issue at a CO-OP is the first of four steps described in the written guidance for establishing and implementing the escalation plan. (See fig. 3.)

Figure 3: Steps in the Centers for Medicare & Medicaid Services' Escalation Plan for Issues Identified at Consumer Operated and Oriented Plans (CO-OPs)

Source: GAO analysis of Centers for Medicare & Medicaid Services policy. | GAO-16-326

Issue identification. CMS initiates the escalation plan when the agency identifies an issue of potential concern at a CO-OP. Identification may be based on information obtained through a variety of sources, including internal channels (e.g., the core monitoring activities, direct analysis, and risk assessments described above) and external channels (e.g., communication with state regulators).

Issue assessment. A CMS account manager conducts a preliminary assessment of the severity, urgency, and nature of the identified issue. Using a standard set of questions, the account manager assesses the issue in light of five sets of considerations: (1) whether the issue was self-

reported by the CO-OP and the frequency with which the CO-OP experienced the same or other issues,[27] (2) the potential impact on the CO-OP's state licensure and exchange participation, (3) the potential impact on the CO-OP's approved business plan, (4) the potential impact on the CO-OP's compliance with program requirements, and (5) the potential impact on the CO-OP's members and markets where it participates. Answers to questions about these considerations result in a score that indicates whether the issue's severity and urgency is of minor, moderate, elevated, or greatest concern. The account manager then refers the preliminary assessment for review and approval by other CMS officials, including a team that has responsibility for evaluating CO-OP program integrity.

Enforcement action. CMS determines an enforcement action based on the final assessment of the issue as of minor, moderate, elevated, or greatest concern. Enforcement actions generally require a corresponding response from the CO-OP to resolve the issue. If the CO-OP's response to an enforcement action does not result in an acceptable resolution to an issue, the agency may elevate the assessment to a higher level and require additional responses from the CO-OP.

- Minor. CMS communicates with CO-OP officials to resolve the issue and prevent a recurrence. Examples of issues that might be assessed as minor—if no other issues were identified—would be challenges in submitting a required report or a divergence of less than 20 percent between the CO-OP's actual enrollment and its most recently projected enrollment.

- Moderate. CMS sends a formal written notice of the issue, known as a warning letter, to CO-OPs that have an issue assessed as a moderate concern. In response, CO-OP officials are required to submit evidence of the development and implementation of a plan to resolve the issue. As of November 9, 2015, CMS had issued warning letters to 11 CO-OPs, of which 7 continue to operate. According to CMS officials, issues for which CMS issued warning letters included the execution of a contract that is core to the CO-OP's business activity (e.g., a contract for a top executive) without the requisite prior CMS approval, and the submission of incomplete data for one of the risk mitigation

[27]All else being equal, CMS considers an unprompted self-reported issue to be a lower risk than an issue brought to CMS's attention by state regulators or other means.

programs.

- Elevated. CMS sends CO-OPs a formal written notice that a corrective action plan is required, an enhanced oversight plan will be implemented, or both. According to CMS officials, they generally require the CO-OP to develop a corrective action plan when they determine that the CO-OP can take action to address the issue and that the action and its effect can be documented; the corrective action plan is subject to CMS approval and monitoring. CMS officials implement an enhanced oversight plan when the issue is urgent or has the potential to become more severe. In response to an enhanced oversight plan, a CO-OP may be required to submit additional reports or may be subjected to additional audits. As of November 9, 2015, CMS had required corrective action plans or implemented enhanced oversight plans (or both) for 15 CO-OPs, of which 8 continue to operate in 2016.[28] Issues for which these were required include CO-OPs failing to comply with state laws and experiencing high enrollment and significant losses. CMS noted that some of the corrective action plans and enhanced oversight plans were the result of unresolved issues that required stronger enforcement actions.

- Greatest. CMS sends CO-OPs a formal written notice, and if a correction action plan and/or enhanced oversight plan cannot resolve the issue, CMS may consider terminating the CO-OP from the program or taking other enforcement measures, such as withholding loan disbursements. As of November 9, 2015, CMS officials had identified an issue of greatest concern at two CO-OPs.[29] For one CO-OP, it required a corrective action plan, and for the other CO-OP, it issued a termination letter. CMS officials noted that these two CO-OPs had issues involving serious and pervasive management problems or financial losses substantial enough to question the

[28]Among the 15 CO-OPs for which CMS required a corrective action plan and/or implemented an enhanced oversight plan, the agency also issued 8 CO-OPs warning letters for issues assessed as moderate concern.

[29]For the two CO-OPs that had issues CMS assessed as greatest concern, CMS issued warning letters for issues the agency assessed as moderate concern to one CO-OP and required corrective action plans for issues the agency assessed as elevated concern for the other CO-OP.

CO-OP's sustainability. Both CO-OPs ceased operations on, or before, January 1, 2016.[30]

Resolution. CMS monitors the CO-OP's progress for resolving an identified issue through status calls, additional reporting requirements, or other actions as appropriate. For some issues determined to be of elevated or greatest concern, CMS may conduct an on-site visit. If CMS determines that an issue has been resolved, CMS returns to a more routine level of monitoring, mindful of the history that the CO-OP had with the issue. If the problem is not resolved, or if the process of investigating an issue reveals other issues, CMS can re-assess the issue and take further actions, and it has done so with several CO-OPs. As already noted, CMS may ultimately determine that a satisfactory resolution is not likely and therefore pursue the option to terminate its loan agreement with the CO-OP. As of November 1, 2015, CMS had issued one termination letter following use of the escalation plan.[31]

[30]Of the 11 CO-OPs that provided coverage during 2015, but no longer operate, 9 had issues assessed as moderate, elevated, or greatest concern under the escalation plan. The CO-OP that offered health plans in Iowa and Nebraska ceased operations shortly after CMS implemented its escalation plan and as a result was not subject to it.

[31]According to CMS officials, 9 of 12 CO-OPs that ceased operations have received a termination letter as of late January 2016. The other 3 CO-OPs will receive a termination letter at a later date.

Escalation Plan Case Study: Louisiana Health Cooperative, Inc.

CMS officials learned in December 2014, through routine communication with the CO-OP and the Louisiana Department of Insurance (LDI), that LDI was preparing to notify the CO-OP that it had been found in a condition that would render continuance of its business hazardous to policyholders, creditors, or others. CMS had previously noted certain risks with the CO-OP's finances. CMS assessed the issue as an elevated concern and issued a letter in January 2015 requiring the CO-OP to provide information and a corrective action plan. The CO-OP responded in February 2015, citing problems with its third-party administrator—an entity with which the CO-OP had contracted to process claims—and describing its corrective action plan. CMS determined that the plan was not sufficient and issued a letter in March 2015 requesting revisions. The CO-OP submitted a revised corrective action plan, which CMS officials also found insufficient. Meanwhile, in response to LDI, the CO-OP submitted updated enrollment and financial data, which led CMS to question whether enrollment was sufficient for financial stability. CMS issued another letter in April 2015, asking for information and a corrective action plan to address these issues and stating that CMS would conduct a site visit. During that visit, CMS officials observed a number of serious and pervasive deficiencies. In response, CMS reassessed the issue as one of greatest concern and issued a letter in June 2015, summarizing its findings and stating that a complete and quick resolution was necessary to avoid termination of the loan agreement; the letter included specific milestones and dates. The CO-OP's board met in July and decided to cease operations by the end of 2015. According to CMS officials, the agency continues to monitor and oversee the CO-OP as the CO-OP and LDI work to cease operations with as few negative consequences as possible.

Source: GAO analysis of Centers for Medicare & Medicaid Services and state information. | GAO-16-326

In addition to developing the tools to evaluate performance and sustainability and the escalation plan, CMS formed a committee that, according to CMS officials, is to look at the CO-OP program as a whole—beyond individual issues or CO-OPs. The committee is to identify and address risks to, and concerns about, the program and make recommendations to address any risks or concerns identified. CMS officials told us that the committee consists of officials from across the agency with actuarial, health insurance, financial, legal, and health insurance exchange experience and expertise.

CMS is also using an independent auditor to conduct another review of CO-OPs, focusing on compliance and financial management. A preliminary audit phase was conducted to determine whether each CO-OP had established and documented controls and processes for five key areas, in accordance with the NAIC Market Conduct Examination Standards: (1) claims, (2) policyholder service, (3) complaint handling, (4)

provider credentialing, and (5) marketing and sales.[32] Based on the results of the preliminary phase, the auditor is to perform one of two types of reviews—a general review or a focused review—at each CO-OP; a more focused review is to be performed at CO-OPs that did not appear to have initially met the NAIC Market Conduct Examination Standards. CMS officials told us that the preliminary phase was completed in June 2015, and that the second phase is on-going and is expected to be completed by the middle of 2016 for the 11 CO-OPs that continued to operate as of January 4, 2016.

CMS officials told us that prior to the start of the 2016 open enrollment period, they assessed the CO-OPs with particular attention to their sustainability through 2016. According to CMS officials, they worked with CO-OPs and states' departments of insurance to address concerns relating to CO-OP sustainability. The goal of these efforts was to provide some assurance that CO-OPs with serious financial or operational difficulties (or both) took timely and effective action to address those difficulties or made plans to cease operations before the 2016 open enrollment period, which began on November 1, 2015. In addition, CMS officials told us that, to the extent possible, they plan to monitor CO-OPs that have ceased operations. When a CO-OP closes, the state's department of insurance takes the lead responsibility in winding down operations. CMS officials told us that their goal is to work with the CO-OPs and their states' departments of insurance to bring operations to an end in a way that minimizes negative effects on members, as well as to recover program loan funding to the extent possible.[33]

[32]In general, market conduct refers to the ways insurance companies distribute their products. Market conduct examinations are one form of oversight used by states' departments of insurance to help ensure insurance companies operate in ways that are legal and fair to consumers and customers have access to beneficial and compliant insurance products.

[33]According to CMS officials, it is too early to conclude whether, and to what extent, CO-OP program loan funding will be recovered. In general, member claims have first priority for payment followed by other liabilities and creditors, including CMS. State departments of insurance generally have responsibility for managing the liquidation process.

CO-OPs' 2015 Premiums Were Generally Lower than Their 2014 Premiums and Other Issuers' 2015 Premiums

Most CO-OPs' Premiums for 2015 Were Lower than Their 2014 Premiums

Our analysis showed that in most of the 20 states where CO-OPs offered health plans on the exchange during both the 2014 and 2015 open enrollment periods, the state-wide average monthly premium for a 30-year-old individual to purchase a CO-OP silver health plan was lower for 2015 than for the previous year. Specifically, there were 14 states where the state-wide average monthly premium for silver plans offered by CO-OPs decreased, with decreases ranging from $1.47 per month in Kentucky to $180.44 per month in Arizona. In 9 of these states, the decrease in the state-wide average premium was more than $30 per month. Of the 6 states where the state-wide average premium for silver plans offered by CO-OPs increased, the increases did not exceed $20 per month. As table 2 shows, the pattern of changes in average premiums for CO-OPs that continued to operate as of January 4, 2016, is similar to the pattern of change for CO-OPs that have ceased operations. Of the 11 states where CO-OPs no longer operate, 5 had decreases in the CO-OP's average monthly premium of more than $30, while the other 6 had increases or decreases less than $30. In the 10 states where CO-OPs continued to operate as of January 4, 2016, 4 had decreases in the CO-OP's average monthly premium of more than $30, while the other 6 had increases or decreases of less than $30.[34]

[34]The 11 states with CO-OPs that no longer operate and the 10 states with CO-OPs that continued to operate as of January 4, 2016, both included Oregon. Oregon initially had two CO-OPs, but one ceased operations on January 1, 2016.

Table 2: State-wide Average Premiums for 30-Year-Old Individuals for Silver Tier Health Plans for Consumer Operated and Oriented Plans (CO-OPs), 2014 and 2015

	Average CO-OP monthly premium		
State	2014	2015	Increase (decrease)
States where CO-OPs continued to operate (as of January 4, 2016)			
Connecticut	$346.07	$312.64	$(33.43)
Illinois	312.10	231.69	(80.41)
Maine	300.59	308.87	8.28
Maryland	251.06	217.97	(33.09)
Massachusetts	263.39	244.87	(18.52)
Montana	239.16	221.73	(17.43)
New Jersey	359.70	288.78	(70.92)
New Mexico	227.85	218.92	(8.93)
Oregon[a]	243.78	240.32	(3.46)
Wisconsin	281.36	300.69	19.33
States where a CO-OP has ceased to operate			
Arizona	$426.50	$246.06	($180.44)
Colorado	315.64	237.07	(78.57)
Kentucky	228.07	226.60	(1.47)
Louisiana	307.69	322.23	14.54
Michigan	367.76	320.62	(47.14)
Nevada	299.91	262.47	(37.44)
New York	313.68	325.43	11.75
Oregon[a]	243.78	240.32	(3.46)
South Carolina	263.91	266.52	2.61
Tennessee	272.67	213.55	(59.12)
Utah	235.53	238.53	3.00

Source: GAO analysis of Centers for Medicare & Medicaid Services and state data. | GAO-16-326

Note: This table includes states where CO-OPs offered health plans on the exchange in both 2014 and 2015. Ohio is not included because the CO-OP did not offer plans on the exchange in 2014.

[a]In 2014 and 2015, two CO-OPs offered health plans in Oregon. One of these CO-OPs ceased operations on January 1, 2016. Amounts for Oregon in this table represent the average premiums of these two CO-OPs.

For 2016, the state-wide average premiums for silver health plans increased from 2015 in 8 of 10 states where CO-OPs continue to operate. (See appendixes II through XIV for more details on the range of premiums in 2014, 2015, and 2016 for silver health plans in the states where CO-OPs continued operate as of January 4, 2016.)

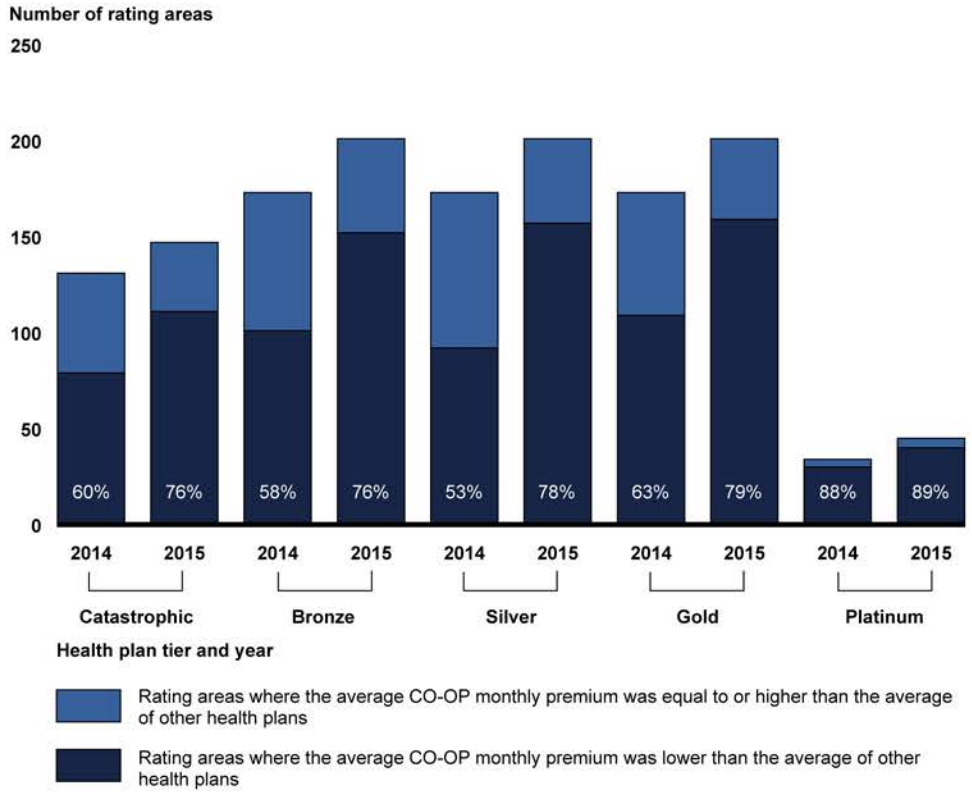
Average CO-OP Premiums in 2015 Were Generally Lower than those for Other Issuers

In the 23 states where CO-OPs offered health plans on the states' health insurance exchanges in 2015, our analysis showed that the average monthly premiums for CO-OP health plans in all tiers were lower than the average monthly premiums for other health plans for 30-year-old individuals in most rating areas.[35] CO-OPs offered bronze, silver, and gold tier health plans in 94 percent of the rating areas where they offered plans; they offered catastrophic and platinum tier health plans in fewer rating areas.[36] For all five tiers, the average premiums for CO-OP health plans were lower than the average premiums for other health plans in more than 75 percent of ratings areas where both a CO-OP and at least one other issuer offered health plans. (See fig. 4.)

[35]The relationship between the average premiums for CO-OPs and other health plans for 30-year-old individuals was similar to the relationship for the other categories of policyholders we analyzed: 40 and 60-year-old individuals; 30, 40, and 60-year-old couples; and 30 and 50-year-old couples with two children

[36]In total, there were 214 rating areas in the 23 states where CO-OPs offered health plans on the states' health insurance exchanges during the 2015 open enrollment period. CO-OPs offered catastrophic health plans in 69 percent of rating areas and platinum health plans in 27 percent.

Figure 4: Rating Areas Where the Average Monthly Premium for Consumer Operated and Oriented Plans (CO-OPs) Was Lower than the Average of Other Health Plans, for 30-Year-Old Individuals, 2014 and 2015



Source: GAO analysis of Centers for Medicare & Medicaid Services and state data. | GAO-16-326

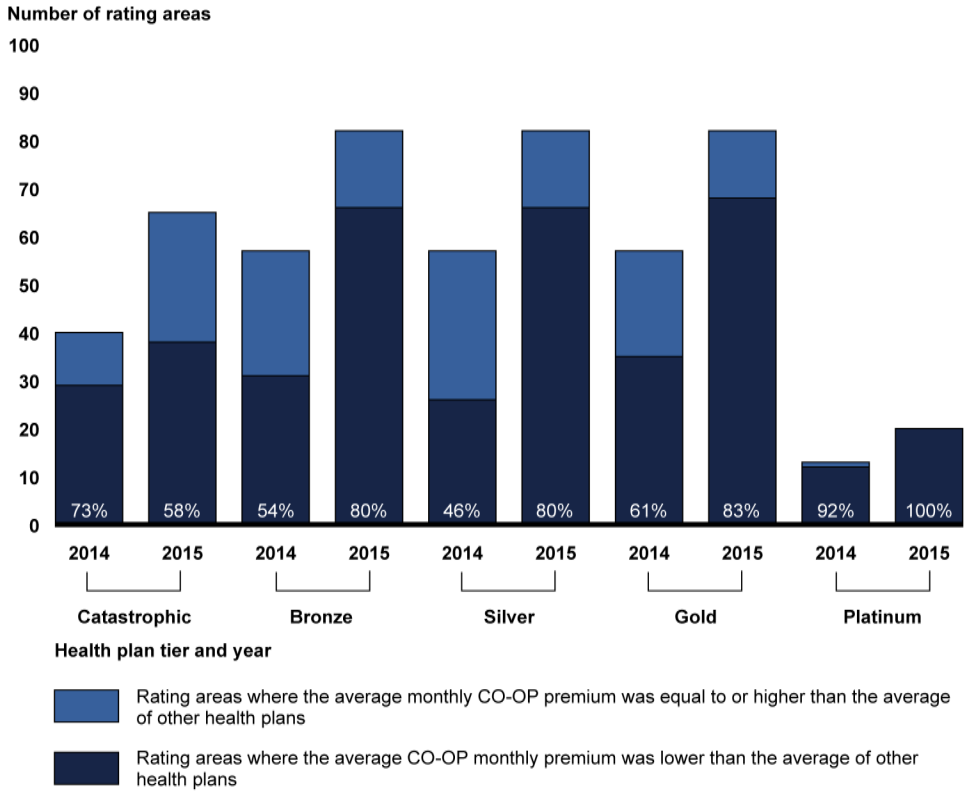
Notes: In total, there were 202 rating areas in the 22 states where CO-OPs offered health plans on the states' health insurance exchanges during the 2014 open enrollment period. In total, there were 214 rating areas in the 23 states where CO-OPs offered health plans on the states' health insurance exchanges during the 2015 open enrollment period.

Plans in the same metal level have the same actuarial value. Catastrophic plans are not required to meet actuarial value targets, but must have actuarial values less than 60 percent.

Counts reflect rating areas where both a CO-OP and at least one other issuer offered health plans.

As shown in figure 4, the average monthly premiums for CO-OP health plans in all tiers were lower than for other issuers in a higher percentage of rating areas in 2015 than in 2014. Moreover, the number of ratings areas where a CO-OP and at least one other issuer offered health plans, and the number of rating areas where the average monthly CO-OP premium was lower than the average monthly premium from other issuers both increased from 2014 to 2015. As shown in figure 5, we found this same pattern of premiums when we restricted our analysis to the states where CO-OPs continued to operate as of January 4, 2016.

Figure 5: Rating Areas Where the Average Monthly Premium for Consumer Operated and Oriented Plans (CO-OPs) Operating in 2016 Was Lower than the Average of Other Health Plans, for 30-Year-Old Individuals, 2014 and 2015



Source: GAO analysis of Centers for Medicare & Medicaid Services and state data. | GAO-16-326

Notes: In total, there were 69 rating areas in the 10 states where CO-OPs offered health plans on the states' health insurance exchanges during the 2014 open enrollment period. In total, there were 94 rating areas in the 13 states where CO-OPs offered health plans on the states' health insurance exchanges during the 2015 open enrollment period. Issuers did not always offer health plans in each tier.

Plans in the same metal level have the same actuarial value. Catastrophic plans are not required to meet actuarial value targets, but must have actuarial values less than 60 percent.

Counts reflect rating areas where both a CO-OP and at least one other issuer offered health plans.

Although average CO-OP premiums for 30-year-old individuals were lower than those of other insurers in most rating areas, the percentage of rating areas where we found this difference varied substantially across states for silver health plans.

- In 10 states, the average monthly premium for CO-OP silver plans was lower than for other silver plans in 100 percent of the states' rating areas. Of these 10 states, CO-OPs continued to operate in 7 as

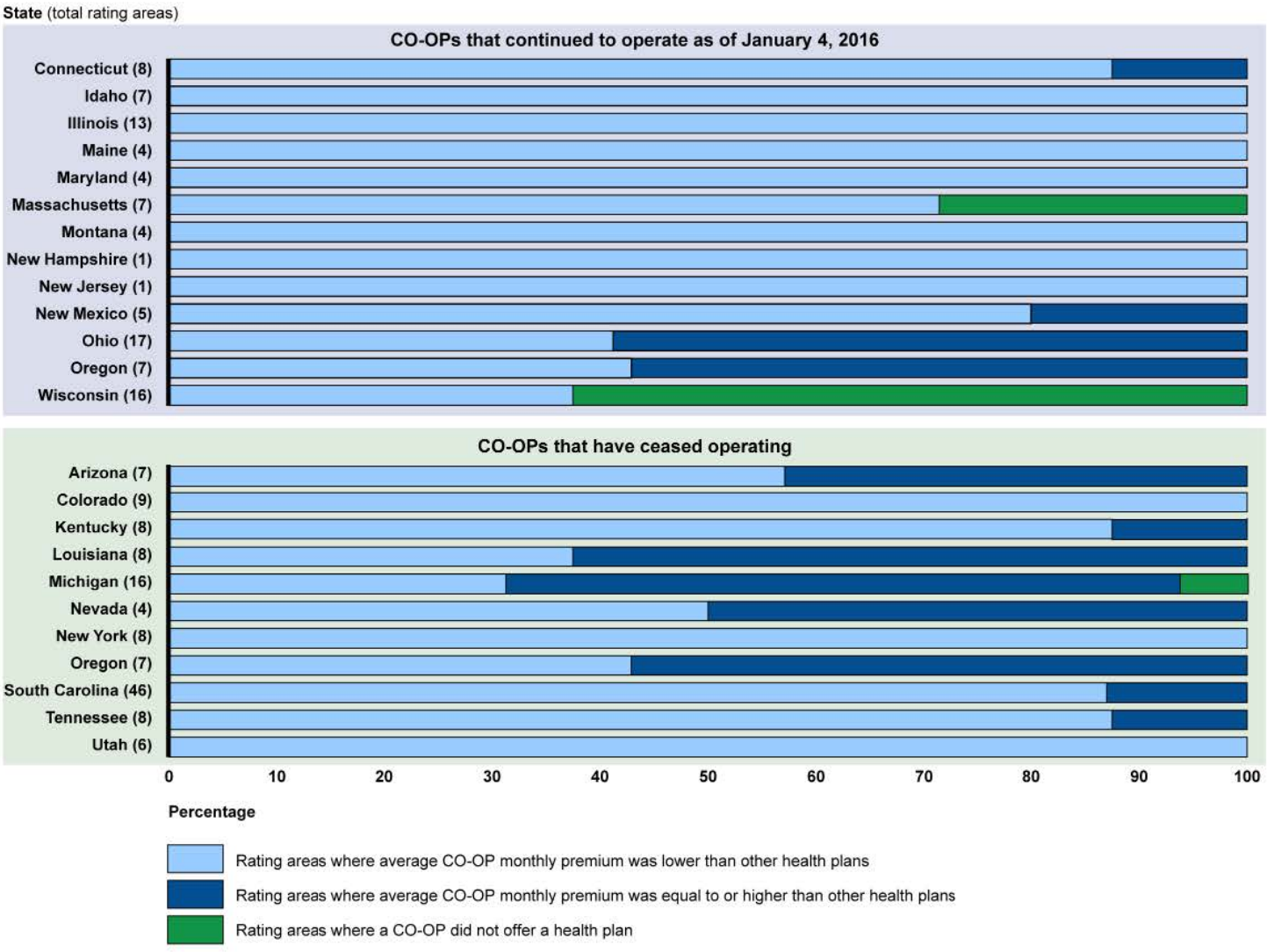
of January 4, 2016.

- In two states where the CO-OPs did not offer silver plans in each rating area, but continued to operate, the average premiums for CO-OPs were lower than for other issuers in all of the rating areas where the CO-OPs offered silver health plans.

- For five states, the average premium for CO-OP silver health plans was equal to or higher than for other silver plans in 50 percent of the rating areas or more.

The percentage of rating areas where the average premium for CO-OP silver plans was equal to or higher than for other silver plans tended to be higher in the 11 states where CO-OPs no longer operate than in those where CO-OPs continued to operate as of January 4, 2016. (See fig. 6 and appendixes II through XIV for more details on how the CO-OPs were priced in relation to other health plans in each of the states where CO-OPs continued to operate as of January 4, 2016.)

Figure 6: Percentage of Rating Areas Where the Average 2015 Monthly Premium for Consumer Operated and Oriented Plan (CO-OP) Silver Health Plans Was Lower than the Average for Other Silver Health Plans, for 30-Year-Old Individuals



Source: GAO analysis of Centers for Medicare & Medicaid Services and state data. | GAO-16-326

Notes: In 2015, two CO-OPs offered health plans in Oregon. One of these CO-OPs ceased operations on January 1, 2016. The percentages for Oregon represent the average premiums of both CO-OPs.

CO-OP Enrollment Doubled from 2014 to 2015, but Less than Half Was in CO-OPs Continuing in 2016, and Enrollment for Most CO-OPs Differed from Projections

The 22 CO-OPs that participated in the 2015 open enrollment period together reported, as of June 30, 2015, enrollment of over 1 million—more than double the total enrollment reported at the same time the previous year. Specifically, the 22 CO-OPs gained 610,420 net new members, with all but one CO-OP experiencing an increase in enrollment.[37] The 11 CO-OPs that continued to operate as of January 4, 2016, reported about 391,855 in enrollment in 2015—representing about 38 percent of the combined CO-OP enrollment. Increases in enrollment for these 11 CO-OPs ranged from 11,139 to 56,889. The 3 CO-OPs that reported the largest enrollment as of June 30, 2015, are among those CO-OPs that no longer operate. (See table 3.)

Table 3: Enrollment in Consumer Operated and Oriented Plan (CO-OP) Health Plans, 2014 and 2015

	Enrollment as of June 30		
CO-OP (State(s) where health plans offered)	**2014**	**2015**	**Increase (decrease)**
CO-OPs that continued to operate (as of January 4, 2016)			
Community Health Options (Maine and New Hampshire)	38,226	70,454	32,228
Health Republic Insurance of New Jersey (New Jersey)	3,111	60,000[a]	56,889
Land of Lincoln Health (Illinois)	3,221	49,126	45,905
Montana Health Cooperative (Montana and Idaho)	12,052	42,302	30,250
Common Ground Healthcare Cooperative (Wisconsin)	25,421	36,560	11,139
New Mexico Health Connections (New Mexico)	9,412	32,812	23,400
HealthyCT (Connecticut)	2,558	31,212	28,654
InHealth Mutual (Ohio)	3,816	21,933	18,117
Evergreen Health Cooperative, Inc. (Maryland)	1,589	19,339	17,750
Minutemen Health, Inc. (Massachusetts and New Hampshire)	1,907	14,814	12,907
Oregon's Health CO-OP (Oregon)	1,055	13,303	12,248
Total	**102,368**	**391,855**	**289,487**
CO-OPs that have ceased to operate			
Health Republic Insurance of New York (New York)	126,738	209,136	82,398

[37]Enrollment in the CO-OP in Kentucky decreased from 56,680 to 51,665—a decline of 5,015 members.

CO-OP (State(s) where health plans offered)	Enrollment as of June 30 2014	2015	Increase (decrease)
Colorado HealthOP (Colorado)	13,466	80,282	66,816
Consumers' Choice Health Insurance Company (South Carolina)	50,155	71,594	21,439
Meritus Health Partners (Arizona)	3,601	56,019	52,418
Kentucky Health Care Cooperative, Inc. (Kentucky)	55,852	51,665	(4,187)
Arches Health Plan (Utah)	19,357	49,198	29,841
Community Health Alliance Mutual Insurance Company (Tennessee)	1,657	31,109	29,452
Consumers Mutual Insurance of Michigan (Michigan)	1,519	26,813	25,294
Nevada Health Cooperative (Nevada)	15,368	20,578	5,210
Louisiana Health Cooperative, Inc. (Louisiana)	13,022	17,176	4,154
Health Republic Insurance of Oregon (Oregon)	5,230	13,328	8,098
Total	**305,965**	**626,898**	**320,933**
Total overall enrollment	**408,333**	**1,018,753**	**610,420**

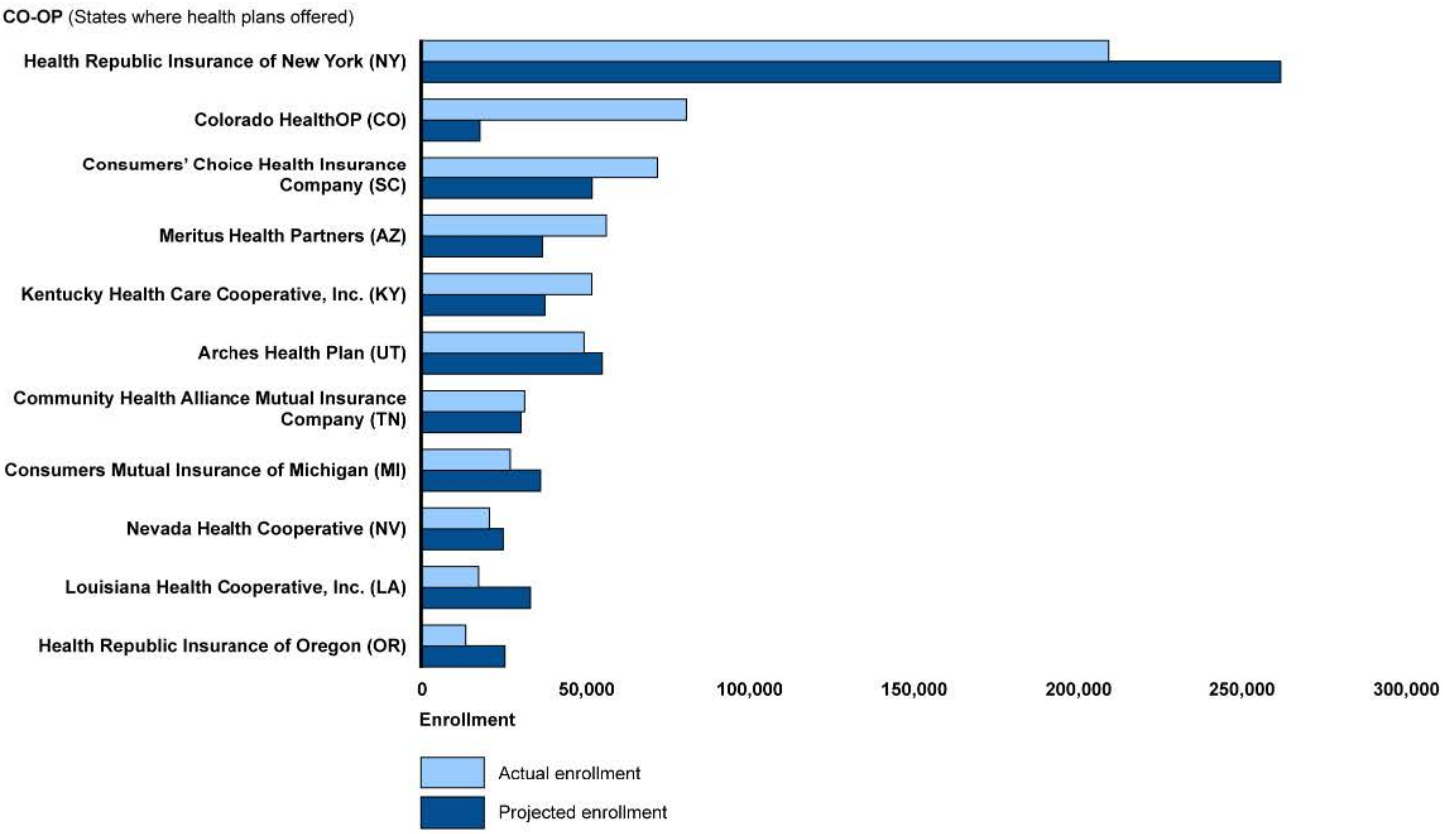
Source: GAO analysis of data from National Association of Insurance Commissioners. | GAO-16-326

Note: Oregon's Health CO-OP and Health Republic Insurance of Oregon both offered health plans in Oregon in 2014 and 2015. On January 1, 2016, the Health Republic Insurance of Oregon ceased operations.

[a]According to the National Association of Insurance Commissioners, enrollment as of June 30, 2015, for Health Republic Insurance of New Jersey was not available due to restrictions from New Jersey Department of Banking and Insurance. This amount is an estimate reported publicly by Health Republic Insurance of New Jersey.

Overall, our analysis showed that CO-OPs' combined enrollment for 2015 exceeded their projections by more than 6 percent, but half of the CO-OPs did not meet or exceed their individual projections. As figure 7 shows, of the 11 CO-OPs that have ceased operations, 6 did not meet their individual enrollment projections, while 5 CO-OPs exceeded their projections. (See fig. 7.)

Figure 7: Actual and Projected 2015 Enrollment for Consumer Operated and Oriented Plans (CO-OPs) that Have Ceased Operations



Source: GAO analysis of National Association of Insurance Commissioners and Centers for Medicare & Medicaid Services data. | GAO-16-326

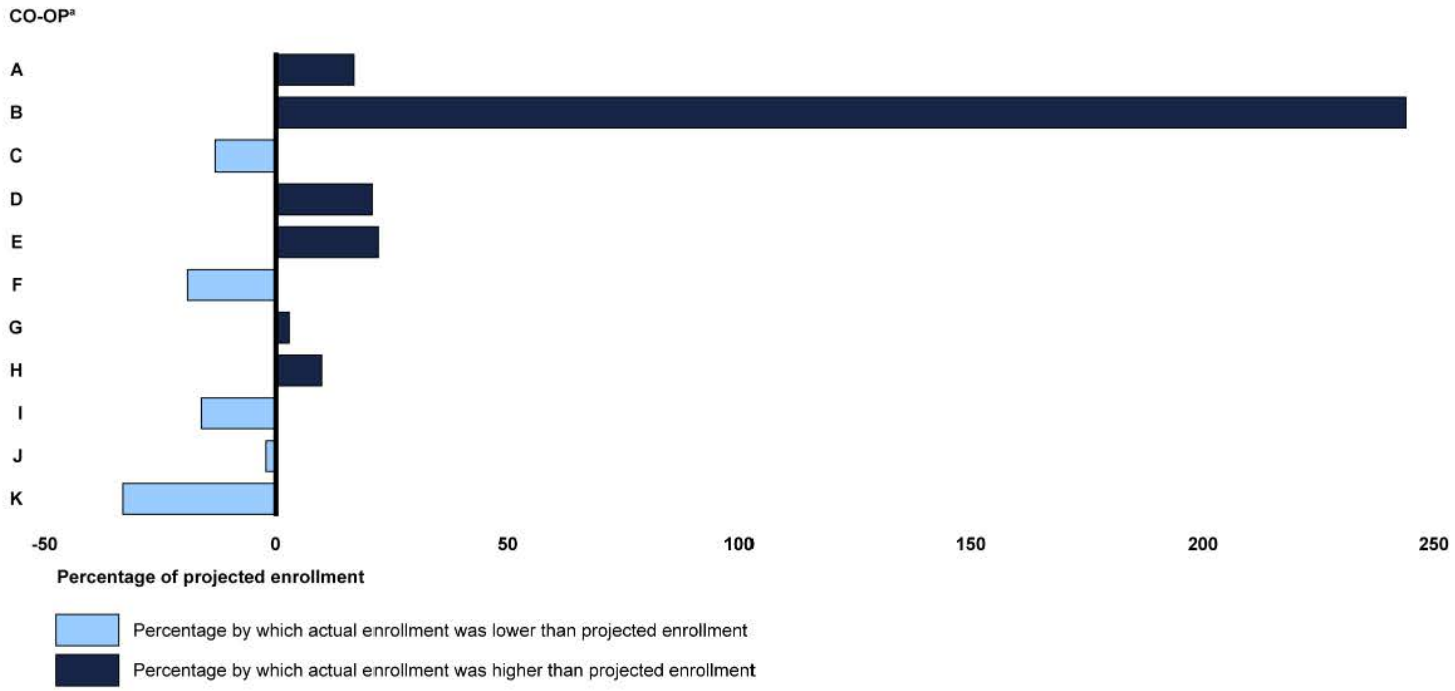
Further, of the 11 CO-OPs that continued to operate as of January 4, 2016, 6 exceeded their 2015 enrollment projections by June 30, 2015.[38] (See fig. 8.) Our analysis, however, also found that 4 CO-OPs had not yet reached a program benchmark of enrolling at least 25,000 members.[39]

[38]According to CMS officials, enrollment projections for the 11 CO-OPs that continued to operate as of January 4, 2016, are considered business-sensitive information. Accordingly, we are not reporting the names associated with specific results of our comparison of projected and actual enrollment.

[39]CMS officials told us that the minimum number of members that can normally be expected to permit a CO-OP to have financial solvency is in the range of 25,000 to 50,000.

According to CMS officials, exceeding this benchmark can be important for CO-OPs, because that number of enrollees should better allow a health insurance issuer to cover its fixed costs. CMS officials told us that they are monitoring the CO-OPs' enrollment with attention to this benchmark.

Figure 8: The Percentage by Which Actual Enrollment, as of June 30, 2015, Differed from Projected 2015 Enrollment for the Consumer Operated and Oriented Plans (CO-OPs) that Continued to Operate as of January 4, 2016



Source: GAO analysis of National Association of Insurance Commissioners and Centers for Medicare & Medicaid Services data. | GAO-16-326

[a]According to officials from the Centers for Medicare & Medicaid Services, enrollment projections for the 11 CO-OPs that continued to operate as of January 4, 2016, are considered business-sensitive information. Accordingly, we are not reporting the names of specific CO-OPs.

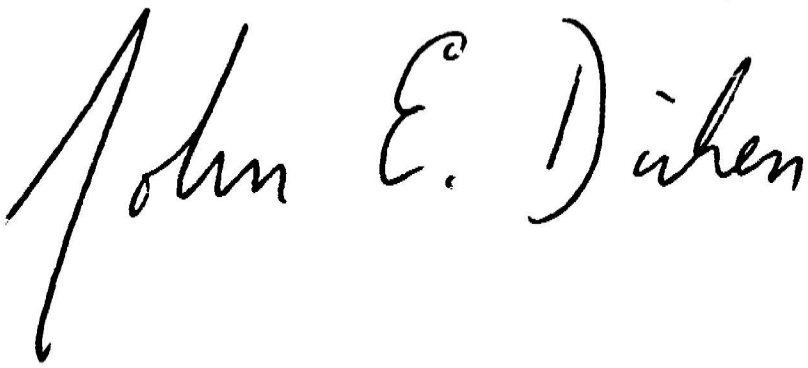
Agency Comments

We provided a draft of this report to HHS for comment. In its written comments, which appear in appendix XV, HHS stated its commitment to CO-OP beneficiaries and taxpayers in managing the CO-OP program, noted the achievements of the CO-OP program to date, and described developments in the department's oversight activities. In addition, HHS stated its goal to help facilitate the acquisition of additional capital or the development of other business relationships that could assist those

CO-OPs that continue to operate in achieving their goals and described its efforts to support them. HHS also provided technical comments, which we incorporated as appropriate.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of Health and Human Services and other interested parties. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or dickenj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix XVI.



John E. Dicken
Director, Health Care

List of Requesters

The Honorable Orrin G. Hatch
Chairman
Committee on Finance
United States Senate

The Honorable Lamar Alexander
Chairman
Committee on Health, Education, Labor, and Pensions
United States Senate

The Honorable Michael B. Enzi
Chairman
Subcommittee on Primary Health and Retirement Security
Committee on Health, Education, Labor, and Pensions
United States Senate

The Honorable Richard Burr
United States Senate

Appendix I: Consumer Operated and Oriented Plans and Loan Awards

The Centers for Medicare & Medicaid Services awarded consumer operated and oriented plan (CO-OP) program loans totaling more than $2.4 billion, of which about $358 million was awarded for start-up loans and about $2.1 billion was awarded for solvency loans. Table 4 provides the total amounts awarded to each of the 23 CO-OPs established with funds disbursed under the CO-OP program loans. As of January 4, 2016, 11 CO-OPs continued to operate while, 12 CO-OPs had ceased operations.

Table 4: Consumer Operated and Oriented Plans (CO-OPs) and CO-OP Program Loan Awards

CO-OP (State(s) where health plans were offered)	Total CO-OP program loan awards
CO-OPs that continued to operate as of January 4, 2016	
Land of Lincoln Health (Illinois)	$160,154,812
Minutemen Health, Inc. (Massachusetts and New Hampshire)	156,442,995
Community Health Options (Maine and New Hampshire)	132,316,124
InHealth Mutual (Ohio)	129,225,604
HealthyCT (Connecticut)	127,980,768
Health Republic Insurance of New Jersey (New Jersey)	109,074,550
Common Ground Healthcare Cooperative (Wisconsin)	107,739,354
Montana Health Cooperative (Montana and Idaho)	85,019,688
New Mexico Health Connections (New Mexico)	77,317,782
Evergreen Health Cooperative, Inc. (Maryland)	65,450,900
Oregon's Health CO-OP (Oregon)	56,656,900
CO-OPs that ceased to operate	
Health Republic Insurance of New York (New York)	$265,133,000
Kentucky Health Care Cooperative, Inc. (Kentucky)	146,494,772
CoOportunity Health (Iowa and Nebraska)	145,312,100
Meritus Health Partners (Arizona)	93,313,233
Arches Health Plan (Utah)	89,650,303
Consumers' Choice Health Insurance Company (South Carolina)	87,578,208
Community Health Alliance Mutual Insurance Company (Tennessee)	73,306,700
Colorado HealthOP (Colorado)	72,335,129

CO-OP (State(s) where health plans were offered)	Total CO-OP program loan awards
Consumers Mutual Insurance of Michigan (Michigan)	71,534,300
Nevada Health Cooperative (Nevada)	65,925,396
Louisiana Health Cooperative, Inc. (Louisiana)	65,790,660
Health Republic Insurance of Oregon (Oregon)	60,648,505
Total loan award amounts	$2,444,401,783

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-16-326

Notes: One additional organization in Vermont received loan awards totaling about $14.4 million. This organization was subsequently denied a license as a health insurance issuer by the state, and, as a result, CMS terminated the organization's participation in the CO-OP program.

Oregon's Health CO-OP and Health Republic Insurance of Oregon both offered health plans in Oregon in 2014 and 2015. On January 1, 2016, the Health Republic Insurance of Oregon ceased operations.

Appendix II: Premiums for the Consumer Operated and Oriented Plan Relative to Premiums for Other Health Plans in Connecticut

The state-wide average monthly premium for the consumer operated and oriented plan's (CO-OP) silver health plans for 30-year-old individuals in Connecticut decreased from 2014 to 2015, but increased from 2015 to 2016. Specifically, the average decrease from 2014 to 2015 was about $33, and the average increase from 2015 to 2016 was about $32. (See table 5.)

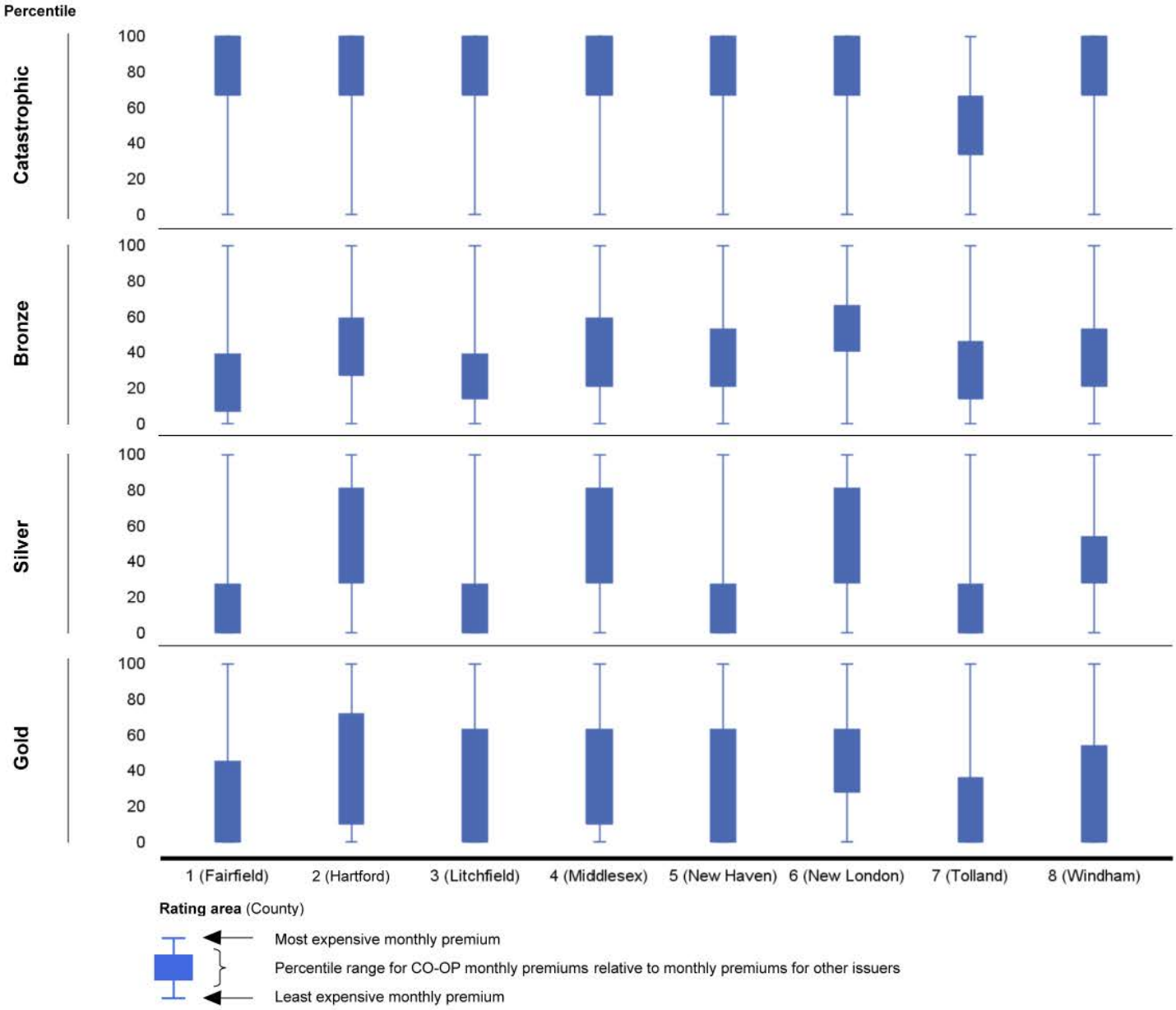
Table 5: Premiums for the Consumer Operated and Oriented Plan's (CO-OP) Silver Health Plans and Other Silver Health Plans in Connecticut for 30-Year-Old Individuals, 2014 though 2016

		Monthly premiums		
Year	Silver health plans	Minimum	Average	Maximum
2014	CO-OP	$311.76	$346.07	$387.41
	Other	280.79	309.02	375.27
2015	CO-OP	286.95	312.64	343.97
	Other	285.10	324.31	379.78
2016	CO-OP	309.62	344.38	383.21
	Other	281.00	324.77	386.59

Source: GAO analysis of state data. | GAO-16-326

For 2015, the CO-OP in Connecticut offered catastrophic, bronze, silver, and gold health plans in each of the state's eight rating areas, but did not offer a platinum health plan. Figure 9 shows the percentile range in which CO-OP monthly premiums for 30-year-old individuals fell after rank-ordering all plans in each rating area. The premiums for health plans offered by the CO-OP in Connecticut were generally among the most expensive premiums for catastrophic health plans. For gold health plans, the CO-OP's premiums were among the least expensive or in the middle. The CO-OP's premiums for bronze and silver health plans were among the least expensive premiums in some rating areas, while ranging from the middle to among the most expensive premiums in others.

Figure 9: Relative Ranking (in Percentiles) of 2015 Premiums for the Consumer Operated and Oriented Plan (CO-OP) Compared to Premiums for Other Health Plans by Rating Area and Tier in Connecticut for 30-Year-Old Individuals



Source: GAO analysis of state data. | GAO-16-326

Notes: In total, there were eight rating areas in Connecticut. The CO-OP did not offer a platinum health plan. Plans in the same metal level have the same actuarial value. Catastrophic plans are not required to meet actuarial value targets, but must have actuarial values less than 60 percent.

Appendix III: Premiums for the Consumer Operated and Oriented Plan Relative to Premiums for Other Health Plans in Idaho

The consumer operated and oriented plans (CO-OP) from Montana offered health plans on the Idaho health insurance exchange for the first time in 2015. The state-wide average monthly premium for CO-OP silver health plans for 30-year-old individuals increased from 2015 to 2016. Specifically, the average increase was about $57. (See table 6.)

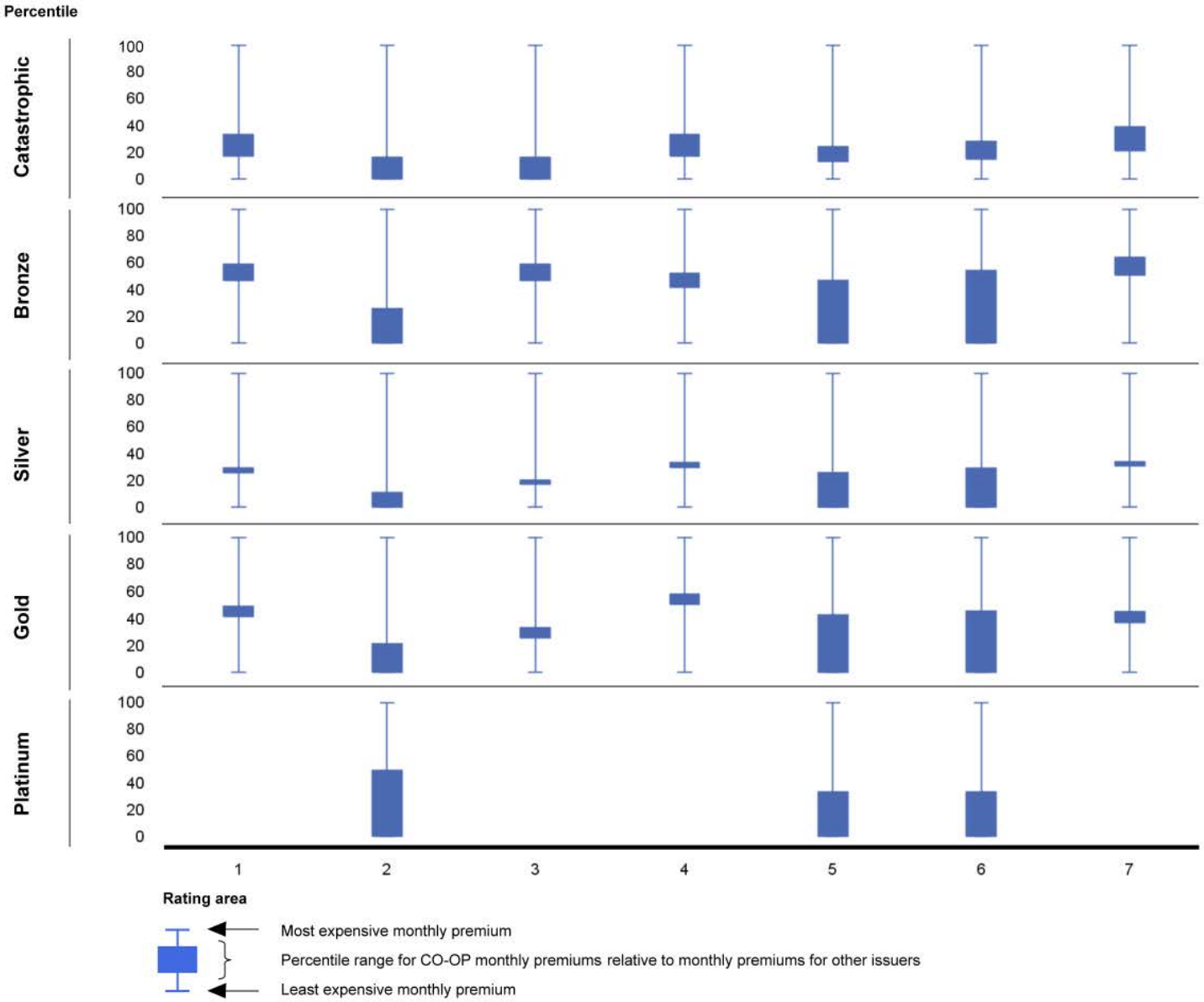
Table 6: Premiums for the Consumer Operated and Oriented Plan's (CO-OP) Silver Health Plans and Other Silver Health Plans in Idaho for 30-Year-Old Individuals, 2015 and 2016

		Monthly premiums		
Year	Silver health plans	Minimum	Average	Maximum
2015	CO-OP	$179.82	$206.61	$243.81
	Other	210.03	270.21	401.00
2016	CO-OP	235.01	263.59	300.91
	Other	242.69	324.88	381.00

Source: GAO analysis of state data. | GAO-16-326

For 2015, the CO-OP in Idaho offered catastrophic, bronze, silver, and gold health plans in each of the state's seven rating areas, but offered platinum health plans in only three. Figure 10 shows the percentile range in which CO-OP monthly premiums for 30-year-old individuals fell after rank-ordering all plans in each rating area. The premiums for health plans offered by the CO-OP in Idaho were generally in the middle with premiums in some rating areas ranging from the least expensive to the middle.

Figure 10: Relative Ranking (in Percentiles) of 2015 Premiums for the Consumer Operated and Oriented Plan (CO-OP) Compared to Premiums for Other Health Plans by Rating Area and Tier in Idaho for 30-Year-Old Individuals



Source: GAO analysis of state data. | GAO-16-326

Notes: In total, there were seven rating areas in Idaho. The CO-OP offered platinum health plans only in rating areas 2, 5, and 6. Plans in the same metal level have the same actuarial value. Catastrophic plans are not required to meet actuarial value targets, but must have actuarial values less than 60 percent.

Rating area 1 includes zip codes that begin with 832.

Rating area 2 includes zip codes that begin with 833.

Rating area 3 includes zip codes that begin with 834.

Rating area 4 includes zip codes that begin with 835.

Rating area 5 includes zip codes that begin with 836.

Rating area 6 includes zip codes that begin with 837.

Rating area 7 includes zip codes that begin with 838.

Appendix IV: Premiums for the Consumer Operated and Oriented Plan Relative to Premiums for Other Health Plans in Illinois

The state-wide average monthly premium for the consumer operated and oriented plan's (CO-OP) silver health plans for 30-year-old individuals in Illinois decreased from 2014 to 2015, but increased from 2015 to 2016. Specifically, the average decrease from 2014 to 2015 was about $80, and the average increase from 2015 to 2016 was about $61. (See table 7.)

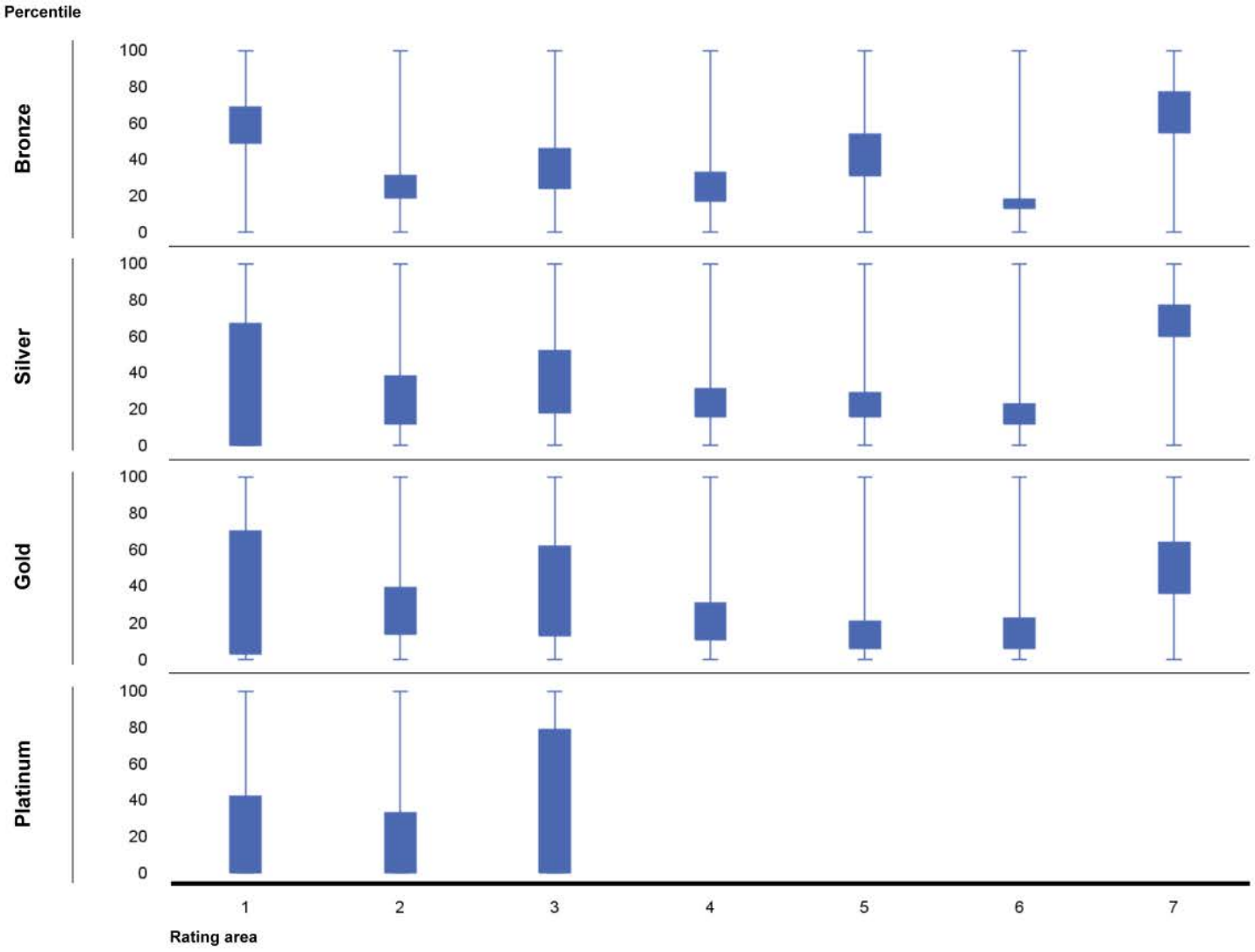
Table 7: Premiums for the Consumer Operated and Oriented Plan's (CO-OP) Silver Health Plans and Other Silver Health Plans in Illinois for 30-Year-Old Individuals, 2014 through 2016

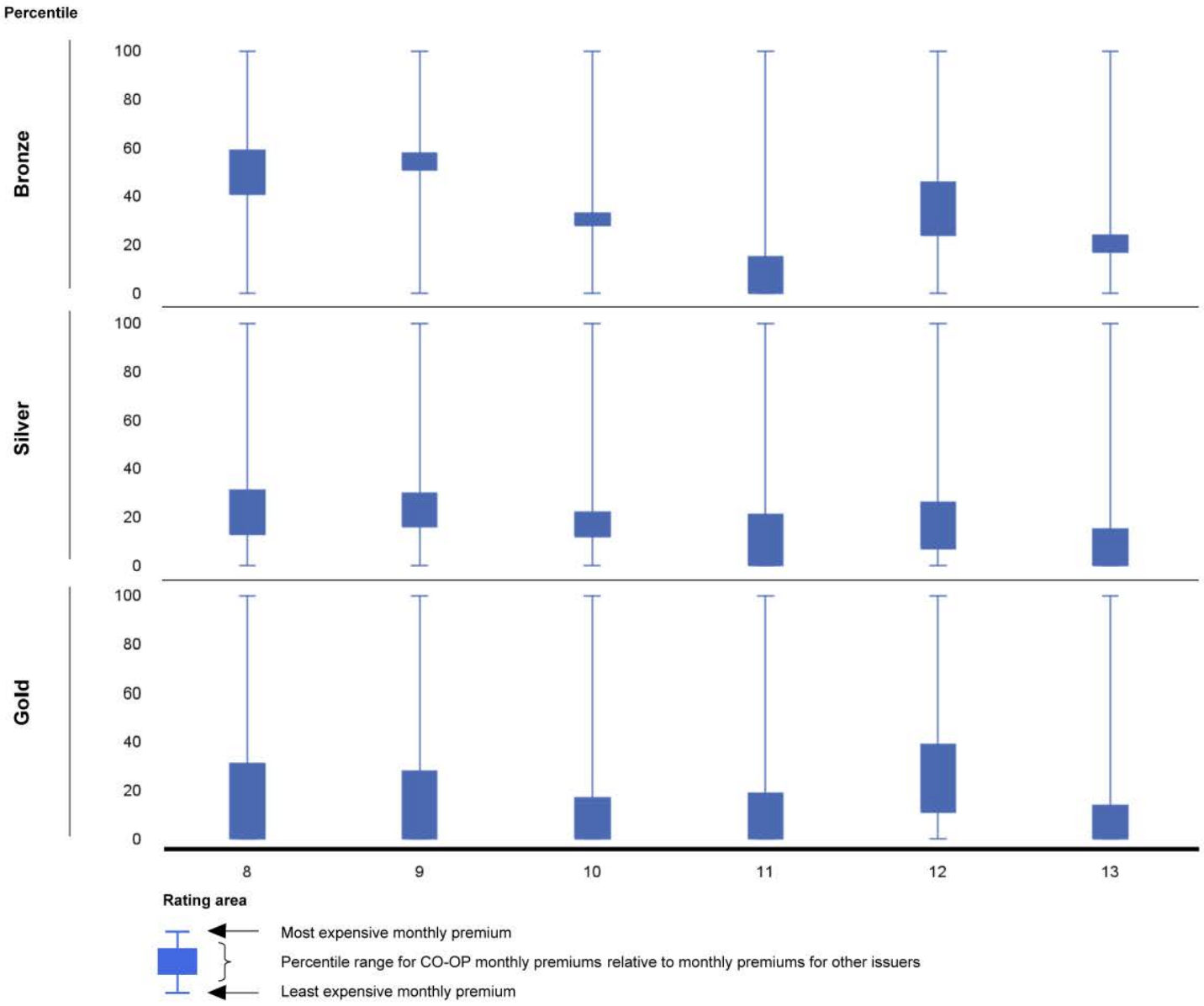
		Monthly premiums		
Year	Silver health plans	Minimum	Average	Maximum
2014	CO-OP	$258.47	$312.10	$355.58
	Other	170.07	260.86	362.00
2015	CO-OP	188.60	231.69	275.53
	Other	185.41	272.10	510.64
2016	CO-OP	225.75	292.33	359.78
	Other	172.99	290.72	446.41

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-326

For 2015, the CO-OP in Illinois offered bronze, silver, and gold health plans in each of the state's 13 rating areas. The CO-OP offered platinum health plans in three rating areas, but did not offer any catastrophic health plans. Figure 11 shows the percentile range in which CO-OP monthly premiums for 30-year-old individuals fell after rank-ordering all plans in each rating area. The premiums for health plans offered by the CO-OP in Illinois tended to be among the least expensive or in the middle.

Figure 11: Relative Ranking (in Percentiles) of 2015 Premiums for the Consumer Operated and Oriented Plan (CO-OP) Compared to Premiums for Other Health Plans by Rating Area and Tier in Illinois for 30-Year-Old Individuals





Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-326

Notes: In total, there were 13 rating areas in Illinois. The CO-OP did not offer catastrophic health plans. The CO-OP offered platinum health plans only in rating areas 1, 2, and 3. Plans in the same metal level have the same actuarial value.

Rating area 1 includes Cook County.

Rating area 2 includes Lake and McHenry counties.

Rating area 3 includes Dupage and Kane counties.

Rating area 4 includes Grundy, Kankakee, Kendall, and Will counties.

Rating area 5 includes Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, and Winnebago counties.

Rating area 6 includes Bureau, Hancock, Henderson, Henry, Mercer, Rock Island, Warren, and Whiteside counties.

Rating area 7 includes Fulton, Knox, LaSalle, Marshall, McDonough, Peoria, Putnam, Stark, Tazewell, and Woodford counties.

Rating area 8 includes DeWitt, Livingston, and McLean counties.

Rating area 9 includes Champaign, Clark, Coles, Cumberland, Douglas, Edgar, Ford, Iroquois, Piatt, and Vermillion counties.

Rating area 10 includes Adams, Brown, Cass, Christian, Logan, Macon, Mason, Menard, Morgan, Moultrie, Pike, Sangamon, Schuyler, Scott, and Shelby counties.

Rating area 11 includes Bond, Calhoun, Clinton, Greene, Jersey, Macoupin, Montgomery, Randolph, and Washington counties.

Rating area 12 includes Madison, Monroe, and St. Clair counties.

Rating area 13 includes Alexander, Clay, Crawford, Edwards, Effingham, Fayette, Franklin, Gallatin, Hamilton, Hardin, Jackson, Jasper, Jefferson, Johnson, Lawrence, Marion, Massac, Perry, Pope, Pulaski, Richland, Saline, Union, Wabash, Wayne, White, and Williamson counties.

Appendix V: Premiums for the Consumer Operated and Oriented Plan Relative to Premiums for Other Health Plans in Maine

The state-wide average monthly premium for the consumer operated and oriented plan's (CO-OP) silver health plans for 30-year-old individuals in Maine increased from 2014 to 2015, but decreased slightly from 2015 to 2016. Specifically, the average increase from 2014 to 2015 was about $8, and the average decrease from 2015 to 2016 was about $1. (See table 8.)

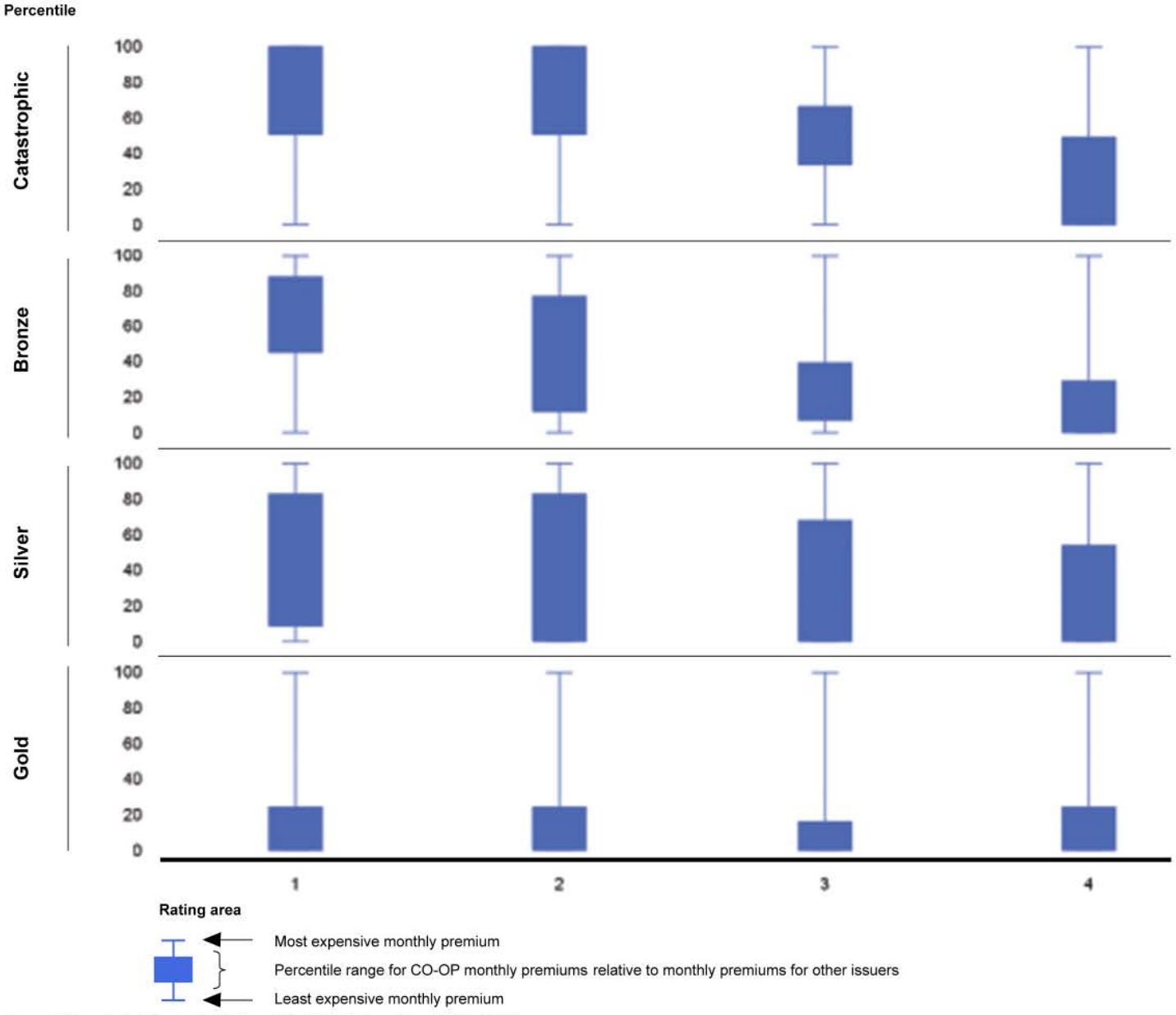
Table 8: Premiums for the Consumer Operated and Oriented Plan's (CO-OP) Silver Health Plans and Other Silver Health Plans in Maine for 30-Year-Old Individuals, 2014 through 2016

		Monthly premiums		
Year	Silver health plans	Minimum	Average	Maximum
2014	CO-OP	$251.83	$300.59	$368.45
	Other	263.96	334.62	400.18
2015	CO-OP	250.38	308.87	393.12
	Other	244.06	341.73	471.55
2016	CO-OP	252.29	307.98	389.44
	Other	252.94	317.32	448.94

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-326

For 2015, the CO-OP in Maine offered catastrophic, bronze, silver, and gold health plans in each of the state's four rating areas, but did not offer a platinum health plan. Figure 12 shows the percentile range in which CO-OP monthly premiums for 30-year-old individuals fell after rank-ordering all plans in each rating area. The premiums for catastrophic, silver, and bronze health plans offered by the CO-OP in Maine were among the most expensive in some rating areas, the least expensive in some, and in the middle in others. Premiums for gold health plans were among the least expensive.

Figure 12: Relative Ranking (in Percentiles) of 2015 Premiums for the Consumer Operated and Oriented Plan (CO-OP) Compared to Premiums for Other Health Plans by Rating Area and Tier in Maine for 30-Year-Old Individuals



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-326

Notes: In total, there were four rating areas in Maine. The CO-OP did not offer platinum health plans. Plans in the same metal level have the same actuarial value. Catastrophic plans are not required to meet actuarial value targets, but must have actuarial values less than 60 percent.

Rating area 1 includes Cumberland, Sagadahoc, and York counties.

Rating area 2 includes Kennebec, Knox, Lincoln, and Oxford counties.

Rating area 3 includes Androscoggin, Franklin, Penobscot, Piscataquis, Somerset, and Waldo counties.

Rating area 4 includes Aroostook, Hancock, and Washington counties.

Appendix VI: Premiums for the Consumer Operated and Oriented Plan Relative to Premiums for Other Health Plans in Maryland

The state-wide average monthly premium for the consumer operated and oriented plan's (CO-OP) silver health plans for 30-year-old individuals in Maryland decreased from 2014 to 2015, but increased from 2015 to 2016. Specifically, the average decrease from 2014 to 2015 was about $33, and the average increase from 2015 to 2016 was about $18. (See table 9.)

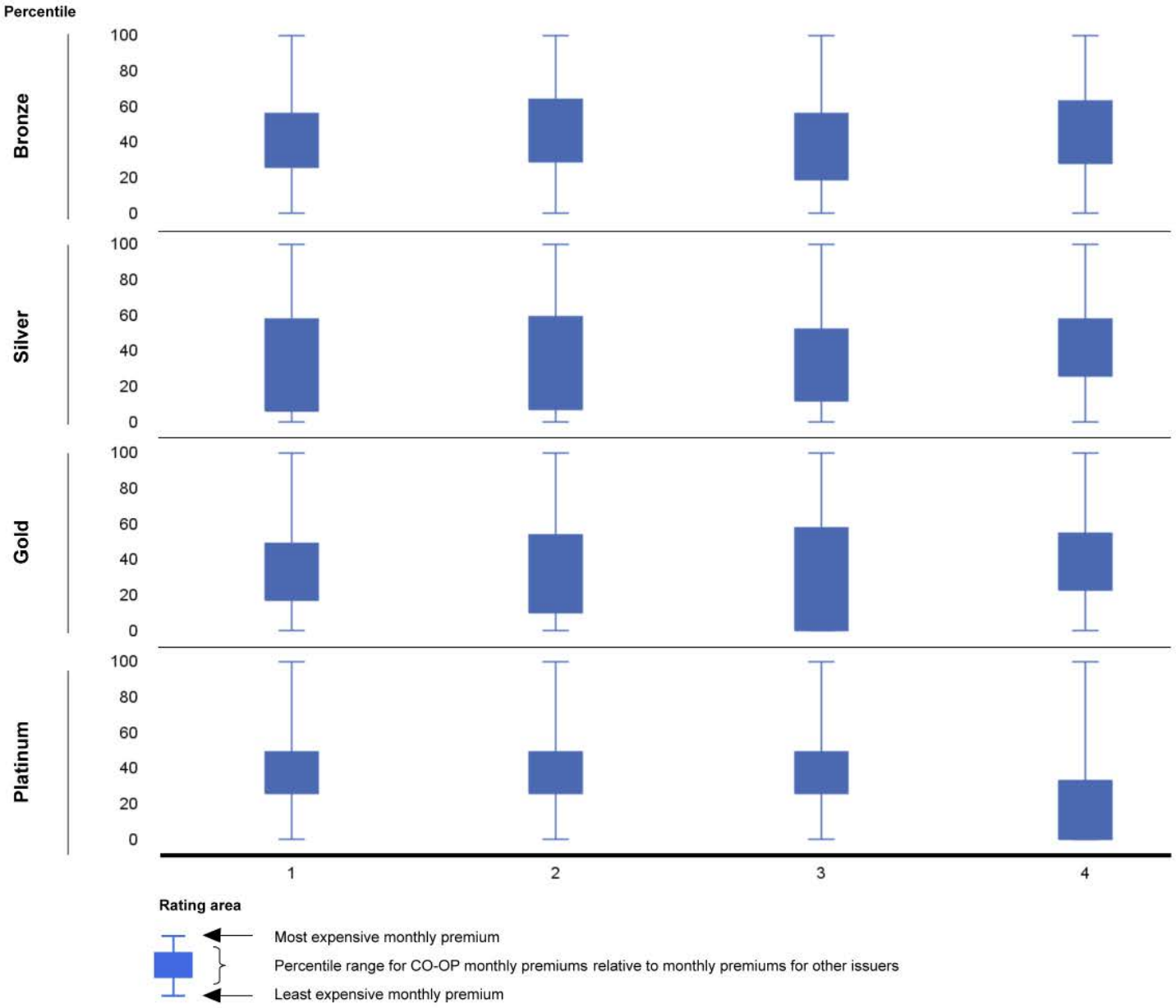
Table 9: Premiums for the Consumer Operated and Oriented Plan's (CO-OP) Silver Health Plans and Other Silver Health Plans in Maryland for 30-Year-Old Individuals, 2014 through 2016

		Monthly premiums		
Year	Silver health plans	Minimum	Average	Maximum
2014	CO-OP	$213.00	$251.06	$282.00
	Other	187.00	248.07	305.00
2015	CO-OP	205.32	217.97	234.55
	Other	199.58	246.43	306.60
2016	CO-OP	224.03	235.66	246.36
	Other	216.15	272.10	313.61

Source: GAO analysis of state data. | GAO-16-326

For 2015, the CO-OP in Maryland offered bronze, silver, gold, and platinum health plans in each of the state's four rating areas, but did not offer catastrophic health plans. Figure 13 shows the percentile range in which CO-OP monthly premiums for 30-year-old individuals fell after rank-ordering all plans in each rating area. The premiums for health plans offered by the CO-OP in Maryland were generally in the middle.

Figure 13: Relative Ranking (in Percentiles) of 2015 Premiums for the Consumer Operated and Oriented Plan (CO-OP) Compared to Premiums for Other Health Plans by Rating Area and Tier in Maryland for 30-Year-Old Individuals



Source: GAO analysis of state data. | GAO-16-326

Notes: In total, there were four rating areas in Maryland. The CO-OP did not offer catastrophic health plans. Plans in the same metal level have the same actuarial value.

Rating area 1 includes Anne Arundel, Baltimore, Baltimore City, Harford, and Howard counties.

Rating area 2 includes Calvert, Caroline, Cecil, Charles, Dorchester, Kent, Queen Anne's, Somerset, St. Mary's, Talbot, Wicomico, and Worcester counties.

Rating area 3 includes Montgomery and Prince George's counties.

Rating area 4 includes Allegany, Carroll, Frederick, Garrett, and Washington counties.

Appendix VII: Premiums for the Consumer Operated and Oriented Plan Relative to Premiums for Other Health Plans in Massachusetts

The state-wide average monthly premium for the consumer operated and oriented plan's (CO-OP) silver health plans for 30-year-old individuals in Massachusetts decreased from 2014 to 2015, but increased from 2015 to 2016. Specifically, the average decrease from 2014 to 2015 was about $19, and the average increase from 2015 to 2016 was about $7. (See table 10.)

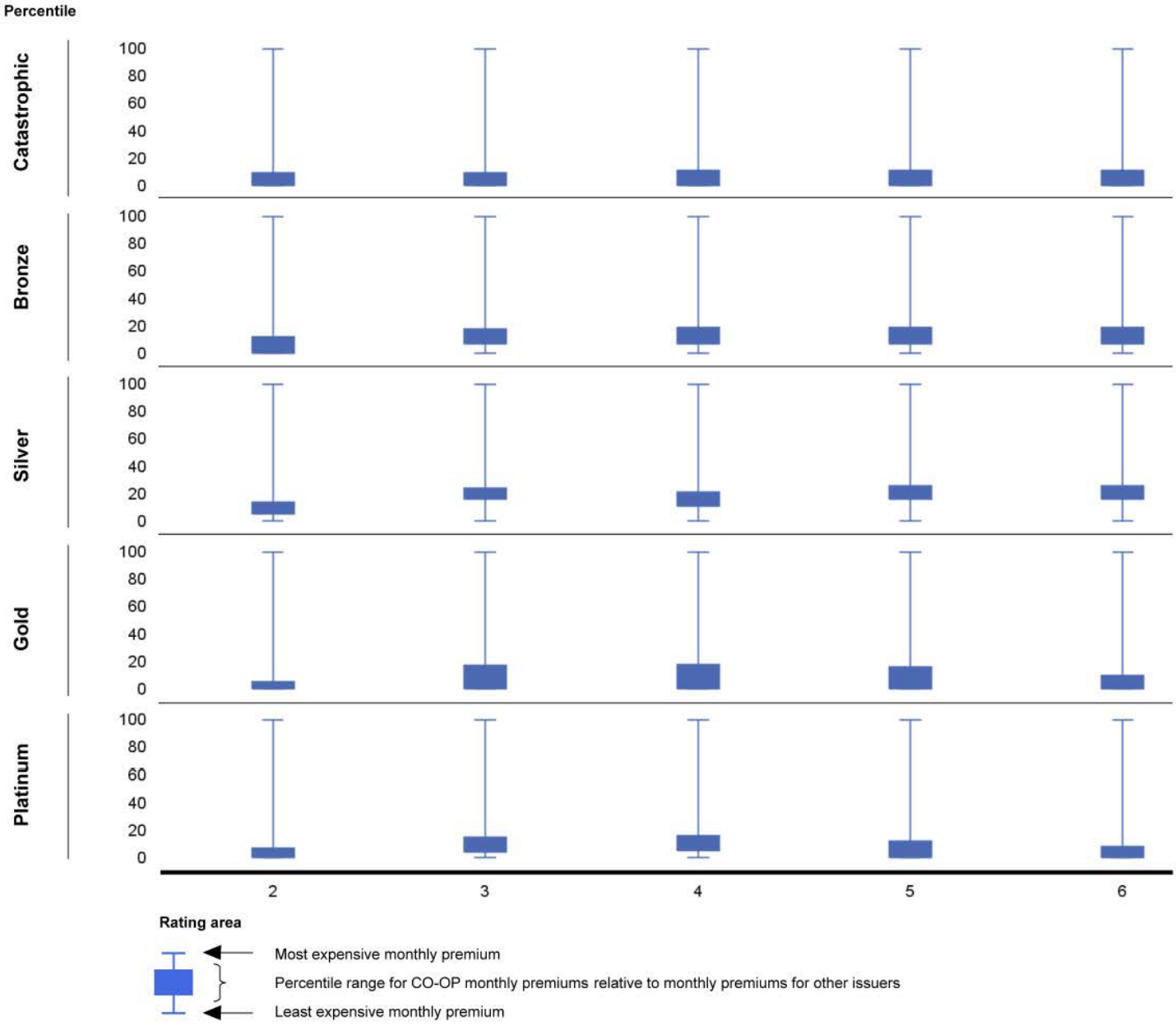
Table 10: Premiums for the Consumer Operated and Oriented Plan's (CO-OP) Silver Health Plans and Other Silver Health Plans in Massachusetts for 30-Year-Old Individuals, 2014 through 2016

		Monthly premiums		
Year	Silver health plans	Minimum	Average	Maximum
2014	CO-OP	$233.44	$263.39	$291.44
	Other	216.31	309.42	423.58
2015	CO-OP	222.36	244.87	264.57
	Other	191.62	314.45	426.00
2016	CO-OP	234.81	251.50	264.31
	Other	221.27	322.16	468.73

Source: GAO analysis of state data. | GAO-16-326

For 2015, the CO-OP in Massachusetts offered plans in all tiers in five of the state's seven rating areas. Figure 14 shows the percentile range in which CO-OP monthly premiums for 30-year-old individuals fell after rank-ordering all plans in each rating area. The premiums for health plans offered by the CO-OP in Massachusetts were among the least expensive across all tiers and rating areas.

Figure 14: Relative Ranking (in Percentiles) of 2015 Premiums for the Consumer Operated and Oriented Plan (CO-OP) Compared to Premiums for Other Health Plans by Rating Area and Tier in Massachusetts for 30-Year-Old Individuals



Source: GAO analysis of state data. | GAO-16-326

Notes: In total, there were seven rating areas in Massachusetts. The CO-OP did not offer health plans in rating areas 1 and 7. Plans in the same metal level have the same actuarial value. Catastrophic plans are not required to meet actuarial value targets, but must have actuarial values less than 60 percent.

Rating area 1 includes zip codes that begin with 010, 011, 012, and 013.

Rating area 2 includes zip codes that begin with 014, 015, and 016.

Rating area 3 includes zip codes that begin with 017 and 020.

Rating area 4 includes zip codes that begin with 018 and 019.

Rating area 5 includes zip codes that begin with 021, 022, and 024.

Rating area 6 includes zip codes that begin with 023 and 027.

Rating area 7 includes zip codes that begin with 025 and 026.

Appendix VIII: Premiums for the Consumer Operated and Oriented Plan Relative to Premiums for Other Health Plans in Montana

The state-wide average monthly premium for the consumer operated and oriented plan's (CO-OP) silver health plans for 30-year-old individuals in Montana decreased from 2014 to 2015, but increased from 2015 to 2016. Specifically, the average decrease from 2014 to 2015 was about $17, and the average increase from 2015 to 2016 was about $75. (See table 11.)

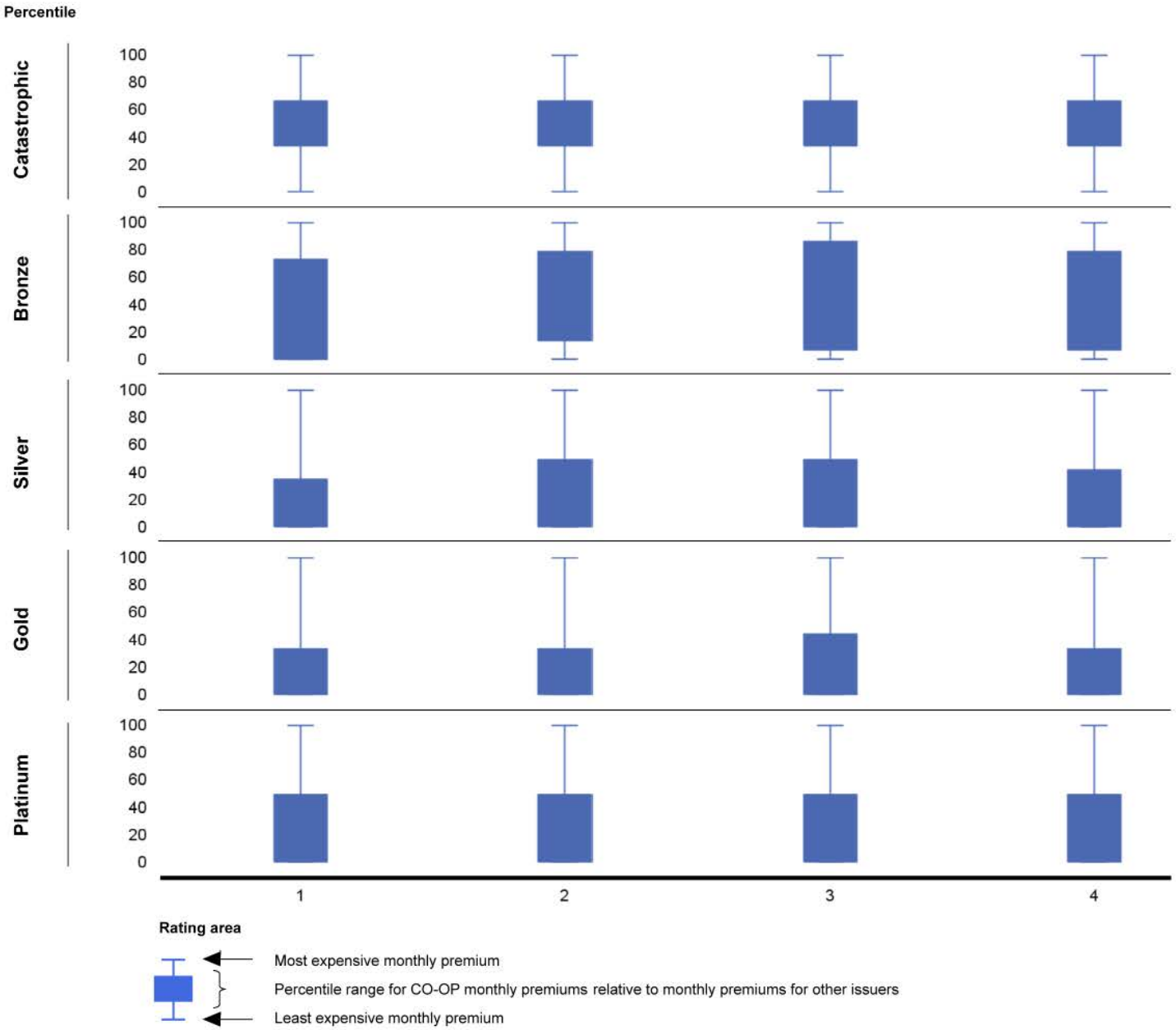
Table 11: Premiums for the Consumer Operated and Oriented Plan's (CO-OP) Silver Health Plans and Other Silver Health Plans in Montana for 30-Year-Old Individuals, 2014 through 2016

		Monthly premiums		
Year	Silver health plans	Minimum	Average	Maximum
2014	CO-OP	$229.15	$239.16	$249.37
	Other	215.00	236.80	275.00
2015	CO-OP	208.96	221.73	243.69
	Other	218.00	251.60	297.19
2016	CO-OP	281.03	296.80	324.65
	Other	286.09	314.51	358.00

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-326

For 2015, the CO-OP in Montana offered plans in all tiers in each of the state's four rating areas. Figure 15 shows the percentile range in which CO-OP monthly premiums for 30-year-old individuals fell after rank-ordering all plans in each rating area. The CO-OP premiums for catastrophic health plans offered by the CO-OP in Montana were generally in the middle. The CO-OP premiums were among the least expensive premiums or in the middle for silver, gold, and platinum plans. CO-OP premiums for bronze plans ranged from among the least to most expensive.

Figure 15: Relative Ranking (in Percentiles) of 2015 Premiums for the Consumer Operated and Oriented Plan (CO-OP) Compared to Premiums for Other Health Plans by Rating Area and Tier in Montana for 30-Year-Old Individuals



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-326

Notes: In total, there were four rating areas in Montana. Plans in the same metal level have the same actuarial value. Catastrophic plans are not required to meet actuarial value targets, but must have actuarial values less than 60 percent.

Rating area 1 includes Carbon, Musselshell, Stillwater, Sweet Grass and Yellowstone counties.

Rating area 2 includes Broadwater, Cascade, Chouteau, Clark, Deer Lodge, Gallatin, Judith Basin, Lewis and Jefferson, Silver Bow, and Teton counties.

Rating area 3 includes Flathead, Lake, and Missoula counties.

Rating area 4 includes Beaverhead, Big Horn, Blaine, Carter, Custer, Daniels, Dawson, Fallon, Fergus, Garfield, Glacier, Golden Valley, Granite, Hill, Liberty, Lincoln, Madison, McCone, Meagher, Mineral, Park, Petroleum, Phillips, Pondera, Powder River, Powell, Prairie, Ravalli, Richland, Roosevelt, Rosebud, Sanders, Sheridan, Toole, Treasure, Valley, Wheatland, and Wibaux counties.

Appendix IX: Premiums for the Consumer Operated and Oriented Plans Relative to Premiums for Other Health Plans in New Hampshire

The consumer operated and oriented plans (CO-OP) from Maine and Massachusetts both offered health plans on the New Hampshire health insurance exchange for the first time in 2015. The state-wide average premiums for CO-OP silver health plans for 30-year-old individuals increased from 2015 to 2016. Specifically, the average increase was about $33. (See table 12.)

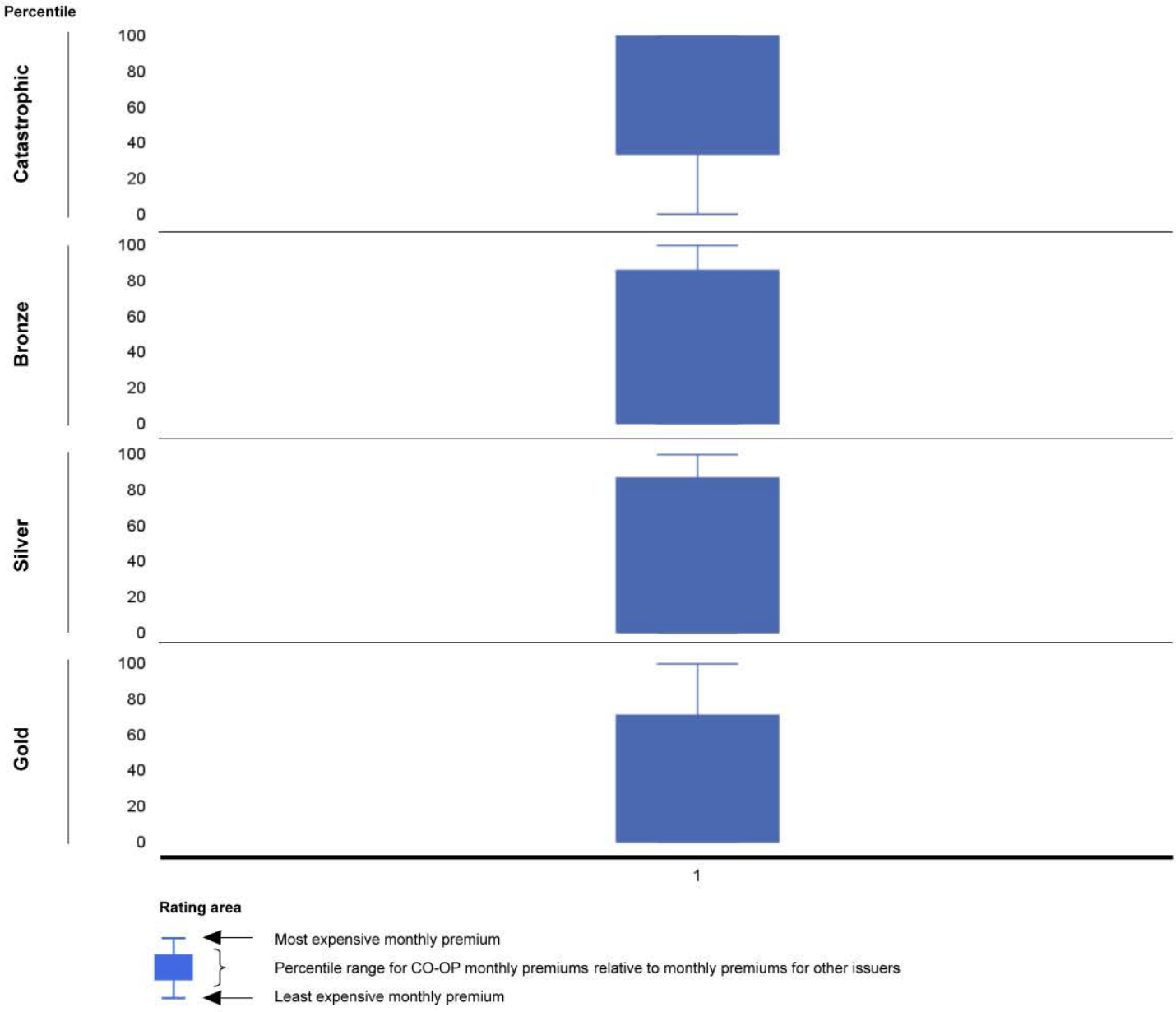
Table 12: Premiums for the Consumer Operated and Oriented Plans' (CO-OP) Silver Health Plans and Other Silver Health Plans in New Hampshire for 30-Year-Old Individuals, 2015 and 2016

		Monthly premiums		
Year	Silver health plans	Minimum	Average	Maximum
2015	CO-OP	$211.18	$270.71	$319.39
	Other	251.86	308.94	429.18
2016	CO-OP	230.87	303.65	371.56
	Other	256.79	286.02	359.03

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-326

For 2015, CO-OPs in New Hampshire offered health plans in all tiers except for platinum in the state's single rating area. Figure 16 shows the percentile range in which CO-OP monthly premiums for 30-year-old individuals fell after rank-ordering all plans in the state's single rating area. The premiums for health plans offered by the two CO-OPs in New Hampshire varied widely. CO-OP premiums for bronze, silver, and gold health plans ranged from the least to the most expensive. Premiums for catastrophic plans ranged from the middle to the most expensive.

Figure 16: Relative Ranking (in Percentiles) of 2015 Premiums for the Two Consumer Operated and Oriented Plans (CO-OPs) Compared to Premiums for Other Health Plans by Rating Area and Tier in New Hampshire for 30-Year-Old Individuals



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-326

Notes: There was one rating area in New Hampshire. The CO-OPs from Maine and Massachusetts both offered health plans in New Hampshire. The two CO-OPs did not offer platinum health plans. Plans in the same metal level have the same actuarial value. Catastrophic plans are not required to meet actuarial value targets, but must have actuarial values less than 60 percent.

Appendix IX: Premiums for the Consumer Operated and Oriented Plans Relative to Premiums for Other Health Plans in New Hampshire

Rating area 1 includes Belknap, Carroll, Cheshire, Coos, Grafton, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan counties.

Appendix X: Premiums for the Consumer Operated and Oriented Plan Relative to Premiums for Other Health Plans in New Jersey

The state-wide average monthly premium for the consumer operated and oriented plan's (CO-OP) silver health plans for 30-year-old individuals in New Jersey decreased from 2014 to 2015, but increased from 2015 to 2016. Specifically, the average decrease from 2014 to 2015 was about $71 and the average increase from 2015 to 2016 was about $54. (See table 13.)

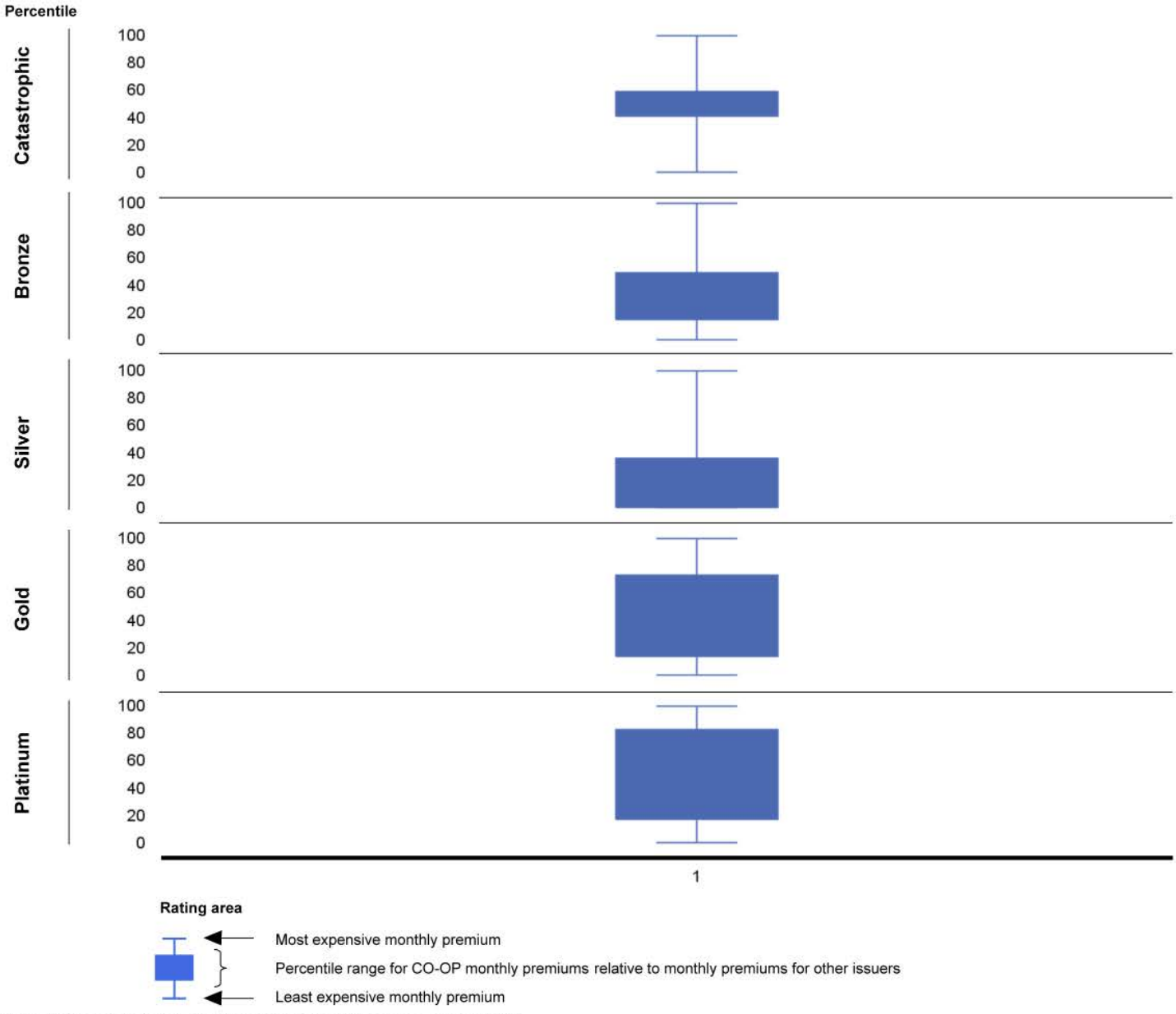
Table 13: Premiums for the Consumer Operated and Oriented Plan's (CO-OP) Silver Health Plans and Other Silver Health Plans in New Jersey for 30-Year-Old Individuals, 2014 through 2016

		Monthly premiums		
Year	Silver health plans	Minimum	Average	Maximum
2014	CO-OP	$356.01	$359.70	$365.50
	Other	273.48	321.43	390.00
2015	CO-OP	279.46	288.78	297.51
	Other	280.38	333.77	430.91
2016	CO-OP	329.75	342.48	351.06
	Other	287.56	334.76	458.49

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-326

For 2015, the CO-OP in New Jersey offered a health plan in all tiers in the state's single rating area. Figure 17 shows the percentile range in which CO-OP monthly premiums for 30-year-old individuals fell after rank-ordering all plans in the state's single rating area. The premiums for the health plans offered by the CO-OP in New Jersey were among the less expensive premiums for bronze and silver health plans and in the middle for catastrophic plans. CO-OP premiums for gold and platinum health plans ranged from among the least to the most expensive.

Figure 17: Relative Ranking (in Percentiles) of 2015 Premiums for the Consumer Operated and Oriented Plan (CO-OP) Compared to Premiums for Other Health Plans by Rating Area and Tier in New Jersey for 30-Year-Old Individuals



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-326

Notes: There was one rating area in New Jersey. Plans in the same metal level have the same actuarial value. Catastrophic plans are not required to meet actuarial value targets, but must have actuarial values less than 60 percent.

Appendix X: Premiums for the Consumer Operated and Oriented Plan Relative to Premiums for Other Health Plans in New Jersey

Rating area 1 includes Atlantic, Bergen, Burlington, Camden, Cape May, Cumberland, Essex, Gloucester, Hudson, Hunterdon, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Salem, Somerset, Sussex, Union, and Warren counties.

Appendix XI: Premiums for the Consumer Operated and Oriented Plan Relative to Premiums for Other Health Plans in New Mexico

The state-wide average monthly premium for the consumer operated and oriented plan's (CO-OP) silver health plans for 30-year-old individuals in New Mexico decreased from 2014 to 2015 and decreased again from 2015 to 2016. Specifically, the average decrease from 2014 to 2015 was about $9 and the average decrease from 2015 to 2016 was about $7. (See table 14.)

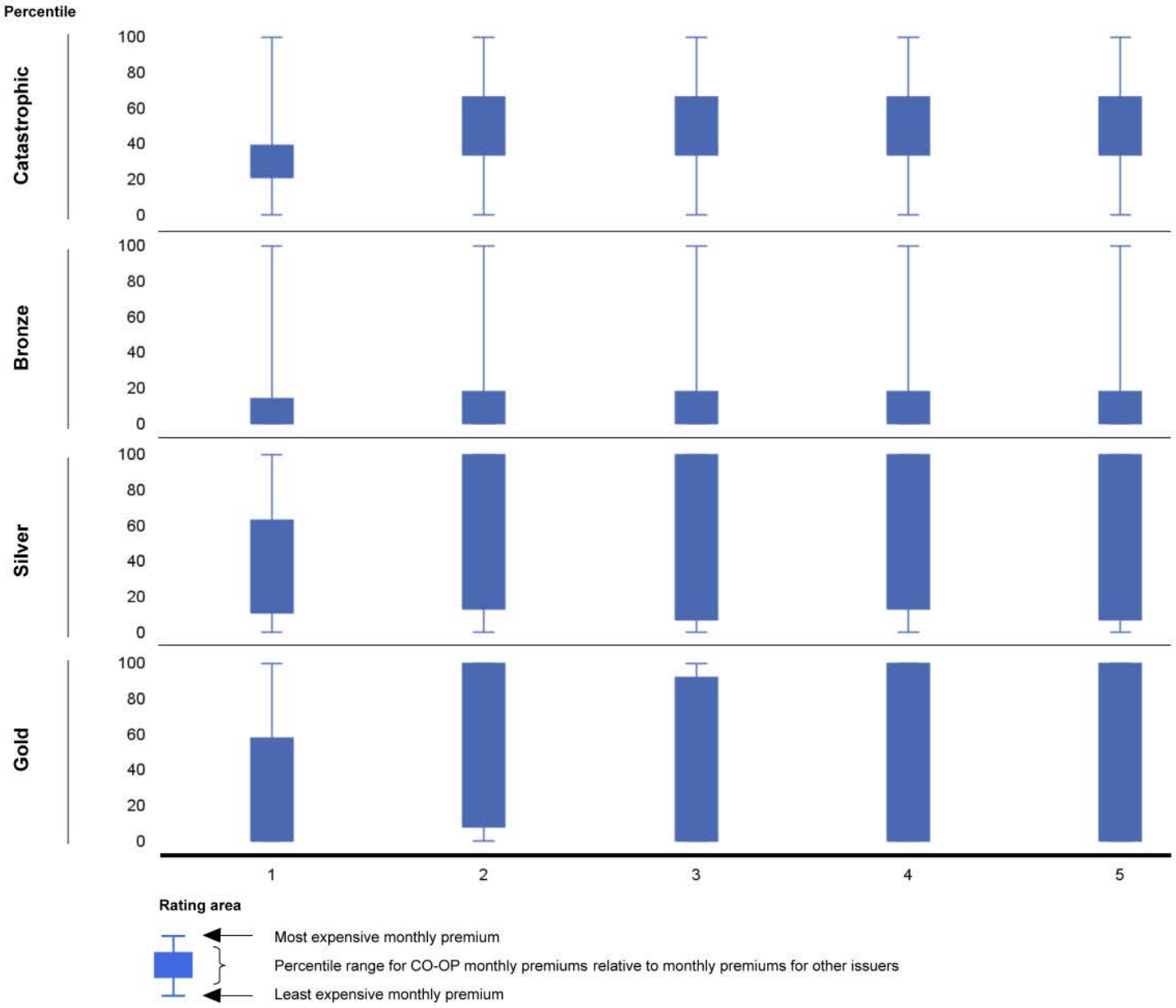
Table 14: Premiums for the Consumer Operated and Oriented Plan's (CO-OP) Silver Health Plans and Other Silver Health Plans in New Mexico for 30-Year-Old Individuals, 2014 through 2016

		Monthly premiums		
Year	Silver health plans	Minimum	Average	Maximum
2014	CO-OP	$193.64	227.85	276.33
	Other	167.43	235.68	282.18
2015	CO-OP	158.08	218.92	285.82
	Other	148.55	227.89	271.72
2016	CO-OP	165.42	212.17	248.13
	Other	160.57	241.58	307.37

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-326

For 2015, the CO-OP in New Mexico offered catastrophic, bronze, silver, and gold health plans in each of the state's five rating areas, but did not offer a platinum health plan. Figure 18 shows the percentile range in which CO-OP monthly premiums for 30-year-old individuals fell after rank-ordering all plans in each rating area. The premiums for silver and gold health plans offered by the CO-OP in New Mexico varied widely, ranging from among the least to the most expensive premiums. CO-OP premiums were often among the less expensive premiums for bronze health plans, and were generally in the middle for catastrophic plans.

Figure 18: Relative Ranking (in Percentiles) of 2015 Premiums for the Consumer Operated and Oriented Plan (CO-OP) Compared to Premiums for Other Health Plans by Rating Area and Tier in New Mexico for 30-Year-Old Individuals



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-326

Notes: In total, there were five rating areas in New Mexico. The CO-OP did not offer platinum health plans. Plans in the same metal level have the same actuarial value. Catastrophic plans are not required to meet actuarial value targets, but must have actuarial values less than 60 percent.

Rating area 1 includes Bernalillo, Sandoval, Torrance, and Valencia counties.

Rating area 2 includes San Juan County.

Rating area 3 includes Don Ana County.

Rating area 4 includes Santa Fe County.

Rating area 5 includes Catron, Chaves, Cibola, Colfax, Curry, DeBaca, Eddy, Grant, Guadalupe, Harding, Hidalgo, Lea, Lincoln, Los Alamos, Luna, McKinley, Mora, Otero, Quay, Rio Arriba, Roosevelt, San Miguel, Sierra, Socorro, Taos, and Union counties.

Appendix XII: Premiums for the Consumer Operated and Oriented Plan Relative to Premiums for Other Health Plans in Ohio

The consumer operated and oriented plan (CO-OP) in Ohio offered health plans on the state's exchange for the first time in 2015. The state-wide average monthly premium for CO-OP silver health plans for 30-year-old individuals increased from 2015 to 2016. Specifically, the average increase from 2015 to 2016 was about $43. (See table 15.)

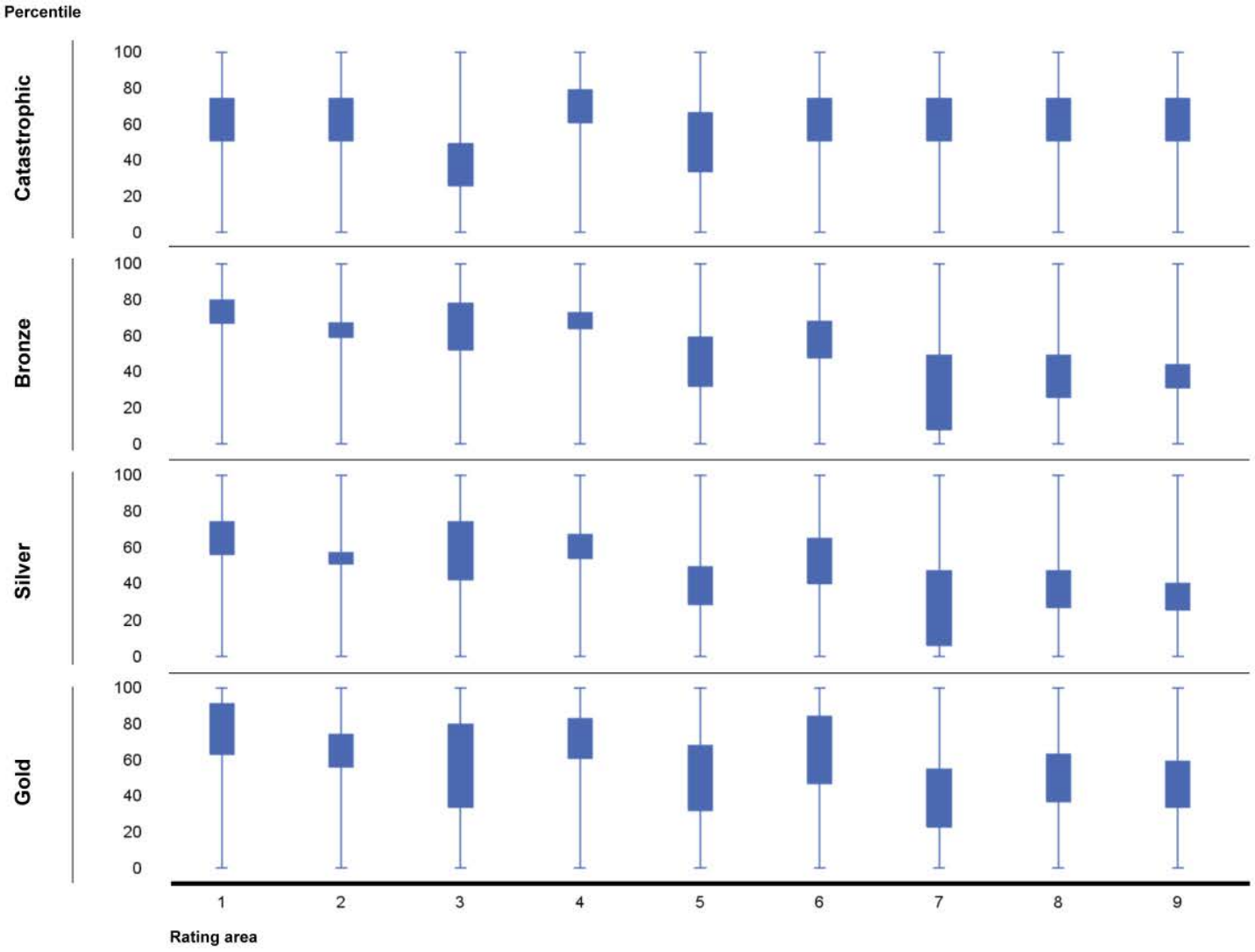
Table 15: Premiums for the Consumer Operated and Oriented Plan's (CO-OP) Silver Health Plans and Other Silver Health Plans in Ohio for 30-Year-Old Individuals, 2015 and 2016

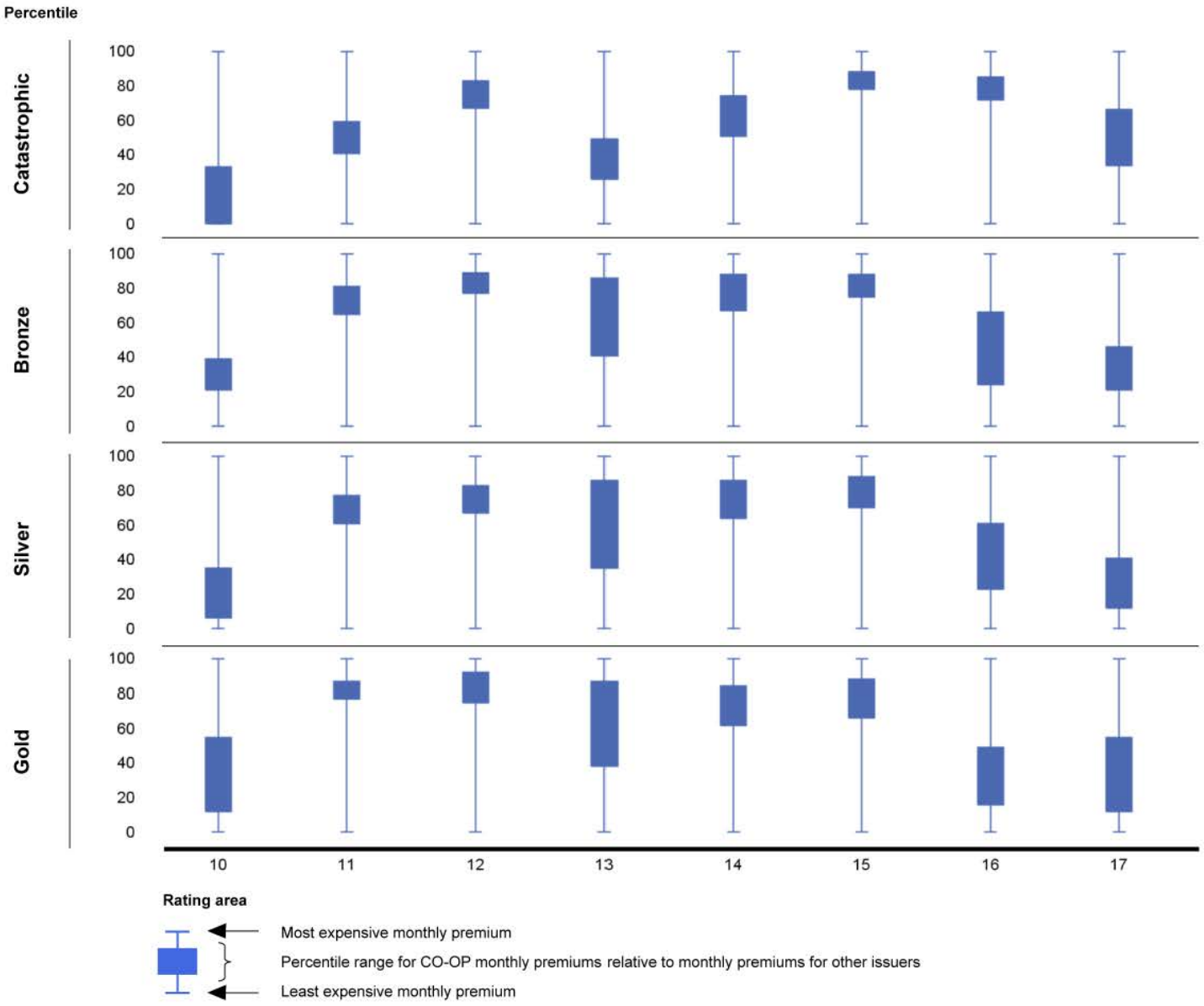
		Monthly premiums		
Year	Silver health plans	Minimum	Average	Maximum
2015	CO-OP	$266.87	$301.92	$345.73
	Other	206.27	290.76	443.39
2016	CO-OP	305.28	344.69	392.86
	Other	195.41	309.41	418.91

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-326

For 2015, the CO-OP in Ohio offered catastrophic, bronze, silver, and gold health plans in each of the state's 17 rating areas, but did not offer a platinum health plan. Figure 19 shows the percentile range in which CO-OP monthly premiums for 30-year-old individuals fell after rank-ordering all plans in each rating area. The premiums for health plans offered by the CO-OP in Ohio were often in the middle or among the most expensive premiums.

Figure 19: Relative Ranking (in Percentiles) of 2015 Premiums for the Consumer Operated and Oriented Plan (CO-OP) Compared to Premiums for Other Health Plans by Rating Area and Tier in Ohio for 30-Year-Old Individuals





Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-326

Notes: In total, there were 17 rating areas in Ohio. The CO-OP did not offer platinum health plans. Plans in the same metal level have the same actuarial value. Catastrophic plans are not required to meet actuarial value targets, but must have actuarial values less than 60 percent.

Rating area 1 includes Defiance, Fulton, Henry, Lucas, Williams, and Wood counties.

Rating area 2 includes Allen, Auglaize, Hancock, Hardin, Mercer, Paulding, Putnam, and Van Wert counties.

Rating area 3 includes Champaign, Clark, Darke, Greene, Miami, Montgomery, Preble, and Shelby counties.

Rating area 4 includes Butler, Hamilton, and Warren counties.

Rating area 5 includes Adams, Brown, Clermont, Clinton, and Highland counties.

Rating area 6 includes Erie, Huron, Ottawa, Sandusky, Seneca, and Wyandot counties.

Rating area 7 includes Crawford and Richland counties.

Rating area 8 includes Marion and Morrow counties.

Rating area 9 includes Delaware, Fairfield, Fayette, Franklin, Knox, Licking, Logan, Madison, Pickaway, and Union counties.

Rating area 10 includes Galia, Jackson, Lawrence, Pike, Ross, Scioto, and Vinton counties.

Rating area 11 includes Ashtabula, Cuyahoga, Geauga, Lake, and Lorain counties.

Rating area 12 includes Ashland, Medina, Portage, and Summit counties.

Rating area 13 includes Columbiana, Mahoning, and Trumbull counties.

Rating area 14 includes Holmes and Wayne counties.

Rating area 15 includes Carroll and Stark counties.

Rating area 16 includes Belmont, Coshocton, Guernsey, Harrison, Jefferson, Monroe, Morgan, Muskingum, Noble, Perry, and Tuscarawas counties.

Rating area 17 includes Athens, Hocking, Meigs, and Washington counties.

Appendix XIII: Premiums for the Consumer Operated and Oriented Plans Relative to Premiums for Other Health Plans in Oregon

The state-wide average monthly premium for the two consumer operated and oriented plans' (CO-OP) silver health plans for 30-year-old individuals in Oregon increased from 2014 to 2015 and, for the one CO-OP that continued to operate in 2016, increased again from 2015 to 2016.[1] Specifically, the average increase from 2014 to 2015 was about $1, and the average increase from 2015 to 2016 about $54. (See table 16.)

Table 16: Premiums for the Consumer Operated and Oriented Plans' (CO-OP) Silver Health Plans and Other Silver Health Plans in Oregon for 30-Year-Old Individuals, 2014 through 2016

		Monthly premiums		
Year	Issuer	Minimum	Average	Maximum
2014	CO-OP	$198.16	$243.78	$304.42
	Other	172.00	235.74	305.09
2015	CO-OP	199.00	245.00	270.00
	Other	188.00	238.25	302.00
2016	CO-OP	236.00	298.67	325.00
	Other	213.00	272.95	367.00

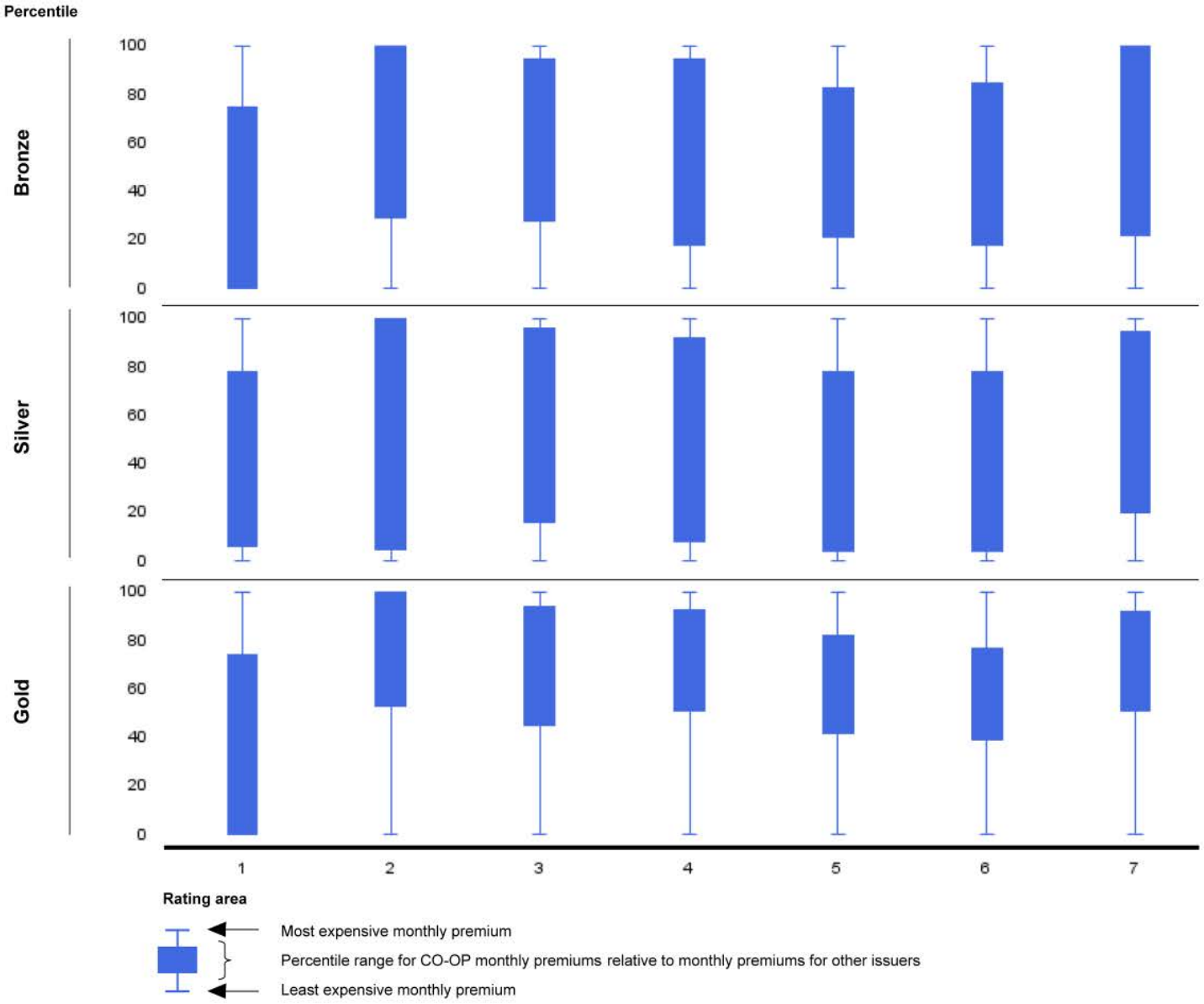
Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-326

Notes: For 2014 and 2015, the CO-OP premiums include premiums for the two CO-OPs that offered health plans in Oregon during those two years. One of the two CO-OPs ceased operations on January 1, 2016.

For 2015, the CO-OP in Oregon that continued to operate as of January 4, 2016, offered catastrophic, bronze, silver, and gold health plans in each of the state's seven rating areas, but offered no platinum health plans. Figure 20 shows the percentile range in which CO-OP monthly premiums for 30-year-old individuals fell after rank-ordering all plans in each rating area. The premiums for bronze and silver health plans offered by the CO-OP varied widely, ranging from among the least to the most expensive premiums. The premiums for gold health plans tended to be in the middle or among the most expensive premiums, except in rating area 1.

[1]CO-OP premiums in 2014 and 2015 include premiums for the two CO-OPs that offered health plans during those two years. One of the two CO-OPs ceased operations on January 1, 2016.

Figure 20: Relative Ranking (in Percentiles) of 2015 Premiums for the Consumer Operated and Oriented Plan (CO-OP) Compared to Premiums for Other Health Plans by Rating Area and Tier in Oregon for 30-Year-Old Individuals



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-326

Notes: In total, there were seven rating areas in Oregon. The CO-OP did not offer platinum health plans. Plans in the same metal level have the same actuarial value.

Rating area 1 includes Clackamas, Multnomah, Washington, and Yamhill counties.

Rating area 2 includes Benton, Lane, and Linn counties.

Rating area 3 includes Marion and Polk counties.

Rating area 4 includes Deschutes, Klamath, and Lake counties.

Rating area 5 includes Columbia, Coos, Curry, Lincoln, and Tillamook counties.

Rating area 6 includes Crook, Gilliam, Grant, Harney, Hood River, Jefferson, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wasco, and Wheeler counties.

Rating area 7 includes Douglas, Jackson, and Josephine counties.

Appendix XIV: Premiums for the Consumer Operated and Oriented Plan Relative to Premiums for Other Health Plans in Wisconsin

The state-wide average monthly premium for the consumer operated and oriented plan's (CO-OP) silver health plans for 30-year-old individuals in Wisconsin increased from 2014 to 2015 and increased again from 2015 to 2016. Specifically, the average increase from 2014 to 2015 was about $19, and the average increase from 2015 to 2016 was about $25. (See table 17.)

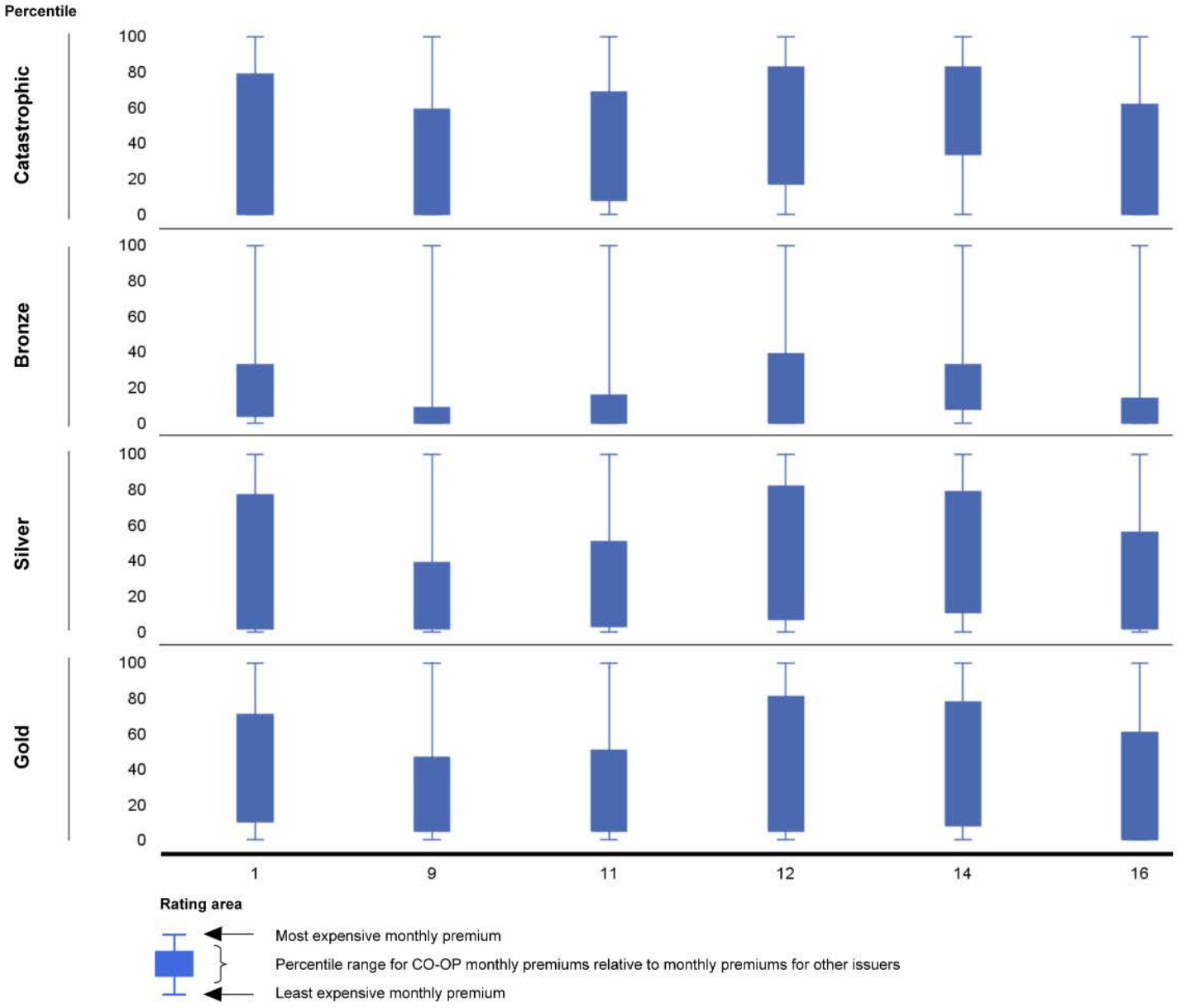
Table 17: Premiums for the Consumer Operated and Oriented Plan's (CO-OP) Silver Health Plans and Other Silver Health Plans in Wisconsin for 30-Year-Old Individuals, 2014 through 2016

		Monthly premiums		
Year	Silver health plans	Minimum	Average	Maximum
2014	CO-OP	$225.47	$281.36	$343.93
	Other	213.72	299.58	463.90
2015	CO-OP	241.28	300.69	370.79
	Other	210.96	319.61	488.08
2016	CO-OP	284.04	325.59	372.07
	Other	200.84	341.22	523.83

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-326

For 2015, the CO-OP in Wisconsin offered catastrophic, bronze, silver, and gold health plans in 6 of the state's 16 rating areas, but did not offer a platinum health plan. Figure 21 shows the percentile range in which CO-OP monthly premiums for 30-year-old individuals fell after rank-ordering all plans in each rating area. The premiums for catastrophic, silver, and gold health plans offered by the CO-OP in Wisconsin varied widely, ranging from among the least to the most expensive. The premiums for bronze health plans tended to be among the least expensive premiums.

Figure 21: Relative Ranking (in Percentiles) of 2015 Premiums for the Consumer Operated and Oriented Plan (CO-OP) Compared to Premiums for Other Health Plans by Rating Area and Tier in Wisconsin for 30-Year-Old Individuals



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-326

Notes: In total, there were 16 rating areas in Wisconsin. The CO-OP did not offer health plans in rating areas 2 through 8, 10, 13, and 15. The CO-OP did not offer platinum health plans. Plans in the same metal level have the same actuarial value. Catastrophic plans are not required to meet actuarial value targets, but must have actuarial values less than 60 percent.

Rating area 1 includes Milwaukee County.

Rating area 2 includes Dane County.

Rating area 3 includes Polk, Pierce, and St. Croix counties.

Rating area 4 includes Chippewa, Dunn, Eau Claire, and Pepin counties.

Rating area 5 includes Ashland, Bayfield, Burnett, Douglas, Sawyer, and Washburn counties.

Rating area 6 includes Buffalo, Jackson La Crosse, Monroe, and Trempealeau counties.

Rating area 7 includes Crawford, Grand, Iowa, LaFayette, and Vernon counties.

Rating area 8 includes Clark, Price, Rusk, and Taylor counties.

Rating area 9 includes Racine and Kenosha counties.

Rating area 10 includes Lincoln, Marathon, Portage, and Rusk counties.

Rating area 11 includes Calumet, Dodge, Fond du Lac, Sheboygan, and Winnebago counties.

Rating area 12 includes Ozaukee, Washington, and Waukesha counties.

Rating area 13 includes Florence, Forest, Iron, Langlade, Oneida, and Vilas counties.

Rating area 14 includes Columbia, Green, Jefferson, Rock, and Walworth counties.

Rating area 15 includes Adams, Green Lake, Juneau, Marquette, Richland, and Sauk counties.

Rating area 16 includes Brown, Door, Kewaunee, Manitowoc, Menominee, Oconto, and Shawano counties.

Appendix XV: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

FEB 2 6 2016

John E. Dicken
Director, Healthcare
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Mr. Dickens:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*Private Health Insurance: Federal Oversight, Premiums, and Enrollment for Consumer Operated and Oriented Plans in 2015*" (GAO-16-326).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: PRIVATE HEALTH INSURANCE: FEDERAL OVERSIGHT, PREMIUMS, AND ENROLLMENT FOR CONSUMER OPERATED AND ORIENTED PLANS IN 2015 (GAO-16-326)

The Department of Health and Human Services (HHS) appreciates the opportunity to review GAO's draft report on Consumer Operated and Oriented Plans (CO-OPs). HHS takes its commitment to both the CO-OP beneficiaries and taxpayers seriously in managing the CO-OP program.

As of January 2016, CO-OPs have provided health insurance coverage to more than one million consumers, helping people access needed medical care. This program has increased competition and provided more consumer choices and control in choosing health insurance coverage. Overall, CO-OPs have added both choice and affordability to health insurance coverage options available to consumers. CO-OPs accomplished these goals by overcoming a variety of challenges, including building a provider network and customer support services, no previous claims experience on which to base pricing, and competing with larger, more experienced issuers. As the CO-OPs work has progressed, HHS's oversight of the CO-OP program has evolved and improved.

HHS closely monitors and evaluates the CO-OPs to assess performance and compliance, and has engaged regularly with state Departments of Insurance (DOIs), which are the primary regulators of insurance issuers in the states. HHS is committed to continuing its work with the current CO-OPs to facilitate progress and expand into new markets when appropriate. Working with state DOIs and the CO-OPs, HHS will continue its rigorous ongoing monitoring and oversight processes.

As part of that oversight process, HHS increased the data and financial reporting requirements for CO-OPs, requiring them to provide a statement on their semi-annual report that they comply with all relevant state licensure requirements or an explanation of any deficiencies, warnings, additional oversight, or any other adverse action or determination by state insurance regulators received by the CO-OP since the last-filed semi-annual report. During their first years of providing coverage, as more data became available, HHS learned more about the financial, management, operational, and compliance issues facing certain CO-OPs. As issues became apparent, HHS took action, including placing many CO-OPs on Corrective Action Plans (CAPs) or Enhanced Oversight Plans.

As the CO-OP program moves forward, HHS's goal is to make it easier for CO-OPs to attract outside capital or enter into new business relationships, if permitted by law, that could assist them in achieving their goals. In January 2016, HHS released general guidance concerning existing CO-OP statutory, regulatory, and contractual requirements and limitations that might affect such planning. CMS continues to explore measures to create an environment as accommodating as possible for CO-OPs and investors. CO-OPs are also introducing local innovation by implementing new programs, such as a harm reduction program launched by the CO-OP operating in New Jersey to help enrollees quit or reduce smoking. HHS will continue its work to support CO-OPs as they pursue innovative approaches to coverage.

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: PRIVATE HEALTH INSURANCE: FEDERAL OVERSIGHT, PREMIUMS, AND ENROLLMENT FOR CONSUMER OPERATED AND ORIENTED PLANS IN 2015 (GAO-16-326)

While the day-to-day oversight of insurance companies and review and approval of their products and rates is performed by state regulators, HHS continues to monitor each CO-OPs progress and remains committed to facilitating access to affordable, high-quality health insurance for all Americans. HHS appreciates the GAO's thorough analysis of the CO-OP program and their efforts in this program.

Appendix XVI: GAO Contact and Staff Acknowledgments

GAO Contact

John E. Dicken, (202) 512-7114 or dickenj@gao.gov.

Staff Acknowledgments

In addition to the contact named above, Robert Copeland, Assistant Director; Kristen Joan Anderson; Sandra George; Giselle Hicks; Aaron Holling; and Drew Long made key contributions to this report.