

REQUEST:

Why has the Texas Mutual Insurance Company been able to successfully function as a quasi-governmental insurance company under seemingly similar circumstances as Health Care Co-ops, while almost half of all ACA Co-ops have collapsed? Are there certain practices or rules governing Texas Mutual that could help improve the solvency and long-term success of Co-ops or is there a fundamental difference that prevents similar practices from being employed?

BACKGROUND:

The Patient Protection and Affordable Care Act (ACA) established health insurance exchanges to allow individuals and small businesses to shop for health insurance in all 50 states and the District of Columbia. To expand the number of health insurance plans available in the marketplaces, the ACA established the Consumer Operated and Oriented Plan (CO-OP) program. The ACA directed the Secretary of Health and Human Services to provide loans to help establish new consumer-governed, nonprofit health insurance issuers, referred to as CO-OPs, in every state. Beginning January 1, 2014, CO-OPs were able to offer health insurance through the new health insurance marketplaces for their states, as well as outside the marketplaces. On that date, 23 CO-OPs offered health coverage in 24 states. Three of the 23 CO-OPs planned to offer coverage to neighboring states beginning in 2015, and one CO-OP planned to offer coverage to a neighboring state beginning in 2016.

The ACA included start-up funding and \$2.4 billion in loans to 23 nonprofit cooperatives designed to compete with private insurers. Loans were to be made solely to private, nonprofit entities that demonstrated a high probability of financial viability. The program was originally funded at \$6 billion, which was reduced to \$3.4 billion in 2011. Funding was eliminated under the fiscal cliff law signed in January 2013. While this did not stop the efforts in the 24 states (one plan encompassed two states) where CO-OPs had been approved for start-up loans, the cliff bill eliminated all new start-up loans.

As of November 4, 2015,, 13 of the 23 CO-OPs had failed – Vermont, Iowa/Nebraska, Louisiana, Nevada, New York, Kentucky, Tennessee, Oregon, Colorado, South Carolina, Utah, Arizona, and

Michigan. These 13 failures caused 718,000 members to lose CO-OP coverage. The House Subcommittee on Oversight and Investigations reports that \$1.23 billion in federal funds may not be paid back. [An Appendix that lists loan amounts and failure status will be forwarded.]

RESPONSE:

Not all ACA CO-OPs failed for the same reasons. When they did fail it was usually a combination of reasons that included:

- **Lack of experience**
 - CO-OPs were start-ups lacking clients, which forced forcing them to have to go to providers and ask for deep discounts like the big established carriers but with no comparable market share.
 - They started with little or no proprietary information about the risk pools and businesses they were entering while the big carriers had lots of data and experienced actuaries and managers.”
- **CO-OP plans were usually priced too low**
 - CO-OP states have 8.4 percent lower premiums on average than the non-co-op states, across the marketplace (Kaiser Health News, April 2, 2014).
 - A 2015 DHHS audit found that inaccurate pricing of premiums was one factor explaining why all but one CO-OP lost money in 2014.
- **Lack of access to private capital**
 - The Centers for Medicare and Medicaid Services forbid CO-OPs from accepting outside capital under loan agreements forged when the CO-OPs first began.
 - While most private insurers have enough reserves or access to funds to continue to operate, state regulators shut down some of the CO-OPs because of solvency concerns. CO-OPs were limited to what the capital the government gave them and could not raise more money in the public markets, or merge with bigger more established players when they got into trouble.
 - The CO-OPs federal loans carried restrictions, like not being able to use the funds for marketing, that made their odds of surviving steeper.
 - CO-OPs were prohibited from merging. CMS stymied their requests to find other sources of money.
- **Lack of diversification**
 - CO-OPs could only sell individual and small group policies—the most problematic part of the health insurance business.
 - They had to compete against health plans with well-diversified market portfolios.

- **High risk patients and low risk corridor payments**
 - CMS expected risk corridor payments to be risk neutral; however, they were not. The risk corridor provision in the Affordable Care Act was to be an important protection for consumers and insurers as millions of Americans transition to a new coverage in a brand new marketplace. The policy was modeled on the risk corridor provision in Medicare Part D.
 - Risk corridor payments turned out to be only 12.6% of the amount needed to bail out plans in trouble.
- **Possibly flawed risk adjustment formula**
 - The National Alliance of State Health CO-OPs has asked for changes to a federal formula known as risk adjustment, which takes money from plans with healthier and younger enrollees and gives it to plans with older and sicker customers to spread out financial pressures on insurers. The health CO-OPs and smaller insurers say the formula, along with another health law program that aims to offset insurers' financial losses, is putting them out of business.
 - Many CO-OPs enrolled more high risk (adverse selection), sicker people than they could afford to carry.

In 1991, the Texas Legislature created Texas Mutual Insurance Company (TMI, at first called the Texas Workers' Compensation Insurance Fund) to ensure the availability and affordability of workers' compensation coverage. In 1992, the Fund began underwriting workers' compensation insurance, and in 1994, it became the state's insurer of last resort for businesses that were unable to find coverage elsewhere. On June 15, 2001, Governor Rick Perry signed House Bill 3458 into law, changing the company's name to Texas Mutual Insurance Company and authorizing the company to operate as a domestic mutual insurance company. In 2015, Texas Mutual Insurance Company is the state's leading workers' compensation provider, insuring approximately 40% of the Texas workers' compensation market. They serve more than 62,000 business owners and 1.3 million workers.

The practices of and rules governing TMI ensure that none of the reasons for CO-OP failure, listed previously, affect the company. TMI was born from the turmoil surrounding worker's compensation insurance in the late 1980's. Employer insurance costs were high and few insurers were willing to enter the market. However, there was an existing knowledge base regarding costs and premiums, with which TMI was able to begin planning. Moreover, the company was and is able to access private capital and to invest. With more than 62,000 employers and 1.3 million employees covered,

they are well-diversified. They have a long history of good data and know what their risks are. The bottom line is that TMI has a history from which to plan, an administration that is business-oriented, the ability to market and advertise, a large pool of clients that lessens the risk that any single event or series of events will cause financial distress, and the ability to invest or access private capital.

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