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Consumer Operated and Oriented Plan (CO-OP) Program: Frequently Asked Questions

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Summary

The Consumer Operated and Oriented Plan (CO-OP) program was included in the Patient Protection and Affordable Care Act (ACA; P.L. 111-148) in an effort to increase the competitiveness of state health insurance markets and improve choice. Under the program, the Centers for Medicare & Medicaid Services (CMS) uses appropriated funds to award low-interest loans to organizations applying to become CO-OPs—nonprofit, member-run health insurance issuers that sell health insurance in the state(s) in which they are licensed.

CMS awarded loans to 24 CO-OPs. One of the 24 CO-OPs was dropped from the program prior to offering health plans. Among the remaining 23 CO-OPs, 7 are considered operational—meaning they are offering health plans and there is no indication that they will stop doing so in the future—as of the date of this report. The other 16 CO-OPs offered health plans at one time but are currently in various stages of shutting down. CMS awarded about $2.4 billion to the 23 CO-OPs that ever offered health plans.

The fact that more than half of the CO-OPs have ceased operations has generated a lot of interest in the program. The purpose of this report is to address frequently asked questions about the CO-OP program. The report includes information about the structure of the CO-OP program, program requirements, the loan awards, and the current operating status of the CO-OPs.

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The Consumer Operated and Oriented Plan (CO-OP) program was established under the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended). The purpose of the program is to foster the creation of CO-OPs—nonprofit, member-run health insurance issuers that sell health plans in states in which they are licensed.[1]

The CO-OP program is intended to increase competition and improve choice in private health insurance markets. It does so by creating new nonprofit issuers that are required to reinvest their profits to reduce premiums, enhance benefits, or improve the health care delivered to CO-OP members. In addition, CO-OPs are intended to be "one vehicle for providing higher quality care that is affordable and uses innovative care models in the exchanges starting in 2014."[2]

The ACA appropriated $6.0 billion of federal funds for the CO-OP program. Subsequent legislation rescinded funds from the program, leaving it with about $1.1 billion of the original appropriation.[3] The Secretary of Health and Human Services (HHS) used the appropriated funds to finance low-interest loans to eligible organizations. CO-OPs could apply for two types of loans: (1) start-up loans to hire staff, secure a state license, and carry out other functions and (2) solvency loans to help meet state requirements that they maintain a certain amount of capital in order sell insurance.[4] The loans must be repaid with interest.

The Centers for Medicare & Medicaid Services (CMS), which administers the CO-OP program, has awarded loans to 24 CO-OPs since 2012.[5] One of the 24 was unable to secure a state license to operate and was dropped from the program prior to offering coverage.[6] CMS awarded about $2.4 billion to the remaining 23 CO-OPs.[7] Seven of the 23 CO-OPs are operational as of the date of this report.[8] The other 16 either have ceased operations or are in various stages of winding down operations. The fact that more than half of the CO-OPs have failed has prompted questions about the program's design, administration, and funding and about the operations of the CO-OPs.

Through a series of questions and answers, this report describes the CO-OP program, outlines program requirements, and explains the terms of the loans. In addition, the report provides information about the loan amounts awarded and the current operating status of the CO-OPs. The information in this report is taken from Section 1322 of the ACA,[9] its implementing regulations,[10] guidance, and loan documents.

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[1] An *issuer* is "an insurance company, insurance service, or insurance organization (including a health maintenance organization) which is licensed to engage in the business of insurance in a state and which is subject to state law which regulates insurance." 45 C.F.R. §156.505.

[2] 76 *Federal Register* 77392, December 13, 2011, p. 77393.

[3] For more details, see the question "How Is the CO-OP Program Funded?"

[4] For more information about the loans, see the "Loans" section of this report.

[5] Centers for Medicare & Medicaid Services (CMS), Center for Consumer Information & Insurance Oversight (CCIIO), "Loan Program Helps Support Customer-Driven Non-Profit Health Insurers," at https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html.

[6] The Vermont Health CO-OP was dropped from the Consumer Operated and Oriented Plan (CO-OP) program after it was denied state licensure to sell health insurance plans in 2013.

[7] For more information about the amount appropriated to the program and how it relates to the amounts awarded, see the question, "How Is the CO-OP Program Funded?"

[8] For a definition of operational as the term is used in this report, see the question "What Is the Current Operating Status of Each CO-OP Issuer?"

[9] 42 U.S.C. §18042.

[10] 45 C.F.R. Part 156, subpart F.

Program Overview

The ACA requires the HHS Secretary to establish the CO-OP program according to the parameters outlined in Section 1322 of the ACA. Final regulations on the CO-OP program were issued in December 2011, and CMS began awarding start-up and solvency loans in 2012.[11] All loans were to be awarded by July 1, 2013.[12]

What Was the Process for Awarding Loans?

The HHS Secretary considered the following factors when awarding loans:

- recommendations from an advisory board established under the ACA statute;[13]
- priority to CO-OP loan applicants that offered plans on a statewide basis, used integrated health care models, and had significant support from the private sector;[14] and
- sufficient funding for the establishment of at least one CO-OP issuer in each state.

If no issuer applied for a CO-OP loan in a given state, the HHS Secretary had the authority to award grants to encourage the establishment of CO-OPs within that state or the expansion of a CO-OP from another state to the state with no applicants.

The Comptroller General established the CO-OP advisory board and made board appointments by June 23, 2010. The advisory board provided recommendations about the criteria that should be considered in awarding CO-OP loans and the process for doing so.[15] CMS issued a CO-OP loan funding opportunity announcement (FOA) in July 2011 and obtained the services of a contractor to assist with reviewing the applications.[16] CMS began awarding CO-OP loans in 2012 (**Table 2** includes all loan award dates).

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[11] For more information about the start-up and solvency loans, see "Loans," below.

[12] 42 U.S.C. §18042(b)(2)(D). All the entities that received loans under the program were awarded initial start-up and solvency loans in 2012. Some of those entities received additional loan awards in 2013 and 2014. For more details, see the question "How Is the CO-OP Program Funded?" and **Table 2**.

[13] The CO-OP advisory board consisted of 15 members appointed by the Comptroller General. Board members were subject to ethics and conflict-of-interest standards, and they did not receive compensation for their duties but were reimbursed for their travel expenses. The board was to terminate either when it completed its duties or on December 31, 2015, whichever was the earliest date. For information about the board's activities, see CMS, CCIIO, "CO-OP Advisory Board Resources," at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Insurance-Programs/CO-OP-Advisory-Board-Resources.html.

[14] These criteria are further explained in the CO-OP loan funding opportunity announcement. Preference was given to applicants that were likely to operate statewide over time; had a delivery model that encouraged care integration and would lead to "improved, more efficient care than is available in the target market(s)"; and had received committed funding or in-kind support, letters of intent to work with the CO-OP from key stakeholders (such as providers), and/or letters of support from community leaders. See CMS, CCIIO, Consumer Operated and Oriented Plan (CO-OP) Program, *Amended Announcement: Invitation to Apply*, Loan Funding Opportunity Number: OO-COO-11-001, December 9, 2011, at http://apply07.grants.gov/apply/opportunities/instructions/oppOO-COO-11-001-cfda93.545-instructions.pdf (hereinafter referred to as the "FOA").

[15] CCIIO, *Report of the Federal Advisory Board on the Consumer Operated and Oriented Plan (CO-OP) Program*, April 15, 2011.

[16] The July 2011 FOA was revised. This report relies on information from the latest revision, which occurred in December 2011. The contractor was Deloitte Consulting, LLP.

Which Entities Were Eligible for a CO-OP Loan?

To be eligible for a CO-OP loan, an entity had to be organized under state law as a nonprofit member organization.[17]

Certain entities were explicitly prohibited from receiving CO-OP loans. Any entity that was, had a relationship with, or was the predecessor of a preexisting health insurance issuer or related entity was ineligible.[18] Any entity that received 25% or more of its total funding (excluding loans received from the CO-OP program) from one of the types of entities noted above likewise was ineligible for CO-OP loans. In addition, an entity that was sponsored by a state or local government or any political subdivision thereof, or by any instrumentality of the political subdivision, was ineligible for CO-OP loans.[19]

What Standards Must CO-OPs Meet to Maintain Eligibility for the Program?

CO-OPs must meet the following standards to maintain eligibility for the program.

State Requirements. Health insurance issuers are primarily regulated at the state level. CO-OPs are required to comply with all the requirements that similar health insurance issuers must meet in each state in which the CO-OP is licensed. These requirements include solvency and licensure standards, provider payment rules, network adequacy standards, rate and form filing requirements, assessments on premiums, and any other applicable state laws or regulations.[20]

Governance Standards. CO-OPs are to "implement policies and procedures to foster and ensure member control of the organization."[21] All CO-OPs must be governed by a board of directors, the majority of whom are elected by a majority vote of a quorum of CO-OP members.[22] CO-OPs must have conflict-of-interest and ethics standards in governing documents to protect against insurance industry interference, and they must operate with a strong focus on consumers, including responsiveness, timeliness, and accountability to members, in accordance with regulations promulgated by the HHS Secretary.[23]

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[17] A *nonprofit member organization* is "a nonprofit, not-for-profit, public benefit, or similar membership entity organized as appropriate under state law." 45 C.F.R. §156.505.

[18] During the period when CO-OP loans were being awarded, the definition of *preexisting health insurance* issuer was an issuer that was in existence on July 16, 2009. CMS has since modified the definition to be an issuer that marketed non-group or group plans on July 16, 2009. The modification does not affect eligibility for CO-OP loans, as loans are no longer being awarded.

[19] In this context, a *sponsor* is "an organization or individual that is involved in the development, creation, or organization of the CO-OP or provides 40% or more in total funding to a CO-OP (excluding any loans received from the CO-OP program)." Ibid.

[20] In addition, CO-OPs were required to coordinate with states' implementation of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) by not offering a health plan in a given state until that state had implemented the ACA market reforms. The market reforms impose federal requirements on private health insurance plans. For more information about the market reforms, see CRS Report R42069, *Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA)*, by Annie L. Mach and Bernadette Fernandez.

[21] 45 C.F.R. §156.515(a)(1).

[22] CO-OP members aged 18 and older must be allowed to vote. A *member* is "an individual covered under health insurance policies issued by a loan recipient." 45 C.F.R. §156.505.

[23] The governance standards must be met no later than five years after the initial drawdown of a start-up loan or three years after the initial drawdown of a solvency loan.

Plan Standards. At least two-thirds of health plans offered by a CO-OP must be offered in the non-group (individual) and small-group markets.[24] In addition, CO-OPs must meet statutory requirements with respect to offering plans through the health insurance exchanges. (See the question "Do CO-OPs Have to Offer Plans Through Health Insurance Exchanges?" for more details.)

Use of Profits. CO-OPs must use any profits to reduce premiums, enhance benefits, or improve the health care delivered to CO-OP members.

Terms Outlined in Loan Agreement. CO-OPs are required to comply with the terms of their loan agreements with CMS according to the specified deadlines. The terms include, but are not limited to, complying with reporting requirements and meeting the agreed-upon milestones to draw down loan funds.[25]

Are CO-OPs Tax Exempt?

CO-OPs qualify for federal tax exemption under Section 501(c)(29) of the Internal Revenue Code (IRC), provided the CO-OPs comply with requirements in the ACA and the IRC and with the terms of any CO-OP loan agreement. Whether CO-OPs qualify for state tax-exempt status is determined at the state level. CO-OPs do not need state tax-exempt status to be eligible for the CO-OP program.

Do CO-OPs Have to Offer Plans Through Health Insurance Exchanges?

CO-OPs must offer some plans through health insurance exchanges.[26] Within the earlier of three years following the initial drawdown of a start-up loan or one year following the initial drawdown of a solvency loan, CO-OPs must offer non-group health plans at the silver and gold benefit levels through every health insurance exchange that serves the geographic region in which the CO-OP is licensed to sell plans.[27] In addition, if the CO-OP chooses to offer at least one plan in the small-group market, the CO-OP must commit to offering small-group plans at the silver and gold benefit levels through every Small Business Health Options Program (SHOP) exchange that serves the geographic region in which the CO-OP is licensed to sell plans.

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[24] CMS clarified this requirement in the preamble to an interim final rule with comment issued May 11, 2016 (81 *Federal Register* 29146). According to the clarification, CMS will not necessarily require a CO-OP to immediately repay its loans if it fails to meet the two-thirds requirement in any given year, as long as the CO-OP is in compliance with other requirements and has a plan in place to meet the two-thirds requirement in future years. CMS indicates that the clarification is intended to help CO-OP issuers pursue other lines of business, such as Medicare products.

[25] In applying for CO-OP loans, entities submitted a business plan that included milestones to be met for corresponding drawdowns of loan funds. These milestone and drawdown plans were finalized in the loan agreement between the entity (the CO-OP) and CMS. As the CO-OP meets the milestones (e.g., initial hiring of staff, vendor contracting, renting provider networks), the CO-OP can receive more of its awarded loan funding, per the terms of the loan agreement.

[26] For information about health insurance exchanges, see CRS Report R44065, *Overview of Health Insurance Exchanges*, coordinated by Namrata K. Uberoi.

[27] Under the ACA, plans offered in the non-group and small-group markets must tailor cost sharing to comply with one of four levels of actuarial value (AV). The AV levels are represented by different metals: bronze, silver, gold, and platinum. The silver level represents plans with 70% AV, and the gold level represents plans with 80% AV.

CMS will deem CO-OP health plans certified for exchanges, provided the health plans comply with all CO-OP requirements.[28] In general, exchanges have the authority to determine which plans to offer; however, exchanges must offer all CMS-certified CO-OP health plans.

According to the Government Accountability Office,[29] 22 of the 23 CO-OPs offering health plans in 2014 offered health plans through exchanges in 22 states. (The CO-OP in Ohio offered plans outside the exchange but did not participate in the exchange for the 2014 plan year.) At the beginning of the 2015 plan year, all 23 CO-OPs offered coverage through exchanges in 25 states.[30] In that year, the CO-OP in Ohio began offering plans through the exchange and three CO-OPs expanded to additional states.[31] At the beginning of the 2016 plan year, 11 CO-OPs offered plans through exchanges in 13 states.[32] (For additional information about the CO-OPs in 2016, see the question, "What Is the Current Operating Status of Each CO-OP Issuer?" in this report.)

How Is the CO-OP Program Funded?

The ACA appropriated $6.0 billion of federal funds for the CO-OP program. Subsequent legislation passed in CY2011 rescinded $2.6 billion from the program, leaving it with $3.4 billion in appropriations.[33] In CY2012, CMS awarded about $2.0 billion in loans to CO-OPs.

The American Taxpayer Relief Act of 2012 (ATRA; P.L. 112-240) was enacted on January 2, 2013. ATRA rescinded all but 10% of the CO-OP funds that were unobligated at the end of 2012. The unobligated balance was $2.5 billion,[34] so ATRA rescinded 90% of that amount (i.e., $2.3 billion). Overall, Congress rescinded a total of approximately $4.9 billion, leaving about $1.1 billion of the original $6.0 billion CO-OP program appropriation.

The remaining 10% of unobligated funds that were not rescinded under ATRA were to be put in a contingency fund to "provide assistance and oversight" to CO-OPs that received loans prior to the enactment of ATRA. In guidance, CMS indicates that providing additional loan funds to existing CO-OPs is a permitted use of the monies in the contingency fund.[35] CMS also indicates that the contingency fund is to be used for the CO-OP program's administrative costs.

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[28] CMS may deem CO-OP health plans certified for up to 10 years following the life of any CO-OP loan provided to the CO-OP. The certification will be revisited every two years.

[29] U.S. Government Accountability Office, *Private Health Insurance: Premiums and Enrollment for New Nonprofit Health Insurance Issuers Varied Significantly in 2014*, GAO-15-304, April 30, 2015.

[30] CoOportunity, the CO-OP in Iowa and Nebraska, stopped accepting enrollment for 2015 in December 2014 (prior to the close of the open enrollment period), when it was placed in rehabilitation. For more details, see Iowa Insurance Division, Insurance commissioner Places Health Insurer CoOportunity Health In Rehabilitation, December 24, 2014, at http://www.iid.state.ia.us/node/9885312.

[31] For the 2015 plan year, the CO-OPs in Maine and Massachusetts both expanded to New Hampshire, and the CO-OP in Montana expanded to Idaho.

[32] In addition to the seven CO-OP issuers listed as currently operational in **Table 2**, the following CO-OP issuers were operational at the beginning of 2016: HealthyCT (Connecticut); Land of Lincoln (Illinois); InHealth Mutual (Ohio); and Oregon's Health CO-OP (Oregon).

[33] The Department of Defense and Full-Year Continuing Appropriations Act, 2011 (P.L. 112-10), reduced CO-OP funding by $2.2 billion, and the Consolidated Appropriations Act, 2012 (P.L. 112-74), rescinded an additional $400 million from the program.

[34] CMS, *Fiscal Year 2014 Justification of Estimates for Appropriations Committees*, March 31, 2013, pp. 285-287, at https://www.cms.gov/about-cms/agency-information/performancebudget/downloads/fy2014-cj-final.pdf.

[35] CMS, "Section 644: Consumer Operated and Oriented Plan Program Contingency Fund," at https://www.cms.gov/CCIIO/Resources/Files/Downloads/04-01-13-CO-OP-rescission-FAQ-cciio.pdf.

Because the CO-OP program uses direct loans, the appropriated amounts for CO-OPs represent the total expected cost to the government over the life of the loans, rather than the total amount of loans that CMS can award. In general, loans and other federal credit programs are scored in the budget in accordance with their *subsidy costs*. A loan's subsidy cost equals the net present value of expected future receipts (loan principal and interest repayment) less expenditures (loan disbursements).[36] Increases in the risk of default—the failure to repay a loan—reduce expected receipt totals, which increases the subsidy costs of a program. Given a certain budgetary cost,[37] more loans can be issued when the likelihood of default decreases and when interest payments on the loan increase. Total loan disbursements therefore exceed the budgetary costs of the program in many cases.

Historical data presented in recent President's budget submissions indicate that the budgetary cost of CO-OP loans totaled $979 million from FY2012 through FY2015.[38] In the FY2017 President's budget, the Office of Management and Budget estimated that a total of $2.085 billion in loan disbursements was made to CO-OPs over the same time period.[39]

What Challenges Are Associated with Estimating the Budgetary Cost of the CO-OP Program?

Estimating the budgetary cost of federal credit programs over the life of the loans is dependent upon a number of factors that may pose unique challenges. Changes in interest rates due to shifts in economic conditions or other factors may lead to changes in the expected subsidy costs of a federal program. Moreover, the projected default rates of loans may fluctuate significantly in response to both economic changes and shifts in the market conditions of relevant industries. Default rate estimates may be particularly uncertain for new programs (such as the CO-OP program) with little evidence of what market demand will be and how industry may respond. The expected budgetary cost of loans made under federal credit programs is reestimated each year to take into account updated conditions and assumptions. Revisions made to the original subsidy cost of CO-OP loan and contingency fund disbursements have increased their estimated budgetary cost by $601 million.[40]

Loans

The CO-OP program provides start-up and solvency loans to qualified nonprofit issuers (CO-OPs). The terms of the loans are described in statute, regulations, the FOA, and the terms of the loan agreements between CO-OPs and CMS (the administrator of the loans). In general, CO-OPs

[36] The Federal Credit Reform Act of 1992 (P.L. 101-58) defines *subsidy costs* as "the estimated long-term cost to the government of a loan guarantee, calculated on a net present value basis, excluding administrative costs." For more information about subsidy costs and their effect on the federal budget, see CRS Report R44193, *Federal Credit Programs: Comparing Fair Value and the Federal Credit Reform Act (FCRA)*, by Raj Gnanarajah.

[37] The budgetary costs of loans include subsidy costs, but may also include other costs associated with loan programs, including administrative costs.

[38] Office of Management and Budget, *Budget of the U.S Government*, Federal Programs By Agency and Account: information taken from FY2014, FY2015, FY2016, and FY2017 submissions.

[39] Office of Management and Budget, *FY2017 Budget of the U.S Government*, Federal Credit Supplement, Table 7.

[40] Ibid. These estimates exclude the estimated cost of loan disbursements made through appropriations that were later rescinded.

that received loans are expected to repay the loans with interest according to the terms of the loan agreement.

How Can CO-OPs Use the Loan Amounts?

The start-up loans are to be used for costs associated with setting up a health insurance issuer. For example, eligible costs include hiring employees, renting space for operations, and developing information technology systems. Start-up loans are not to be used for brick-and-mortar construction or clinical costs (e.g., payments to providers for clinical services).[41]

The solvency loans are to be used to assist the CO-OP issuers in meeting state solvency requirements. Each state has requirements related to the amount of capital an issuer must maintain to remain licensed to sell insurance in the state. The funds provided under the solvency loans are intended to help CO-OP issuers meet those requirements.

Statute prohibits the start-up and solvency loans from being used for "carrying on propaganda, or otherwise attempting, to influence legislation; or for marketing."[42] The FOA further restricts the use of loans by prohibiting the use of loan funds for meeting matching requirements of other federal programs, providing "excessive executive compensation," and "funding activities unrelated to CO-OP planning and establishment, including but not limited to staff retreats and promotional giveaways."[43]

How Are the Loan Amounts Disbursed to CO-OPs?

Start-up and solvency loan awards are disbursed to a CO-OP according to the terms of the CO-OP's loan agreement with CMS.[44] In applying for CO-OP loans, entities submitted a business plan that included milestones to be met for corresponding drawdowns of loan funds. These milestone and drawdown plans were finalized in the loan agreement between the entity (the CO-OP) and CMS. The award amounts a CO-OP is able to draw down at any given time are subject to the agreement and to any modifications to the agreement made by CMS.

What Are the Repayment Terms for the Loans?

In general, the start-up and solvency loans must be repaid with interest in accordance with the requirements in statute, regulations, and the terms of the loan agreement. **Table 1** presents an overview of those requirements.

[41] For more details about how start-up loans can and cannot be used, see the FOA, p. 40.

[42] 42 U.S.C. §18042(b)(2)(C)(ii).

[43] See the FOA at http://apply07.grants.gov/apply/opportunities/instructions/oppOO-COO-11-001-cfda93.545-instructions.pdf.

[44] Ibid.

Table 1. Repayment Terms for CO-OP Program Start-Up and Solvency Loans

	Start-Up Loans	Solvency Loans
Repayment Period	Within 5 years of the disbursement date.[a]	Within 15 years of the disbursement date.[a]
Repayment Terms	Recipient must make payments consistent with repayment schedule approved by the Centers for Medicare & Medicaid Services (CMS).	
Modifications to Loan Terms	CMS may execute a modification to the repayment terms if CMS determines that the loan recipient is unable to repay the loans in the event of certain circumstances.	
Interest Rates	Interest is accrued from the date of drawdown on the loan. In general, the interest rate is equal to the average interest rate on marketable Treasury securities of similar maturity minus one percentage point (but the interest cannot be less than 0%).[b]	Interest is accrued from the date of drawdown on the loan. In general, the interest rate is equal to the average interest rate on marketable Treasury securities of similar maturity minus two percentage points (but the interest cannot be less than 0%).[b]

Source: 42 U.S.C. §18042; 45 C.F.R. §156.520; Department of Health and Human Services, CMS, Center for Consumer Information and Insurance Oversight (CCIIO), Consumer Operated and Oriented Plan (CO-OP) Program, *Amended Announcement: Invitation to Apply,* Loan Funding Opportunity Number: OO-COO-11-001, December 9, 2011.

a. CO-OPs draw down loan funds as they meet the milestones specified in the loan agreement. Repayment periods are separate for each drawdown—each draw from a start-up loan must be repaid within 5 years, and each draw from a solvency loan must be repaid within 15 years.

b. Penalty interest applies in certain circumstances. (See the question "What Happens If a Loan Agreement Is Terminated?" in this report for more information.)

What Happens If a Loan Agreement Is Terminated?

Loan agreements between CO-OPs and CMS may be terminated under various circumstances.[45] CMS may terminate a loan agreement because the CO-OP is not in compliance with program requirements or the terms of its loan agreement or because CMS has cause to believe the CO-OP has engaged in criminal or fraudulent activities. If CMS terminates an agreement under these circumstances, the CO-OP must pay a penalty in the form of repaying 110% of the aggregate amount of start-up and solvency loans received. In addition, the interest rate on the amount for the period in which the loans were outstanding is to be increased.[46]

CMS may approve a CO-OP's request to terminate its loan agreement, or CMS may initiate a loan termination to which a CO-OP consents. Under these circumstances, the CO-OP will not be subject to the penalty or the increased interest rate in place for other types of terminations.

In all terminations, a CO-OP is expected to comply with the terms of termination outlined in its loan agreement. These terms include complying with any state regulations that are relevant to the termination and repaying to CMS any unused loan funds and other loan amounts owed. In the event of a termination, no additional loan disbursements will be made to the CO-OP. CO-OPs subject to CMS-initiated terminations may appeal the decision within 30 days of receiving the notice of termination.

[45] This answer provides general information about the termination of CO-OP loan agreements. CRS does not have information about whether any CO-OP loan agreements have been terminated, including the agreements between CMS and the 12 CO-OPs that are in various stages of shutting down.

[46] The interest rate is increased to the average interest rate on marketable Treasury securities of similar maturity.

Program Status

How Many Entities Received CO-OP Loans? How Much Was Awarded?

CMS has awarded loans to 24 CO-OPs.[47] One of the 24, the Vermont Health CO-OP, was denied state licensure to sell health insurance plans in 2013 and was dropped from the CO-OP program.[48] The loans awarded to the other 23 CO-OPs total about $2.4 billion. These 23 CO-OPs and the amounts they were awarded are shown in **Table 2**.

Table 2. CO-OP Operational Statuses and Loan Awards

(as of July 13, 2016)

CO-OP Issuer	State(s) Served	Initial Award (in millions of dollars)		Additional Award(s) (in millions of dollars)		Total Award (in millions of dollars)
		Amount	Date	Amount	Date	
Operational CO-OP Issuers (7 Total)[a]						
Community Health Options	Maine and New Hampshire	$62.1	3/23/2012	$2.6 $67.6	7/19/2013 9/26/2014	$132.3
Evergreen Health Cooperative Inc.	Maryland	$65.5	9/27/2012	—	—	$65.5
Minuteman Health, Inc.	Massachusetts and New Hampshire	$88.5	8/13/2012	$2.1 $65.8	11/22/2013 12/12/2013	$156.4
Montana Health Cooperative	Montana and Idaho	$58.1	2/17/2012	$26.9	11/22/2013	$85.0
Health Republic Insurance of New Jersey	New Jersey	$107.2	2/17/2012	$1.9	11/22/2013	$109.1
New Mexico Health Connections	New Mexico	$70.4	2/17/2012	$5.4 $1.5	6/28/2013 12/18/2013	$77.3
Common Ground Healthcare Cooperative	Wisconsin	$56.4	2/17/2012	$0.2 $28.5 $22.7	12/17/2013 9/26/2014 12/15/2014	$107.7
Non-operational CO-OP Issuers (16 Total)[a]						
Meritus[b]	Arizona	$93.3	6/7/2012	—	—	$93.3
Colorado HealthOp	Colorado	$69.4	7/23/2012	$2.9	10/18/2013	$72.3
HealthyCT	Connecticut	$75.8	6/7/2012	$3.8 $48.4	11/5/2013 9/26/2014	$128.0

[47] CCIIO, "Loan Program Helps Support Customer-Driven Non-Profit Health Insurers," at https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html.

[48] CCIIO's CO-OP loan website does not currently include information for the Vermont Health CO-OP According to information that was previously available on the website, the Vermont Health CO-OP was awarded $33.8 million dollars on June 22, 2012.

CO-OP Issuer	State(s) Served	Initial Award (in millions of dollars)		Additional Award(s) (in millions of dollars)		Total Award (in millions of dollars)
		Amount	Date	Amount	Date	
Land of Lincoln Health	Illinois	$160.2	12/21/2012	—	—	$160.2
CoOportunity	Iowa and Nebraska	$112.6	2/17/2012	$32.7	9/26/2014	$145.3
Kentucky Health Cooperative, Inc.	Kentucky	$58.8	6/19/2012	$2.5 $20.2 $65.0	12/11/2013 11/26/2013 11/10/2014	$146.5
Louisiana Health Cooperative	Louisiana	$65.0	9/27/2012	$0.8	12/17/2013	$65.8
Michigan Consumer's Healthcare CO-OP	Michigan	$71.5	5/17/2012	—	—	$71.5
Nevada Health Cooperative	Nevada	$65.9	5/17/2012	—	—	$65.9
Health Republic Insurance of New York	New York	$174.4	2/17/2012	$90.7	9/26/2014	$265.1
InHealth Mutual	Ohio	$129.2	10/12/2012	—	—	$129.2
Oregon's Health CO-OP	Oregon	$56.7	3/23/2012	—	—	$56.7
Health Republic Insurance of Oregon	Oregon	$59.5	2/21/2012	$1.2	11/15/2013	$60.6
Consumers' Choice Health Insurance Company	South Carolina	$87.6	3/27/2012	—	—	$87.6
Community Health Alliance Mutual Insurance Company	Tennessee	$73.3	8/29/2012	—	—	$73.3
Arches Mutual Insurance Company	Utah	$85.4	7/6/2012	$4.3	9/6/2013	$89.7

Source: Information about states served and total award amounts is from CCIIO, "Loan Program Helps Support Customer-Driven Non-Profit Health Insurers," at https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html. Information about the operational status of CO-OP issuers was collected from state departments of insurance and media reports. Congressional clients may contact the author of the report for specific citations.

Notes: Award figures may not sum precisely due to rounding.

a. For purposes of this table (and report), a CO-OP issuer is considered *operational* if it is currently offering health plans and there are no indications that the CO-OP will stop renewing or offering health plans in the future. Conversely, a CO-OP issuer is considered *non-operational* if it is no longer offering health plans or if there is an indication that it will not renew or offer health plans in the future. For example, Connecticut's Insurance Commissioner issued an order of supervision to HealthyCT on July 1, 2016. Under the order, HealthyCT continues to provide coverage to its current enrollees but is not allowed to offer new health plans or renew any plans for current enrollees. HealthyCT is considered *non-operational* in the table.

b. Includes Meritus Health Partners and Meritus Mutual Health Partners.

What Is the Current Operating Status of Each CO-OP Issuer?

As of the date of this report, seven CO-OP issuers are operational. For purposes of this report, a CO-OP issuer is considered operational if it currently offers health plans and there are no indications that the CO-OP issuer will stop renewing or offering health plans in the future. The seven operational CO-OP issuers offer health plans in nine states for the 2016 plan year (see **Figure 1**).

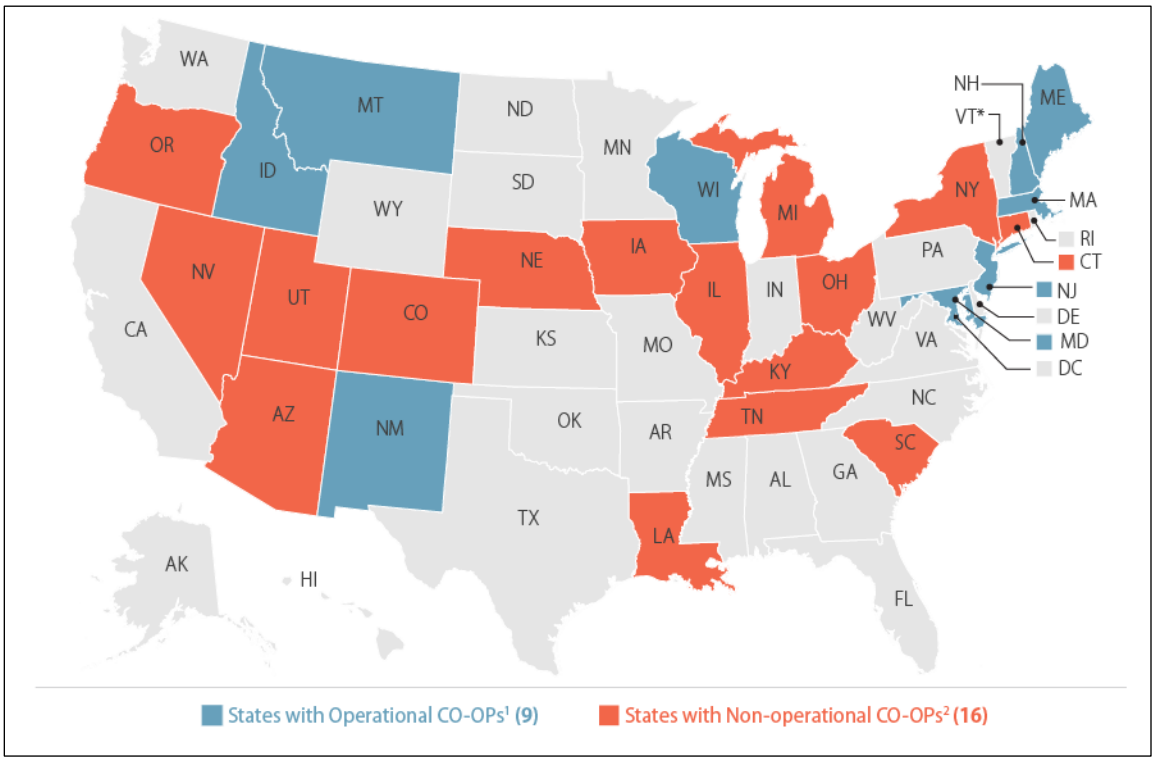
The other 16 CO-OPs (of the 23 that ever offered health plans) are considered non-operational, which means either they are not offering health plans in 2016 or there is an indication that they will not renew or offer health plans in the future.[49] State insurance commissioners are the primary regulators of the business of insurance. As state-licensed health insurance issuers, CO-OPs must adhere to all applicable requirements in the state(s) in which they are licensed. One of the oversight responsibilities of state insurance commissioners is to monitor the financial health of issuers. If a state insurance commissioner determines that an issuer is, or is at risk of becoming, undercapitalized or insolvent, the state insurance commissioner may conduct additional reviews of the issuer's financial situation and operations; subject the issuer to a rehabilitation plan; or declare the issuer insolvent and subject it to a state-administered insolvency proceeding. The 16 non-operational CO-OPs are in various stages of these procedures due to their troubled financial conditions.

Although each of the 16 non-operational CO-OP issuers has its own unique reasons for its troubled financial conditions, some factors that could have played a role include the challenges associated with being a new entrant in health insurance markets; the CO-OP program's statutory and regulatory requirements; decisions made by federal policymakers during implementation of the program; and poor or misfortunate business decisions.

[49] For example, Connecticut's Insurance Commissioner issued an order of supervision to HealthyCT on July 1, 2016. Under the order, HealthyCT continues to provide coverage to its current enrollees but is not allowed to offer new health plans or renew any plans for current enrollees. For purposes of this report, HealthyCT is considered *non-operational*.

Figure 1. Status of CO-OPs in Each State

(as of July 13, 2016)



Source: Congressional Research Service analysis of information from state-level entities that oversee states' insurance markets.

Notes: Three of the seven operational CO-OP issuers sell plans in more than one state. See **Table 2** for details.

*The Vermont Health CO-OP was denied state licensure to sell health insurance plans in 2013 and was dropped from the CO-OP program.

[1] For purposes of this report, an operational CO-OP is one that is currently offering health plans and there is no indication it will stop renewing and offering plans in the future.

[2] For purposes of this report, a non-operational CO-OP is one that either does not currently offer health plans or has indicated that it will not continue to renew or offer health plans.

What Happens When a CO-OP Fails?

As noted, of the 23 CO-OPs that ever enrolled individuals in health plans, 16 are in various stages of winding down their operations. These failures have led to a variety of questions, particularly regarding what happens to coverage for individuals enrolled in health plans offered by failed CO-OPs, what happens to the health care providers to whom failed CO-OPs owe payments; and what happens to the federal money lent to failed CO-OPs.

Answers to these questions vary based on a number of factors. One factor is the laws and regulations of the state(s) in which the CO-OP is licensed. Health insurance issuers are primarily regulated at the state level; therefore, what happens when a health insurance issuer fails (including a CO-OP) is largely a matter of state law. Answers to these questions also are affected

by Section 1322 of ACA[50] and its implementing regulations,[51] the terms of the CO-OP's loan agreement with CMS, and the CO-OP's financial condition.

What Happens to Members When a CO-OP Fails?

When a health insurance issuer, including a CO-OP, is declared insolvent, the relevant state insurance commissioner[52] typically will be appointed as a receiver to liquidate the issuer in an orderly fashion. The individual health insurance policies of the failed issuer generally will either be transferred to and assumed by a different (and solvent) issuer or transferred to a state guaranty association (GA).

GAs, which have been established in all 50 states and the District of Columbia,[53] protect customer insurance policies issued by insolvent insurance companies, subject to certain benefit limits and various exclusions specified by state law.[54] A GA could either maintain the insolvent issuer's policies or issue new policies to supplant the failed issuer's policies.[55] Health insurance GAs protect policyholders and health care providers who may be owed payments, but GAs do not provide financial protection to issuers. While all states have health GAs, not all types of health issuers or health insurance plans are covered.[56]

What Happens to Health Care Providers When a CO-OP Fails?

The aforementioned GAs also may protect health care providers by covering the cost of certain medical services provided to policyholders of the failed CO-OPs. As with individuals, the protection offered to health care providers by a GA is dependent on how the GA is designed and its application to a failed CO-OP.[57]

Additionally, health care providers, similar to other creditors, may file claims against the estate of a failed CO-OP. How much, if any, providers would recover for valid claims against the estate would depend on the financial condition of the CO-OP, the liquidation value of the CO-OP's assets, and the liquidation payment priority scheme established by relevant state law.

[50] 42 U.S.C. §18042.

[51] 45 C.F.R. Part 156, subpart F.

[52] Or an agent of the commissioner.

[53] See summaries of state guaranty association (GA) laws at National Organization of Life & Health Insurance Guaranty Associations (NOLHGA), "Guaranty Association Laws," at http://www.nolhga.com/factsandfigures/main.cfm/location/stateinfo.

[54] See NOHLGA, "State Laws and Provisions Report: Coverages," October 1, 2015, at http://www.nolhga.com/factsandfigures/main.cfm/location/lawdetail/docid/15.

[55] GAs may be established for different types of insurance including, but not limited to, health insurance.

[56] According to CRS analysis of NOLHGA's compilation of GA laws (http://www.nolhga.com/factsandfigures/main.cfm/location/stateinfo), the life and health insurance GAs in 48 states and the District of Columbia exclude health policies issued by certain types of insurers (e.g., health maintenance organizations, or HMOs). CRS does not have information about the application of states' GAs to CO-OPs.

[57] Ibid.

What Happens to Loan Repayments to the Federal Government When a CO-OP Fails?

All CO-OPs are contractually obligated to adhere to the repayment schedule detailed in their loan agreements and other supporting documents, regardless of a CO-OP's operational status or whether its loan agreement with CMS is terminated. CMS may use any remedies available under the law to collect monies owed.[58] However, CMS's ability to collect from failed CO-OPs will be complicated by the fact that each CO-OP is subject to the state insurance receivership proceedings that are discussed above. In testimony given February 25, 2016, a CMS official indicated that "it was too early to tell how much money may be recovered [from the 12 CO-OPs that had failed by the date of the testimony]."[59]

Author Information

Annie L. Mach
Specialist in Health Care Financing

Grant A. Driessen
Analyst in Public Finance

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[58] See, for example, 31 U.S.C. §§3701 et seq; 31 C.F.R. ch. XI; and CMS, *Medicare Financial Management Manual*, ch. 4, at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/fin106c04.pdf.

[59] Testimony of Dr. Mandy Cohen, Chief Operating Officer and Chief of Staff, CMS, in U.S. Congress, House Committee on Oversight and Government Reform, Subcommittee on Health Care, Benefits, and Administrative Rules, *Review of Obamacare Consumer Operated and Oriented Plans*, hearings, 114th Cong., 2nd sess., February 25, 2016.