DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
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CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT

Section 644: Consumer Operated and Oriented Plan Program Contingency Fund

Q: What happened to the CO-OP money appropriated by the Affordable Care Act?

A: The American Taxpayer Relief Act of 2012 (Pub. L. 112-240) transfers 10 percent of the unobligated balance of funds appropriated by section 1322(g) of the Affordable Care Act to a new CO-OP contingency fund and rescinds the remaining 90 percent of the unobligated funds. The law directs the Secretary of Health and Human Services (HHS) to use the contingency fund to provide assistance and oversight to CO-OP loan recipients that have received a loan or grant award prior to the date of enactment. These remaining CO-OP funds remain available until expended.

Q: What happens to current CO-OP loan recipients?

A: To date, 24 private, nonprofit entities have been awarded loans to establish CO-OPs across 24 states. Because such funds are considered to be obligated when the awards are made upon execution of a loan agreement, loan or grant awards issued to CO-OPs prior to enactment of the American Taxpayer Relief Act of 2012 are not subject to or affected by the rescission. The Centers for Medicare & Medicaid Services (CMS) will continue to provide assistance and oversight to these CO-OPs as they work to achieve program milestones, receive licensure from their respective state Departments of Insurance, qualify as a Qualified Health Plan (QHP), and prepare to participate in the new Health Insurance Marketplace. This assistance may include additional loan funds, as needed, to cover costs of specific systems, contracts or work not anticipated and budgeted during loan closing or to extend operations to a new state conditioned on approval of a separate request specifically for that proposed expansion.. This financial assistance will be important to each CO-OP's success and allow them to respond to changing market conditions.

Q: What happens to CO-OP applicants that were in active negotiations with CMS to complete a CO-OP loan agreement, submitted a request for reconsideration of a previous application, or were given the option to reapply?

A: CMS no longer has the authority to make loan awards to new borrowers or enter into loan agreements with new borrowers.

Q: The last application deadline for the Funding Opportunity announcement was December 31, 2012. What happens to the applicants who applied for the last round of funding?

A: CMS no longer has the authority to make loan awards to new borrowers. This applies to both new applications and applications received, but not awarded, during earlier application rounds. However, CMS has the authority to provide additional funding to existing borrowers, including funds for expansions to new states. CMS is currently accepting and reviewing the applications submitted by existing borrowers.

Q: How does the rescission affect state Departments of Insurance (DOIs), which are making the determination whether or not to grant licensure to CO-OPs?

A: The statute does not rescind funding from the 24 existing CO-OP loan recipients and CMS will continue to disburse funds to CO-OPs as they reach milestones outlined in the loan agreements. Solvency loans will continue to be available to CO-OPs to complete the state licensure process and to support the regulatory capital of the CO-OPs as they begin providing health insurance coverage. A CO-OP must meet all the requirements of state law and regulations in order to successfully complete the licensure process.

Q: Will CO-OPs be financially viable?

A: Yes, CMS believes the CO-OPs will be financially viable. Each of the 24 CO-OP awardees has undergone a thorough application review process and extensive loan negotiations. Loans have been made only to entities demonstrating a high probability of financial viability, and we expect that these CO-OPs will become active participants in the new health insurance marketplaces. CMS will closely monitor CO-OPs to ensure they are meeting program goals and will be able to repay loans. To ensure strong financial management, CO-OPs are required to submit quarterly financial statements, including cash flow and enrollment data, receive site visits, and undergo annual external audits. This monitoring is initially conducted by CMS and will continue concurrently with the financial and operational oversight by state insurance regulators once the CO-OP is approved for state licensure.

Q: **Can the Secretary use the new CO-OP contingency fund to provide additional loans to CO-OPs that have received a loan award prior to the date of enactment?**

A: Yes. Congress authorized the remaining CO-OP funds to be used for "assistance and oversight" for entities awarded loans under section 1322 of the Affordable Care Act. It has been determined that providing additional funds to existing CO-OPs is a permitted activity under the American Taxpayer Relief Act of 2012 (Pub. L. 112-240). Additional funds may be provided to existing CO-OPs to meet constraints in their start-up activities or to expand their operations to another State..

The assessment process for additional funding is rigorous. The available program funds will be prioritized first to ensure the viability of the existing business plans, and secondly to fund modifications to business plans for the purpose of expanding to new states. Expansion requests will be reviewed against the same scoring criteria as were the original loan applications. Preference will be given to expansions that align with the program goal of increasing consumer choice in states that may otherwise face limited issuer competition in their Health Insurance Marketplace.

We note that, under the Affordable Care Act, administrative costs related to CO-OPs are supported by the CO-OP fund.