Op-Ed

Co-ops Discover the Challenges of Starting an Insurance Business

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JUST BEFORE CHRISTMAS 2014, THE IOWA INSURANCE commissioner took over the management of CoOpportunity Health, the Iowa-based health insurance co-op serving Iowa and Nebraska, because of an inadequate amount of cash on hand, and ordered its liquidation in January. Because this means the likely loss of the \$145 million in federal funds provided to the co-op, in the form of start-up loans and solvency funding, concerns have been raised about the financial health of other cooperatives that were started by and have received funding from the Affordable Care Act (ACA).

Co-ops in Health Care

Health care cooperatives, which provide economic benefits to its members, have been in existence since the Great Depression, and some large ones, such as Group Health in Washington State, have been active for more than 60 years. The idea of encouraging cooperatives to be a part of the ACA was promoted by former senator Kent Conrad (D-ND) as an alternative to the public option when it became clear that the public option did not have sufficient political support among congressional Democrats to be included in the final legislation.

Some hoped the co-ops would increase the amount of competition available in exchanges. Others seem to have confused the attraction of a co-op as a nonprofit alternative, but with the involvement of many of the Blue Cross and Blue Shield plans in the exchanges, co-ops are not needed to provide nonprofit insurance options. Rather, the co-op's distinguishing factor is its consumer governance structure, whose directors, elected by a majority of the membership, set the co-op's policies and directions.¹

The Centers for Medicare and Medicaid Services (CMS) granted 2 types of low-interest loans to co-ops, totaling \$2.4 billion thus far, to help with their capitalization: (1) *start-up* loans, which must be repaid in 5 years; and (2) *solvency* loans, which are issued as surplus notes to help meet the co-ops' reserve requirements and must be repaid within 15 years of the date of disbursement.

Most of the information on how the co-ops are faring is currently available only through the third quarter of 2014 and does not tell us how they did in the ACA's second enrollment period. Reports issued by Standard and Poors and by A.M. Best Company in early 2015, however, indicate that losses persist at the majority of health co-ops and that others could be in serious difficulty unless their performance in 2015 substantially improves over that in 2014.^{2,3}

In 2014, although 23 co-ops had a total membership of slightly more than 500,000, only Maine had a positive net income and favorable underwriting. Forty percent of the others had medical loss ratios that exceeded 100%, and all but 3 had administrative expenses that exceeded 20%. Aggregate underwriting losses more than tripled from the end of the first quarter in 2014 to the end of the third quarter, reflecting higher uses of medical services than anticipated.³

With hindsight, it is clear that many of the co-ops increased their membership by offering lower premiums than could be sustained. Operating in markets in which individuals are price sensitive, as those in the health insurance exchanges are, makes setting low premiums an enticing strategy to increase membership. But getting the pricing "right" becomes especially challenging using this strategy, particularly when membership numbers are small.

The co-ops' low membership raised their vulnerability to losses from catastrophic medical claims and meant that only a small base was available to absorb overhead and other administrative costs. The increase in solvency loans, which exceeded \$1 billion by September 2014, reflected the net losses being incurred as well as the growth in co-op membership.

CoOpportunity Goes Under

CoOpportunity failed because of 2 unfavorable developments, both of which could affect other co-ops. Officially, the failure was attributed to the Iowa insurance commissioner's concern that the co-op was insufficiently capitalized. The immediate drivers were higher than expected

utilization among its 91,000 members and the passage of the Omnibus Appropriation Act in December 2014, which required budget-neutral risk corridor payments.

Risk corridors are one of 3 types of adjustments offered in the ACA to help guard against adverse risk selection (unusually high users of health care). But the risk corridors and the reinsurance provisions are in place only from 2014 to 2016. The ACA did not provide funding for risk corridors, and the 2014 legislation made it clear that only funds contributed by plans that experienced lower than expected risk could be used, not any other funds that CMS might try to use.

It is unclear how much (if any) funding will be available for risk corridors, and in any case, payments will not be available until the second half of 2015. This was a significant problem for the Iowa co-op because it was allowed to book its expected risk corridor payments as a \$60 million receivable, the highest absolute dollar amount, recording it as an “accrued retrospective premium.”

Kentucky Health Cooperative booked a \$45 million receivable but had a worse ratio of retrospective premium adjustments relative to its capital and surplus. Fortunately, not all co-ops have done this, although 5 others besides Iowa and Kentucky have booked risk corridor receivables and counted them as assets.

Tennessee’s co-op, Community Health Alliance, had a net loss-to-surplus ratio of 314%, the highest of any co-op. Concerns about its near-term sustainability following a 35% price cut for 2015 led to a freeze in January, on all additional enrollments for 2015, although the co-op is expected to enroll more people for 2016.

The co-ops’ experience with enrollment and use in 2015 will be key to their financial stability.

Maine as the Exception

The one exception to these challenging experiences is Maine’s Community Health Option, which reported a positive net income of \$10 million through September 2014. The Community Health Option’s membership was larger than had been forecast—40,000 versus 15,000—but even with higher than expected membership, it reported early challenges involving staff recruitment and adequate third-party financing. Last fall, the co-op received an additional \$68 million in solvency funds, as did several of the other co-ops, which helped meet their capitalization requirements and supported their expansion into New Hampshire. The

most important reason for their success is that they priced their products better (ie, more accurately) than did most other co-ops.

Co-ops Going Forward

Some of the co-ops' challenges are to be expected with new start-ups. The CMS requirement of a higher risk-based capital ratio than for other insurers (500% versus 300% in most states) added to the co-ops' challenges, although they have had more low-interest, long-term funding available than the market would have provided, despite the \$3.4 billion being not as much as the \$6 billion originally expected. The co-ops' main problems have been "higher than expected" utilization and higher administrative costs than their size could sustain.

Whether their lower than prudent pricing was a deliberate strategy to increase their enrollment is hard to know. If risk corridors had not been required to be budget neutral, "low-balling prices" might have looked like a smarter short-term policy than it does today.

Whether there is a "need" for co-ops (ie, whether they are sustainable on a nonsubsidized basis) is another matter. Unfortunately, we will not know the answer to this question for at least 2 or 3 years.

References

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