

**Open Information Teleconference for Applicants of the  
Consumer Operated and Oriented Plans (CO-OP) Program  
Funding Opportunity Announcement  
CFDA#: 93.545  
Transcript- May 16th, 2011**

Coordinator: Standing by and welcome to today's conference. At this time, all participants are in a listen-only mode. After the presentation, we'll conduct a question and answer session. To ask your question, you may press star one on your touch-tone phone. Today's conference call is being recorded. If you have any objections, you may disconnect. I will now introduce your conference host, Miss (Barbara Smith). Ma'am, you may begin.

(Barbara Smith): Thank you. Hi, this is (Barbara Smith). I'm the director of the CO-OP division here at CMS, and I'd like to go around the table first of all and just introduce the other people at CMS who - and here at CCIIO who are on the call and who will be available to answer your questions.

Anne Bollinger: Hi, this is (Annie) Bollinger.

(John Fox): (John Fox).

(Carl Szasz): (Carl Szasz).

(Johanna Fabian-Marks): (Johanna Fabian-Marks).

(Megan Elrington): (Megan Elrington).

(Tanchica Terry): (Tanchica Terry).

(Barbara Smith): And we will have (Reed Cleary) joining us as well, and (Ilana Cohen), (Chanda McNeal), and (Heidi Kaczowka). Okay, and with that I would just like to thank you for joining us today. We very much appreciate your interest in the CO-OP program, and we especially want to thank those people who have been involved in applying to the program and working to establish CO-OPs in your state.

We recognize that this is a substantial undertaking requiring extraordinary amounts of time, effort, and dedication, and we tremendously appreciate your work. We hope this call will guide you in your decisions, your work plans, and your application preparation.

The purpose of the call is to provide an overview to you and convey some guidance based on our experience with the program thus far. It is also to provide an open forum to you to ask questions and hopefully get some answers. We have received a number of questions by email that we think will answer many of your concerns out there, so we're going to start with the email questions and the answers to them, and then we will be happy to open it up to questions.

The first question that we got is how long does the grants.gov registration process take if our organization has never used this process before? And the short answer is weeks, weeks and weeks, maybe a month. And it sort of varies by the applicant, and therefore we strongly encourage you to start this process as early as possible.

In order to use grants.gov, you'll be required to have an employer identification number, which is an EIN number that you should be familiar with, a data universal numbering system, so a DUNS number. You'll also need to register with the central contractor registration database. This is

known as the CCR. Getting a CCR number is essential to being able to apply, and is often the most time-consuming part of the task.

If you intend to submit an application, you need to start this process now, and by “now” I mean that if you are planning to submit an application in July, as soon as you’re off this call with us, you need to start this process. For specific information about the various numbers and databases please go to [grants.gov](http://grants.gov) and search for CFDA #93.545, and if you have additional questions about that or difficulties, you should contact (Annie Bollinger), and she will give you her email address at the end of this call.

The second question that we had was that the FOA indicates that there’s \$100,000 available to assist applicants with preparing their applications. This is usually for getting expert help in preparing your business plans and feasibility studies, and the question is, how do we access or apply for this funding? As indicated in the FOA, the funding opportunity announcement, the cost of preparing the feasibility study and business plan that will be considered eligible costs for start-up loans is a total amount of \$100,000.

But the loans for these costs will only be provided to successful applicants; only people who are actually awarded a start-up loan will be reimbursed for these costs. For applicants approved to operate in more than one state, an additional \$50,000 attributable to the cost of preparing feasibility studies and business plans per additional state in which the applicant is approved to operate will be considered eligible costs, and you can do this for up to four additional states.

The maximum amount that you would be reimbursed for this if you are successful is \$300,000, which would cover the cost, the feasibility study costs,

for five states. Funding for these pre-application expenses should be included in your start-up loan request, and it does not require a separate application.

Then we were asked if CMS offers technical assistance to support applicants in preparing an application. Since this is a competitive process, we do not offer formal technical assistance to support the actual preparation of the application. However, we're more than willing to have individual conference calls with individual applicants or respond by emails to answer your questions related to program requirements, the review process, and the application process. So please contact (Annie Bollinger) at 301-492-4395 or (Ilana Cohen) at 301-492-4371 if you wish to have such a call.

The question was asked, how do we ensure that both the formation board and operational board have sufficient expertise to manage a CO-OP. As stated in the rule in the FOA, the CO-OP board can include experts who are not members of the CO-OP if you need special expertise in, for example, actuarial work, finance, risk management, business management, quality care help, whatever expertise you feel you need to have. The only requirement is that designated seats for non-members, because of their expertise, cannot constitute a majority of the board, and the people in these seats much also be elected by the full membership of the CO-OP.

The next question is one that we get a lot, and so I'm going to really ask that you pay special attention to this, and this is: under what circumstances will multiple CO-OP applicants in the same state receive loans. We have talked about this in previous open door forums and have indicated that where the CO-OPs are likely to directly compete, it is much less likely that both will receive a loan.

Both the CMS review committee and the external reviewers take into consideration whether both can operate in the same state without jeopardizing the viability of either CO-OP or putting the repayment of the loans at greater risk. So when CO-OPs target the same populations or service areas, it's going to be much more difficult to meet that viability standard.

Here are a number of the factors that you need to keep in mind if you are preparing an application in an area where a loan has already been awarded or if you know that there will be another applicant in your state. First is whether both CO-OPs target the same enrollment population or whether the enrollment projections of either CO-OP would be significantly reduced or narrowed if both CO-OPs were awarded loans.

The second is whether the proposed service area for both CO-OPs is the same geographic region of the state. Another consideration is whether an additional award in the state could jeopardize the viability of a previously awarded CO-OP or could force a CO-OP to significantly change its business plan. Then another consideration is whether the CO-OP would be unable to meet state network adequacy requirements because of competition for the same provider networks.

Whether the market structure in that state would be detrimentally affected by the operation of more than one new CO-OP, whether there is an insufficient uninsured population to award more than one CO-OP in a state, whether the award of multiple CO-OPs in a state or more than one would create a competitive advantage for existing issuers, and diminish competition and choice over the long term, whether the award of an additional CO-OP divides or weakens the consumer-governed entity's ability to establish business networks, relationships, and purchasing power in their market, and finally as we have indicated before, whether the awarding of multiple CO-OPs will

jeopardize the ability of either CO-OP or any of the CO-OPs to repay their loans in a way not previously outlined above.

Therefore we would anticipate that multiple CO-OPs in the same state would be most likely be awarded in large states where there is not primarily overlapping service areas, so that they could have a large enough enrollment base to be viable and ensure that risk was spread substantially and not overlap. The states that I'm thinking of, although this is not intended to be an exclusive list, would be places like Texas, Florida, California, New York, and Pennsylvania. These are large states with large populations that could have naturally divided markets.

That gives you some insight into how that will proceed. We have also been asked to provide greater clarification on the difference between marketing, which federal start-up loans may not be used for, and community outreach and education, which they may be used for. And so again trying to provide as much guidance as possible, any activities related to the sale of a specific product to a specific customer would be marketing that is prohibited by the rule and the statute. For example, direct advertising and mailing - would be a prohibited use of loan funds.

It does not mean that you can't use other funds for the purposes of direct marketing; for example, funds from premium revenues, money from other sources, or from lines of credit. But you just can't use Federal loan funds for these purposes. Loan funds can be used for community outreach. An example of this would be informing and educating your community about the CO-OP model.

We've had some questions about the financial aspects of the loans once they're awarded. One of them was would we consider a staggered rate of

interest on the payback. One person said that they'd like to invest borrowed funds, an investment grade bond, and use the interest on the bond to pay back the federal government interest only. I think that we need to be clear about what is actually happening in the disbursement of start-up loans once you are awarded one.

Start-up loans are disbursed according to a defined disbursement schedule which has been negotiated with the applicant and reflects the expected timing of key business milestones and their related outlays and working capital requirements. The start-up loans are not going to be disbursed in a single lump sum award, and because the disbursement schedules have to be tied to specific outlays, we don't anticipate that the CO-OPs will have significant excess start-up funds to enable investments. They are structured this way intentionally.

Solvency loans are provided to help meet regulatory capital requirements, and these funds have to be managed and invested in a manner that is consistent with state regulation insurance standards to ensure the security of the investments. Typically state insurance departments require that solvency funds (your regulatory capital) be invested conservatively, in ways that generally yield lower rates of return. Higher returns, more speculative investment instruments typically are not permitted.

In addition as indicated in the FOA, the specific loan terms are individually negotiated to reflect the business plans, the market environment, the state regulation, and individual CO-OPs. The repayment terms which are also individually negotiated can include grace periods, interest only phases, and interest and principal payment phases.

We've also had a question about how many years of the line item budget and budget narrative are needed. Is it just for the start-up loan period? For

example, if we only had a start-up period of two years, would you only need the duration of the budget line and narrative to be for two years? So consistent with the FOA, and it's extremely important to read the FOA very carefully and be sure that you are conforming to its requirements in every single detail and in a meticulous way, the budget and budget narrative must account for all the uses of the start-up loans and cover the full period through which the start-up loans are expended.

You are expected to submit a budget plan for both the start-up and the solvency loans with as much specificity as is feasible, and we of course have the expectation that CO-OPs would be updating their business plans as they become operational. The next question is where on the standard form 424A do you include the solvency request? If the solvency loan request goes on the 424A, do you spread the loan amount over the years of anticipated draw-down for the performer, or is there another way this should be represented? Under which object class category would the solvency request fall?

I know these are technical questions, but they are clearly questions that arrived in the course of application preparation, and the answer is your total funding request should be included on the form, including both the start-up and solvency loan requests, and for specific questions on how to fill-out this form again, contact (Annie Bollinger,) whose number I've already provided.

The next question is: does an existing non-profit entity have to form a separate entity to apply for funds and become a CO-OP? The key thing that you need to understand is that the applicant has to be the entity that will become the CO-OP, so unless your non-profit entity actually expects to be the CO-OP, it will need to form a separate organization.

Then of course we've had the standard generic question of what makes an application successful, what in the first three rounds led to successful results in the applications, and this is the long answer, but I think that it will be useful to everyone. And obviously the converse of these characteristics accounts for what has resulted in applications being not successful. But strong applications typically were built on strong foundations of community support, where they had created strategic alliances with providers, business leaders, and community and business organizations.

This building of community support is essential to the ultimate outreach strategy of the CO-OP and to its ability to get adequate enrollment and be successful. This is a strong contrast to people that may have had a lot of expertise but were working together quietly in their own space and were removed from the larger community in which they intended to operate. Isolation in CO-OP building just doesn't work. It doesn't work in the application, and we don't think it bodes well for their ultimate viability.

You need to develop strategic partners. They need to be deeply embedded in the communities in which you plan to operate. They need to ultimately be your business partners in attracting enrollment and be the foundation for your ability to market the CO-OP and be successful. Successful CO-OPs usually had a clear sense of what they wanted to accomplish. They had a strong, strategic mission associated with their application.

Another strength of the successful applications were their internal consistency within their proposal, what we would call matching or "ticking and tying" between the different domains so that if they were proposing to go statewide, their operational infrastructure and provider network, all matched a statewide objective.

Their enrollment projections, network projections, marketing strategy, cost assessments, the relationship of costs to premiums, and enrollment strategy all ticked and tied; their budget presentations and financial pro formas were consistent. When they're inconsistent the reviewers have no way of knowing which one is the right one.

They can't pick and choose, and if they're inconsistent, it conveys a certain amount of insecurity among the reviewers that you really know what you're doing, so that consistency is extremely important.

Okay, one of the critical aspects I think are tying the business plan to the feasibility study, and making sure that all of the elements of the business plan supported what would be considered feasible and feasibly operating in the market. This was the critical dimension. Inconsistencies between the feasibility study and the business plan typically resulted in rejections.

Another point I just want to talk about briefly is substantiation and justification, and we just cannot emphasize this enough, and it's true for every element of the application. The reviewers need to know the basis for the enrollment projections: how did you get there, what are the populations that you're drawing from, and why are they going to come to you?

If you're claiming that you have operational savings, where did those savings come from? How did you get there? If you're saying you're going to operate statewide, or even not, who are your providers? Do you have a relationship with them? Have you substantiated that relationship in the application by showing that the letters from the providers indicating that they want to work with you, and at favorable rates? If you are outsourcing, how is the outsourcing going to add to costs or savings?

How will these costs be reflected in your ultimate premium projections, and in your enrollment projections? So these things were all well substantiated in the successful applications, and it enabled the reviewers to see that applicants had a roadmap to building a CO-OP. Next, we would say that it's just extremely important to know the market in which you're planning to compete, to understand the role of the exchanges and its impact on the market, to know the level of competition in your market, and to know how your market varies across different areas.

For example, if you're in a large state, the market in the large state may be very different in the northern part of the state than in the southern part of the state. The populations may be different. You would need to reflect an understanding of all of that in your application. There are you know, some states where there's already a lot of competition and many players and consumers have choices.

Examples of that would be Oregon and Wisconsin, but those states were awarded loans because the applicants understood what was going on in their markets, and they had a strategy to get to their enrollment goal even within that competitive context. I think that all of the successful applications have shown some element of improved care. It's very hard for applicants to come in with fully integrated care, but they have all shown the use of more integrated care, better coordination of care, use of medical homes, bundling of payments, and increased use of pay for performance.

They didn't all do the same thing, and very few of them did all of it, but they all did something. In every instance where applications were awarded, there was a credible and substantiated plan to improve care, as opposed to just an aspirational statement that we're going to provide better care. There was actually a credible and substantiated plan on how they were going to do that.

Finally, although I guess not finally because we have a lot to go, they showed an understanding of what it means to be an insurance company as opposed to a care delivery system of clinics or individual providers. Being an insurance company is a different undertaking; successful applicants demonstrated an understanding of what was involved in that, the importance of product development that would attract enrollees, and the ability to manage risk.

They had people involved in their organization with insurance experience, marketing experience, and product development experience. They understood what coverage meant. They understood the importance of having continuous and consistent coverage that moved with the person as they traveled, as they went back and forth between work and home, all of these things that are the key elements of being an insurance company and not just a provider or an advocacy group or anything else.

They also demonstrated clear compliance with the letter and the spirit of the law. They proposed robust presences in the exchanges. They showed an ability and intention to reach out to a broad community of individuals and not just their employee groups. They understood guaranteed issue and the fact that they would have to be open to all comers and be engaged in the appropriate use of wellness programs as a way to improve and provide preventive care, and they didn't use proxies for discrimination against those with higher health care needs.

They reflected good coordination with their departments of insurance, state regulators, and an understanding of the licensure process. These are just the highlights, and obviously unsuccessful applicants were on the flip side of this. I'll briefly highlight some things. Again, operating in isolation, without good

ties to your broader community tends to be considered a substantial weakness in an application.

The other thing is that CO-OPs can't be flipped on in states like light bulbs. Even if you have a large rental network and back office functions in place, it doesn't mean that you can construct a risk-bearing entity that will attract enrollment, customer loyalty, or operate durably in the market. So there has to be the whole package, and not having ties to the local community, not having partners and affinity groups within the local community is very difficult, because your enrollment strategies tend to be much weaker.

Another weakness of applicants that failed were service areas or enrollment projections that were too low to sustain a viable risk pool. In front of the federally appointed (GAO) advisory board, expert witnesses testified that to be successful a CO-OP should be able to demonstrate that they can achieve an enrollment of at least 25,000 people by the end of the first three years.

We have seen applications that are substantially lower than that and it is hard to imagine how that works from an actuarial perspective.

We would certainly caution against biting off more than you can chew; but you need to have a broad enough service area to ensure that your risk pool will be viable.

Another consistent weakness was that the provider network plans were insufficiently mapped out or substantiated without evidence of concrete engagement by the range of providers covering the full service area proposed.

For example proposing statewide coverage but your provider network engagement only covers two-thirds of the state, portions of the state, or certain population centers. Your application is not going to be approved.

I would say that in an overarching way the two most consistent failures that led to application rejection were enrollment strategy and network strategy.

One other thing that I think is really important. I'll summarize quickly here because I want to give you all time to answer questions. Is that unsuccessful applicants tended to have less detail in their budget, disbursement schedules, repayment schedules, and financial projections and more inconsistencies across all of those domains.

You need to really show a detailed roadmap to how you are setting up this plan and how you will operate financially.

Unsuccessful applicants generally had less understanding of the complexities of the markets in which they propose to operate, especially in large states.

Finally, I would just say that clarity of the application, creating a roadmap for the reviewers is really important. If you are referring to Excel spreadsheets or if you have Excel spreadsheets it's very important that in your application narrative you cross-reference clearly and directly to exactly where the substantiating detail is in the attachment that you provide.

The reviewers have to be able to find the substantiation and compare the data that you are providing them in an efficient and reasonable way.

If that kind of clarity and cross-referencing and clear presentation of what you are proposing to do is not there, it will be very difficult for the reviewers to try

and figure it out or attribute different attachments and different aspects of the application without being certain that that's really what you're talking about. Clarity, a clear roadmap for the reviewers is absolutely essential.

I would caution against biting off more than you can chew. You should only submit an application for that which you can completely substantiate in all of the dimensions, operationally from a provider perspective, and financially.

This is a long presentation, but I hope that addressed a lot of your questions.

And with that (Catherine) I think we can just open it up to questions.

Coordinator: Once again if you would like to ask your question at this time please press star 1 on your touchtone phone. You will be announced prior to asking your question. To withdraw your question you may press star 2. Once again to ask your question, please press star 1 on your touchtone phone; one moment for the first question.

We do have questions coming through, one moment.

The first question is coming from (Randall South), Health Insurance CO-OP. Your line is open.

(Randall South): I have a question. What does the rate of premium that you'd like to see as a proportion of your expense? In other words, do you have a ratio for expense-to-premium that you use as a standard?

(Barbara Smith): Under the Medical Loss Ratio Standards in the Affordable Care Act, and I hope that I'm remembering the percentages correctly, you are required to have an 80% medical loss ratio.

In the regulations governing medical loss ratio there are exceptions for startup plans, new plans that in the early years provide some flexibility for that.

But the aspirational goal should be to get to 80% attributable to medical loss.

Does that answer your question?

(Randall South): Yes. So if I understand that correctly, hypothetically for every \$10 that we charge, 80% of that would be our expense.

(Barbara Smith): That's correct.

(Randall South): Okay.

(Barbara Smith): It would be your expense on the claim.

(Randall South): Right, okay.

(Barbara Smith): Okay.

Coordinator: The next question is coming from (Kurt Sattler), Washington Insurance Alliance. Your line is open.

(Kurt Sattler): Okay, thank you. I noticed that there haven't been any announcements in 60 days. Any specific reason for that or are there going to be announcements shortly?

(Barbara Smith): There will be announcements shortly.

(Kurt Sattler): Okay.

(Barbara Smith): There will be announcements shortly. But the review period for each round of applications is 60 days.

(Kurt Sattler): Okay.

Coordinator: The next question is coming from (Joe Albers) CO-OP Care, Minnesota. Your line is open.

(Joe Albers): Hi. My question is do the federal premium subsidies apply to small employers that have more than or your contracts with organizations that have greater than 99 employees which the rules say that we can do it to some extent?

(Barbara Smith): The federal premium subsidies apply only to people in the individual market. They do not apply to businesses.

People that come into the exchanges through the Shop Exchange, the Small Business Exchange, or the Small Business Program within the exchanges, are not eligible for subsidies because they are getting insurance through their employer.

(Joe Albers): So there's no small employer subsidy at all then?

(Barbara Smith): There is a small employer tax credit.

(Joe Albers): Right, that...

(Barbara Smith): And that goes directly to the employer who provides insurance to its employees.

Under the Affordable Care Act this is for employers with less than 25 employees and who have an average wage below a certain amount, which I don't remember off of the top of my head.

But that is a tax credit that goes directly to the employer and is basically between the employer and the IRS.

(Joe Albers): Thank you.

Coordinator: The next question is coming from (Mike Strong), (Milliman). Your line is open.

(Mike Strong): Hi. I'm wondering now that you've given out ten CO-OPs loans, solvency loans, and startup loans. Have you looked at the percentage of the total dollar amount of the 3.4 billion that you've set aside relative to your geographic goals? Have you thought about scaling back the loan, the solvency loan amounts, or the startup loan amounts?

(Barbara Smith): Yes. We have examined our total loan authority and are confident that we have adequate funding without scaling back the solvency amount.

(Mike Strong): Thank you.

(Barbara Smith): Thank you.

Coordinator: Once again if you do have a question, please press star 1 on your touchtone phone; one moment for the next question.

And we have another question coming through, one moment.

The next question is coming from (Randall South), Health Insurance CO-OP.  
Your line is open.

(Randall South): With respect to establishing both a provider base as well as an enrollment base will you folks allow detailed surveys as to needs as a demonstration? In other words the survey would cover things such as pricing and acceptability, in other words in lieu of a letter of support.

(Barbara Smith): I don't think there are particular standards for whether something could be substituted for letters of support to providers.

However what I would ask you to bear in mind is that the Review Committee has generally not been particularly tolerant of provider network strategies that are not tangible and largely enhanced, which does not mean that there have to be specific letters of intent for a fee schedule.

But it does mean that there has to have been a specific level of engagement with providers and some indication from them that they are willing to work with you at favorable rates that would result in affordable premium. It could also result in letters of intent, providers saying that they are willing to consider alternative reimbursement models such as bundled payments, enhanced payments for advanced primary care management in lieu of fee-for-service, or other things. It doesn't have to be rate specific.

But my concern with what you're saying is that it suggests that you don't have providers who have specifically engaged with you and that it's at a more abstract higher level. I think in general the Review Committees have not assigned a great deal of weight to those types of representations.

It has to be tangible and not theoretical. You know I think that's the thing to bear in mind.

Coordinator: The next question is coming from Joe Albers. Your line is open.

(Joe Albers): That'll be me.

(Barbara Smith): Yes.

(Joe Albers): That would be (Joe Albers) at CO-OP Care in Minnesota.

There's a question of what takes precedent, the federal law versus state law in terms of licensure with your state department. In this case Minnesota Department of Health has a contracting arrangement under statutes that allow something like CO-OPs to form contracts with accountable provider networks. This has been a statute in place since 2001.

Can individuals now become part of that? Our Minnesota statute is called Healthcare Purchasing Alliances. They normally under state law would include groups to pool together and not really individuals.

Is there any way that the Affordable Care Act would now allow individuals into that pool?

(Barbara Smith): That sounds like something that's governed entirely by state law to me.

The CO-OPs apply to the State Insurance Department to become licensed issuers in their state. They can be organized in any way under state law that is consistent with the way state law recognizes or enables insurance companies to be formed.

If Minnesota allows a cooperative to become an insurance company then you could be a cooperative. If Minnesota says that you have to be a corporation to be an insurance company then you could be a corporation.

But beyond that in terms of which issuers are or how people are permitted to be in different types of state pools, that's something that's governed entirely by state law.

(Joe Albers): Thank you.

(Barbara Smith): Doesn't seem to be particularly related to the CO-OP Program.

(Joe Albers): Thank you.

(Barbara Smith): Thank you.

Coordinator: Once again to ask your question, please press star 1 on your touchtone phone; one moment for the next question.

The next question is coming from (Scott Porter), Simple HX. Your line is open.

(Scott Porter): Yes, good afternoon. I have a question about how the Professional Board seats are to be filled and specifically being filled by non-member professionals when the CO-OP requirements are that the operating Board members must be elected via contested election.

(Barbara Smith): Right.

(Scott Porter): This is specifically the case if we plan to designate seats on our Board for specific professional expertise in the field of healthcare insurances, must those seats also be elected and contested?

Does that change over time, startup versus later on in the life of the organization?

(Barbara Smith): Sure. That's a good question. First of all, the startup if you look at the rule, it describes in some detail the difference between what we call formation Board versus operational Boards.

The formation Board is the development Board. Those are the people that bring the CO-OP to life.

Clearly those on the formation Board can't be elected because you don't have enrolled members yet.

The first elected Board does not have to be phased in until one year after your first member is enrolled, not enrolled but the coverage takes effect on your first member.

Let's say that hypothetically, which is what we hope a successful CO-OP will achieve, your first member has effective coverage on January 1, 2014. That means that you would have to start to phase-in the election of your elected Board starting January of 2015 because by that point you have enrollment that can then elect a Board.

You would have your development Board in place until you start to phase-in the elected Board members. The phase-in of elected Board members must be

complete two years after the enrollment of your first member which means by January 1, 2016 in this example.

(Scott Porter): In that example then is it the ultimate goal to still maintain some professional people on that Board? If so, how does CMS see that occurring for retired insurance executives or whomever may serve on the formation Board?

(Barbara Smith): Sure. We do envision and the law requires that all of the members of the Board be elected in contested elections. That does not mean that for every seat there have to be two people running.

What it means, let's say you have 11 Board members. You would have to have maybe 13 or 15 or whatever people running for the Board.

(Scott Porter): I see.

(Barbara Smith): This means that your people with expertise on the Board would also have to be elected.

The other thing I would just point out in terms of the experience of existing co-ops is that we do have four models of highly successful health insurance co-ops in the country all of which have received some of the highest rankings available for quality of care and efficiency of coverage.

In all of the four models, 100% of their Board members have to be elected members and have to be members of the co-op.

But what they have done with some success is recruit people to run who actually are members and have a lot of understanding of health policy, health

insurance, finance and they have been able to get them to run to be on the Board.

We allow designated seats for special expertise to come on the Board, provided that they are elected. We think that you can amplify that expertise from your membership and that has certainly been the experience of the existing co-ops.

(Scott Porter): Sure. May I ask one more question?

(Barbara Smith): Oh please, as many as you like.

(Scott Porter): On the SF-424A Form you had touched on it briefly before and I was typing away at something that just said prior to that and I couldn't catch it all.

Where do you include the solvency requests?

I understand that you want it to be spread out over the anticipated drawdown I believe is what you had said.

And with that under what object class category would the solvency request fall?

Lastly, a multipart question, do we need to include projected revenues from our own premiums under program income? How many years should we do that?

Did you get all that?

(Barbara Smith): Yes. You want to...

((Crosstalk))

Anne Bollinger: Yes, hi. This is Anne Bollinger. So you're right in that your funding request for both startup and solvency need to be included on your SF-424A.

(Scott Porter): Yes.

Anne Bollinger: It might be better to set up time to talk about this offline so that we can both be looking at the form.

(Scott Porter): Okay.

Anne Bollinger: Because I can't remember all of the certain letters and numbers, where all the line items go.

But I'd be happy to do that.

(Scott Porter): All right, could - and I missed your contact information. Could you give that one more time or if you're so inclined?

Anne Bollinger: My phone number is 301-492-4395.

(Scott Porter): Thank you so much.

Anne Bollinger: You're welcome.

Coordinator: Once again to ask your question you may press star 1 on your touchtone phone. The next question is coming from (Dudley Zane), Washington Insurance Alliance. Your line is open.

(Dudley Zane): Thank you. What effect if any will the Supreme Court ruling have on CO-OPs?

(Barbara Smith): Well we fully expect the law to be upheld in its entirety. We have a program that we are going forward with every day and are fully implementing. Those that have been awarded loans have contracts and are performing according to those contracts.

That's the way we expect to continue. So we would expect for people who are working hard to continue to work hard.

(Dudley Zane): Good. Can I ask one more question?

(Barbara Smith): Sure.

(Dudley Zane): Moving forward where will the future forms be posted for the CO-OPs and all of the changes and the updates? Would that be through NASHCO or will that be through the HHS?

(Barbara Smith): Yes. We have our own web site and we generally have responsibility for making our own information available to the public.

I'm going to let Annie give you our web site information, but generally when we have updates we post them on our web site. If there is any update in the funding opportunity announcement, we will provide notification to that effect on our web site, but it would also be found on [grants.gov](http://grants.gov).

Anne Bollinger: You can access our funding opportunity announcement at [grants.gov](http://grants.gov) by searching CFDA Number 93.545.

And then the CO-OP web site is [cciio.cms.gov/coop](http://cciio.cms.gov/coop).

(Dudley Zane): Thank you. I appreciate that.

Anne Bollinger: You're welcome.

Coordinator: Once again if you have a question, please press star 1 on your touchtone phone; one moment for the next question.

And we do have a question coming through, one moment.

The next question is coming from (Randall South) at Health Insurance CO-OP. Your line is open.

(Randall Scott): Just wanted to clarify the web site. I'm pretty sure we've got it but just could you go ahead and repeat the web site again for the CO-OPs.

Anne Bollinger: Sure. It's [cciio.cms.gov/coop](http://cciio.cms.gov/coop).

(Randall Scott): Okay, thank you.

Anne Bollinger: You're welcome.

(Barbara Smith): And while we're waiting for more questions, I would just like to encourage everybody to check the web site frequently as you're preparing your application and also to read in great detail and with careful attention the answers to the frequently asked questions that are posted there. That will help you a lot in your application preparation and in understanding the program.

I would also encourage anybody who is applying to have complete fluency with the regulation which is also posted on our web site and with the FOA.

Make sure you understand how the FOA and the regulation interact so that both of these things are second nature to you as you are preparing your application.

Coordinator: At this time we have no further questions.

(Barbara Smith): Great. Well, thank you very much. We very much appreciate the time you have devoted to the call and continued participation in the program.

We of course look forward to hearing from you as needed. So thank you very much.

Coordinator: This will conclude today's conference. All parties may disconnect at this time.

END