# CO-OP Program Guidance Manual

**(Version 1, July 29, 2015)**

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## 1. Introduction and Background

The purpose of this guidance manual is to provide CO-OPs with a resource to quickly access guidance issued by the CO-OP program. CMS will compile issued guidance in this manual at least twice per year. CMS intends to continue to issue guidance to CO-OPs directly in order to disseminate information in a timely manner.

This manual contains guidance on the following subject matters:

- Core contract requirements including the review of employment agreements and executive compensation;
- Risk-based capital (RBC) requirements;
- Start-up Loan disbursements; and
- Semi-annual and quarterly reporting requirements.

Also included in this manual is draft guidance regarding best practices for establishing executive compensation. Per section 3.6 (d) of the Loan Agreement, CO-OPs are not permitted to use Loan Funds to pay excessive executive compensation. The draft executive compensation guidance included in this manual provides information to a CO-OP's management and board of directors on the process by which executive compensation should be determined by a CO-OP's board of directors. CMS intends to finalize this guidance following a 30-day comment period, and will update the manual to reflect the final guidance.

**Background**

Section 1322 of the Affordable Care Act authorized the establishment of the Consumer Operated and Oriented Plan (CO-OP) program. The purpose of the CO-OP program is to foster the creation of nonprofit member-run health insurance issuers to offer qualified health plans in the individual and small group markets in the states in which the issuers are licensed to offer such plans. To facilitate their creation, the Centers for Medicare & Medicaid Services (CMS) awarded these new nonprofit health insurance issuers, referred to as CO-OPs, Start-up Loans to assist with meeting the initial costs associated with the creation of a new health insurance issuer and Solvency Loans to assist with meeting state reserve requirements.

Background information including the amount of loan funds awarded to each CO-OP is available at http://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html. To participate in this program, CO-OPs entered into a Loan Agreement with CMS as a condition of receiving loan funds from CMS. The Loan Agreement sets forth, among other things, the CO-OP Program's programmatic requirements.

Per section 7.1 of the Loan Agreement, a CO-OP must satisfy and meet all applicable requirements of the Affordable Care Act, and regulations promulgated thereunder. This includes but is not necessarily limited to the regulations codified at 45 CFR Part 156, the terms of the CO-OP Program Funding Opportunity Announcement, and any and all additional CO-OP Program guidance as may be issued or released by CMS.

## 2. Method for Submitting Comments on Guidance Manual

This guidance manual will be published on CCIIO's website at www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/index.html#Consumer Operated and Oriented Plan (CO-OP) Program. If you have any questions or concerns regarding the guidance in this manual including the draft executive compensation guidance, please submit your comment or questions to CO-OPProgram@cms.hhs.gov with the subject "Comments on CO-OP Manual" by no later than 8pm ET on August 28, 2015. After this thirty (30) day comment period, CMS will update this manual and publish the final guidance on September 28, 2015.

# 3. Standard Reporting

## 3.1 Semi-Annual & Quarterly Reporting Guidance

***(Released on February 2, 2015)***

### Introduction

Per section 10 of the CO-OP Program Loan Agreement, CO-OP Program loan recipients (referred to as "CO-OPs" throughout these instructions) are required to submit progress reports to CMS on a quarterly and semi-annual basis.

The information collected in these reports will assist CMS in administering the program, tracking the progress of CO-OP loan recipients, and monitoring program integrity and compliance. Furthermore, the Progress Report will allow CMS to monitor both expenditure of loan funds and CO-OP loan recipient progress toward repayment of loans within the timeframes specified in regulations at 45 CFR 156.520 and Section 6 of the Loan Agreement. Selected information from each Progress Report may be shared with other CO-OPs to assist them in their development and contribute to the overall success of the CO-OP Program. Information that may be shared with other CO-OPs is clearly marked in the Progress Report, and no other information will be shared with other CO-OPs without prior permission.

Pursuant to Section 10.1 of the Loan Agreement, CMS has access to any data submitted to applicable Marketplaces and State Departments of Insurance. CMS intends to minimize reporting burden by using a collaborative approach to oversight. CMS recognizes that substantial oversight occurs at the state level and will coordinate with the Marketplaces and State Departments of Insurance as appropriate to ensure that CMS makes efficient use of data already collected by other oversight entities.

For more information on CO-OP Program reporting requirements, please refer to your Section 10 of the Loan Agreement, the CO-OP Program Paperwork Reduction Act package, available at https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS1251043.html[1], and the CO-OP Program Funding Opportunity Announcement available at www.Grants.gov (CFDA 93.545).

### General Instructions

- This report is focused solely on activities that occurred during the relevant reporting

[1] This link is no longer available. Please use the following link: http://www.reginfo.gov/public/do/PRAViewIC?ref_nbr=201504-0938-015&icID=198655.

period. Do not enter information that pertains to periods before or after the reporting period unless these instructions specifically direct you to do so.

- In all fields asking for the CO-OPs name, please enter the organization's legal name as reflected in the current CMS Loan Agreement.
- NOTE: Please provide a complete report submission. If there are any sections or questions which no longer apply to your organization, please enter N/A to indicate that the item is "Not Applicable."

### Specific Instructions

The following provides clarification for each section of the Semi-Annual Progress Report. If you have any further questions, please contact your Account Manager.

### 1-Changes to the Bylaws

Please attach a copy of your original bylaws. If you have amended or changed your bylaws in any way during this reporting period, please attach a copy of the amended bylaws as well and answer the specific questions about the amended bylaws. All CO-OPs must attach their original bylaws (and amended bylaws, if applicable) for the March 2015 submission. **After the March 2015 submission, only amended or changed bylaws need to be submitted.**

### 2-Licensure and Accreditation

Please indicate when your state licensure expires for each state in which you are licensed. Additionally, please indicate with which agency you are accredited, when that accreditation was acquired and when that accreditation will expire.

### 3-Member Control

Please identify the dates of all Board elections held in this reporting period. Please ensure that each listed question is answered for each election date separately.

### 4-Ethics, Conflict of Interest, and Disclosure Standards for Board of Directors and Executive Officers; Limitation on Government and Issuer Participation

45 CFR 156.515(b)(3) mandates that CO-OPs have certain mechanisms in place to address ethics and conflict of interest. Please answer the questions in this section to ensure you are in compliance with these requirements. The following is further clarification on terms used in these questions.

For question 4(a), Changes in Leadership means change to any Director position or Executive Officer position, including, but not limited to, the Chief Executive Officer, Chief Operating Officer

and Chief Information Officer.

For question 4(b)(2)(iii), "Changes" means any changes that alter the scope or to whom the ethical, conflict of interest, or disclosure standards may apply.

### 5-Consumer Focus

The questions in this section are designed to collect data to track timeliness, responsiveness and accountability to members as required by Section 156.515(b)(4). **These questions should only be answered during the March submission and should account for the average time of the previous calendar year.** For example, in March 2015, you should provide average times for phone calls, complaints, appeals and claims for January 2014 through December 2014.

### 6-Standards for Health Plan Issuance and Plan Management

Section 156.515(c)(1) requires that at least two thirds of policies or contracts for health insurance coverage issued by a CO-OP in each state in which it is licensed must be Qualified Health Plans offered in the individual and small group markets.

For this section, please answer questions based on the number of **total, active** policies or contracts in each specified type of market in each state in which you are licensed. Active policies are those in which the member is currently covered. Do not include policies or contracts that were previously issued and from which the member has since disenrolled.

For questions regarding qualified health plans, please use the number of current plans you are offering. Do not include any plan that has been discontinued in answering these questions or any plan for which you have applied and received permission to enroll members at a future date.

### 7-Communication with the State

"DOI Requirements" means any action, paperwork, or milestone set by your Department of Insurance for your CO-OP. Please answer each question for each separate DOI requirement.

### 8-Communication with the Marketplace

"Marketplace" means any representative of the state or federal marketplace for each state in which you are licensed. "Marketplace Requirements" means any action, paperwork, or milestone set by your state or federal Marketplace for your CO-OP. Please answer each question for each separate Marketplace requirement.

### 9-Updated Business Plan

Please follow the guidance provided to ensure that all updates to your business plan are captured in this submission.

### 10-Financial Information

All CO-OPs are required to submit a life of loan pro forma financial report for the March 2015 submission and the August 2015 submission. In subsequent submissions, the pro forma submissions will be required only for the March submission, unless specifically requested for the August submission by the CO-OP Division.

### 11-Agents and Brokers

These questions were answered by all CO-OPs in the March 2014 submission. Please only answer this question in subsequent submissions if there have been any changes to the answers to these questions since the March 2014 submission.

### 12-Best Practices

These questions were answered by all CO-OPs in the March 2014 submission. Please only answer this question in subsequent submissions if there have been any changes to the answers to these questions since the March 2014 submission.

For your reference, the reporting periods and related due dates are in Table 1 below:

**Table 1.**

| REPORTS: | REPORTING PERIOD: | NAIC DEADLINE: | CMS DEADLINE: |
|---|---|---|---|
| ***Quarterly 1*** | January 1 – March 31 | May 15 | **May 15** |
| ***Quarterly 2*** | April 1 – June 30 | August 15 | **August 15** |
| ***Quarterly 3*** | July 1 – September 30 | November 15 | **November 15** |
| ***Annual Financial Statements*** | October 1 – December 31 | March 1 | **March 1** |
| ***Semi-annual 1*** | January 1 – June 30 | N/A | **August 15** |
| ***Semi-annual 2*** | July 1 – December 31 | N/A | **March 1** |
| ***Annual Audited Report*** | January 1 – December 31 | *June 1 | ***June 1** |

| | | | |
|---|---|---|---|
| ***Annual Pro Formas***[2]<br><br>***[Quarterly Pro Formas]*** | January 1 – December 31 | N/A | **August 15/March 1 [April 1/ June 15/ September 15/ December 15]** |

*Generally the Audited Reports are due June 1 but some states have an exception and the report is due June 30. CMS expects that the CO-OPs would follow their State requirements.

### Access Tips and Tools

The following are tools used for data collection in this Progress Report:

- Drop-Down Menus: The grey arrow at the right of a text box will reveal a drop down menu. Please select an answer from the menu. If you do not see a corresponding response in the drop down menu, please enter your response manually.
- Date Calendars: In fields where dates are requested, a date calendar icon will appear to the right of the text box. Click on this icon to open a calendar from which you can select a date.
- Attachments: Attachments can be made using designated text boxes. Please click on the icon of the small paperclip to make the appropriate attachments.

### Checklist (Quarterly Report)

- ☐ **Attachment 1:** Quarterly Pro Forma
- ☐ **Attachment 1:** NAIC Quarterly Statement
- ☐ **Attachment 2:** NAIC Annual Statement: Financial Statement Underwriting and Investment Exhibit Part 3 – Analysis of Expenses.
- ☐ ***Attachment 3: [Provide only if CO-OP is not licensed in its expansion state]*** *Attestation (signed by the CEO, CFO or Official Designee. If signed by an Official Designee, official documentation of the designation is required, and it must be signed by the Board Chair, CEO, or CFO.)*

### Checklist (Semi-Annual Report)

- ☐ **Attachment 1:** CO-OP Program Semi-Annual Progress Report Access Database
- ☐ **Attachment 2:** Attestation (signed by the CEO, CFO or Official Designee). If signed by an Official Designee, official documentation of the designation is required, and it must be

[2] Per the 5/29/5015 Paperwork Reduction Act (PRA) package for the CO-OP Program, pro formas must be submitted to CMS quarterly rather than annually. The quarterly pro formas are due 30 days following the regulatory filings.

signed by the Board Chair, CEO, or CFO.

### Checklist (Annual Reporting)

- ☐ **Attachment 1:** Pro Formas (utilize NAIC Annual Statement format, projected throughout life of loan)
- ☐ **Attachment 2:** NAIC Annual Statement (or an audited annual report in NAIC Annual Statement format if not yet licensed)

### Checklist (Audited Annual Financial Report)

- ☐ **Attachment 1:** Please submit the Audited Annual Financial Report that is due to the NAIC annually on June 1.

# Attachment 1: CO-OP Program Semi-Annual Progress Report Access Database

The semi-annual progress report inquiries have been edited and streamlined to gather specific data to be used by the CO-OP Program. The following are the inquiries to be answered in the Access Database. Please complete all applicable fields. Entries will be reviewed and assessed and if there are incomplete fields, the CO-OP will be required to provide the requested information. Please note that the legal name of your organization will need to be filled out on each form in the Access Database. Additionally, please note the specific instructions for the "Updated Business Plan" section. If you have any further questions, please contact your Account Manager.

### 1-Changes to the Bylaws

a. Please attach a copy of your original bylaws.
b. If you have made changes to the Bylaws in this reporting period:
    1. Please attach the amended Bylaws;
    2. Identify the sections and page numbers where there have been changes; and
    3. Provide a detailed reason for the amendments or changes.

### 2-Licensure and Accreditation

a. For each state in which you are licensed, please indicate when your license expires.
b. If you are accredited, please answer the following questions.
    a. By which agency are you accredited?
    b. When did you earn this accreditation?
    c. When does your accreditation expire?

### 3-Member Control and Board Elections

a. What is the total number of positions for the Board?
b. If the CO-OP has held elections to elect members for the Board of Directors in this reporting period, please identify the date of each election and answer the following questions pertaining to each election.
    1. What was the date of the election?
    2. How many total vacant seats were available at the time of election?
    3. How many total candidates were considered at the time of election?
    4. How many Directors were elected during this election?

4. How many votes did each Director receive during this election?
5. Were all Directors elected during the election elected by a majority vote of a quorum of CO-OP members 18 or older?
6. How many of the Directors elected during this election are members of the CO-OP?
7. What is the percentage of your enrollees that voted in the election?

### 4-Ethics, Conflict of Interest, and Disclosure Standards for Board of Directors and Executive Officers; Limitation on Government and Issuer Participation

a. If there have been any changes to Leadership in this reporting period, please:
    1. Identify the changes; and
    2. Explain in detail the reason for the changes.
b. Do the bylaws address ethical, conflict of interest, and disclosure standards?
    1. Please provide a section and page number where the bylaws address ethical, conflict of interest and disclosure standards.
    2. Have there been any changes in your internal control processes to identify potential ethical or conflict of interest issues? If yes, please answer the following questions:
        i. What are the specific changes?
        ii. What were the reasons for the changes; and
        iii. Are these changes reflected in your internal control process documentation?
c. Does each Director and Executive Officer meet the ethical, conflict of interest and disclosure standards as mandated by the statute?
    1. Does the CO-OP require a conflict of interest form to be signed by its Directors?
        i. Please attach all signed conflict of interest forms that were signed by any Directors in this reporting period.
    2. Have there been any ethics or conflicts of interest issues with Directors or Executive Officers in this reporting period? If "Yes," please describe in detail how the issue was handled.
d. Does a representative of the Federal, State, or local government currently serve on the board?
e. Does a representative of the pre-existing issuer or other organization described in 45 CFR 156.510(b)(1)(i) currently serve on the board?
f. Did each member Director have one vote?
g. How many non-member Directors are on the board?
h. Are there currently any positions on the operational board designated for individuals

with specialized experience as allowed by 45 CFR 156.515(b)(2)(iii)? If "Yes," please indicate:

1. The number of positions designated for individuals with specialized experience;
2. The number of positions designated for individuals that are filled by members of the CO-OP; and
3. If the positions designated for individuals with specialized experience constitute a majority.

## 5-Consumer Focus

1. What is the average wait time for a phone call from a member?
2. What is the average time to respond to complaints?
3. What is the average processing time for a claim?
4. What is the average time to respond to appeals?

## 6-Standards for Health Plan Issuance and Plan Management

a. Are at least two thirds of the policies or contracts issued by you in each state in which you are licensed CO-OP qualified health plans offered in the individual or small group markets? If "No," please provide:
    1. A detailed explanation as to why you are currently unable to meet this requirement; and
    2. Any steps you will be taking to meet this requirement in the next reporting period.
b. How many active policies or contracts do you have in the individual Marketplace in each state in which you are licensed?
c. How many active policies or contracts do you have in the small group Marketplace (SHOP) in each state in which you are licensed?
d. How many active policies or contracts do you have in the individual market outside of the Marketplace in each state in which you are licensed?
e. How many active policies or contracts do you have in the small group market outside of the Marketplace in each state in which you are licensed?
f. How many active policies or contracts do you offer in the large group market in each state in which you are licensed?
g. Have you issued policies or contracts in any of the following alternative lines of business? If "Yes," please specify how many active policies or contracts and the type of policies or contracts in each state in which you are licensed for each alternative line of business.

1. Medicare Advantage
2. Medicaid
3. Administrative Services Only
4. Other (please specify)

h. How many plans do you currently offer?
    1. How many of these plans are Qualified Health Plans (QUALIFIED HEALTH PLANs)?
        i. How many of the QUALIFIED HEALTH PLANs are offered in the individual Marketplace?
            1. Are these plans offered at the silver and gold benefit levels in every individual Marketplace that serves the geographic regions in which the CO-OP is licensed and offers health coverage?
        ii. How many of the QUALIFIED HEALTH PLANs are offered in the small group Marketplace (SHOP)?
            1. Are these plans offered at the silver and gold benefit levels in every small group Marketplace that serves the geographic regions in which the CO-OP is licensed and offers health coverage?
    2. How many of these plans are not certified as QUALIFIED HEALTH PLANs?
        i. How many of the plans not certified as QUALIFIED HEALTH PLANs are offered in the individual market outside of the Marketplace?
        ii. How many of the plans not certified as QUALIFIED HEALTH PLANs are offered in the small group market outside of the Marketplace?
i. If your CO-OP is not statewide, in how many counties do you offer products?

## 7-Communication with the State

a. Please list any specific Department of Insurance (DOI) requirements for your CO-OP during this reporting period. For each DOI requirement listed, please indicate the following:
    1. If that requirement is complete or a projected completion date;
    2. If you met with the DOI regarding that requirement;
    3. When the meeting with the DOI occurred;
    4. The result of the meeting with the DOI; and
    5. If there are any follow up actions required by you as a result of that meeting.
b. Please list any meetings you have had with your DOI that are not related to the specific DOI requirements. For each meeting, please indicate the following:
    1. The date of the meeting;
    2. The reason for the meeting;
    3. The outcome of that meeting; and

4. If there are any follow up actions required by you as a result of that meeting.

c. If your DOI has issued any orders related to the CO-OP's business in this reporting period, please list each order separately and provide the following information for each order:
    1. Identify the reason for the order; and
    2. Identify your follow up actions to address the order.

### 8-Communication with the Marketplace

a. Please list any specific Marketplace requirements for your CO-OP during this reporting period. For each Marketplace requirement listed, please indicate the following:
    1. If that requirement is complete or a projected completion date;
    2. If you met with the Marketplace regarding that requirement;
    3. When the meeting with the Marketplace occurred;
    4. The result of the meeting with the Marketplace; and
    5. If there are any follow up actions required by you as a result of that meeting.
b. Please list any meetings you have had with your Marketplace that are not related to the specific Marketplace requirements. For each meeting, please indicate the following:
    1. The date of the meeting;
    2. The reason for the meeting;
    3. The outcome of that meeting; and
    4. If there are any follow up actions required by you as a result of that meeting.

### 9-Updated Business Plan

CMS expects an effective business plan to include a thorough presentation of business strategy and goals, substantiation of facts and assumptions, and a detailed implementation plan including: tasks, methods, resources, schedule, and performance milestones. The ultimate goal of the updated business plan is to provide CMS with a full understanding of the business strategy, confidence that risks have been considered, and an ability to determine the probability of success. As such, any description of changes to the business plan must be based on assumptions supported by source documentations, a methodology and quantification of components of the assumptions. The following question is presented in the Progress Report:

a. Please describe any significant changes to your business plan that occurred during the reporting period or are anticipated in the next reporting period. Significant changes include, but are not limited to, changes in: sponsors, governance structure/management team, provider arrangements, target markets, service areas (e.g.

expansions), products, enrollment strategy, any plan to use integrated care models, and significant contracts or vendors.

**Please use the following outline as guidance on what is needed in an updated business plan.**

### A. Sponsor

- *Description of Change*: Describe any changes to the CO-OP's sponsorship, e.g., the loss of a sponsor, the addition of a new sponsor, or a significant change in an existing sponsor's contribution to the CO-OP.
- *Expected Impact*: Describe the expected impact of the change.
- *Documentation Attached*: Attach documentation of the sponsor changes.

### B. Governance Structure and Management Team

- *Description of Change*: Describe any changes to the CO-OP's governance structure and/or management team. Changes to the governance structure include, but are not limited to, changes to:
    - The number of Directors on the Board of Directors,
    - The authorities of the Board of Directors, and
    - The number or percent of voting seats on the Board of Directors designated for non-CO-OP members with special expertise.

  Changes to the management team include any changes to the CEO, CFO, COO, or other executive-level managers.
- *Expected Impact*: Describe the expected impact of the change.
- *Documentation Attached*: Attach documentation of the governance structure or management team changes.
    - Documentation of a management team change must include the new executive's resume and contract of employment with the CO-OP. If the State requires insurers to submit NAIC Biographical Affidavits for new executives, submit to CMS the NAIC Biographical Affidavit that was submitted to the State instead of the new executive's resume.

### C. Provider Arrangements

- *Description of Change*: Describe any significant changes in the CO-OP's provider arrangements or plan for provider arrangements. Changes include but are not limited to:
    - Changes to the provider networks with which the CO-OP contracts or plans to contract, or
    - Significant changes to provider compensation structure (e.g., the CO-OP originally planned to use fee-for-service compensation and is now planning to use a mix of fee-for-service and bundled payment). If changes to provider compensation structure are explained in section G, Plans to Use integrated

care models, below, briefly note the change in this section and refer the reader to section G for more detail.

- *Expected Impact*: Describe the expected impact of the change.
- *Documentation Attached:* Attach documentation of changes to provider arrangements.

### D. Target Markets

- *Description of Change*: Describe any significant changes to the market that the CO-OP intends to target. For example, if the CO-OP now plans to offer products in the small group market or outside the Exchange, but did not previously plan to offer products in those markets, describe those changes.
- *Documentation Attached*: Attach documentation of changes to the market that the CO-OP intends to target.

### E. Products

- *Description of Change*: Describe any significant changes in the type of products the CO-OP is offering or plans to offer. For example, if the CO-OP now plans to offer a Qualified Health Plan at the Bronze level, describe that change.
- *Expected Impact*: Describe the expected impact of the change.
- *Documentation Attached*: Attach documentation of changes to products.

### F. Enrollment Strategy

- *Description of Change*: Describe any significant changes to the CO-OP's enrollment strategy.
- *Expected Impact*: Describe the expected impact of the change.
- *Documentation Attached*: Attach documentation of changes to enrollment strategy.

### G. Plans to Use Integrated Care Models

- *Description of Change*: Describe any significant changes to the CO-OP's plans to use integrated care models.
- *Expected Impact*: Describe the expected impact of the change.
- *Documentation Attached*: Attach documentation of changes to plans to use integrated care models.

### H. Change in Significant Contractor or Vendor

- *Description of Change*: Describe changes to the CO-OP's major contractors or vendors. For example, selection of a new TPA vendor must be described here.
- *Expected Impact:* Describe the expected impact of the change.
- *Documentation Attached:* Attach documentation of change in the contract.

### I. Other

- *Description of Change*: Describe any significant changes to the CO-OP's business plan that were not described in categories A-G of this section.
- *Expected Impact*: Describe the expected impact of the changes.

- *Documentation Attached*: Attach documentation of the changes described.

## 10-Financial Information

a. Will you be able to maintain an RBC level of 500% as mandated by the Loan Agreement for each state in which you are licensed? If not, please provide the following:
    1. A detailed explanation for falling below the required 500% RBC level including the reason(s) for dropping below 500% RBC, when those drops below 500% will occur, and how this will affect the CO-OP's viability and sustainability.
    2. The State's minimum RBC requirement, if applicable.
b. Is the DOI requiring the CO-OP to maintain a RBC higher than 500%? If "Yes," please explain why and describe the event that triggered this requirement.
c. Please list all sources of non-CMS funding other than premium income. For each source of funding, please describe:
    1. The type of funding;
    2. The amount of the funding; and
    3. The repayment terms (if any) of the funding.
d. If you currently have a reinsurance contract in place, please answer the following questions:

    1. What type of reinsurance option do you have (Specific Stop Loss, Aggregate Stop Loss, or Attachment Point)?

    2. What type of contract do you have (Incurred/Paid Basis, 12/12; Incurred/Paid Basis, 12/15; or Paid Basis, 15/12)?

## 11-Agents and Brokers

a. Are agents and brokers selling your products?
b. If yes, please describe your process for oversight of agents and brokers.

## 12-Best Practices

a. If you have developed any best practices for integrated care, please provide the following information:
    1. How many members were affected; and
    2. What target markets were affected?
b. Have you developed any best practices for consumer focus?
    1. How many members were affected; and

2. What target markets were affected?

c. Have you developed any best practices for innovative payments?
    1. How many members were affected; and
    2. What target markets were affected?
d. Have you developed any best practices for shared savings?
    1. How many members were affected; and
    2. What target markets were affected?
e. Have you developed any best practices for securing private support?
    1. How many members were affected; and
    2. What target markets were affected?
f. How many outreach activities have you conducted this reporting period?
    1. Of the individuals that became members this reporting period, what percentage of these members were reached through outreach activities conducted this reporting period?

# Attachment 2: Attestation of Information in Semi-Annual Progress Report

### 1. Attestation

In the appropriate box at the top of the page, enter the borrower name. In the appropriate boxes at the bottom of the page, enter the name and title of the person attesting to the accuracy of the information in the Progress Report. The attestation must be signed by the CEO or CFO of your organization or an individual designated to sign on their behalf (official documentation of the designation is required signed by the Board Chair, CEO, or CFO). The person attesting must sign on the line and a scanned copy of the attestation with their signature must be emailed with the Progress Report to the CO-OP's Account Manager. This scanned copy should be saved with the file name "SAP Attestation – QX&X 20XX," where QX&X 20XX is completed with the quarter numbers and year of the reporting period (e.g., "SAP Attestation – Q1&2 2012").

### 2. Exceptions to Attestation of Information in Semi-Annual Progress Report

In order to provide an accurate, complete, and truthful attestation, you must complete this section. In the first drop down menu, select either, "There are no exceptions" or "The exceptions are as follows." If there are any applicable requirements of the CO-OP Program or any applicable eligibility criteria for the CO-OP Program that the CO-OP does not meet, you must select "The exceptions are as follows" and provide a clear and concise explanation of the specific requirements or criteria that the CO-OP does not meet in the text box below the drop down menu.

# Attachment 3: Updated Life of Loan Pro Forma Financial Report

The pro formas, including the premium forecast, must be prepared by an independent certified public accountant or actuary, certified by an actuary, and submitted in PDF format. The pro formas must be based on calendar years.
All statements should be consistent with one another.

**The pro forma PDF must include:**

- Financial statements in the same format as they are shown in Attachment 3. Attachment 3 contains six template Excel sheets:
    - A1. Balance sheet – assets;
    - A2. Balance sheet –liabilities, capital and surplus;
    - B. Revenue and expenses (income) statement;
    - C. Cash flow statement;
    - D. Estimated regulatory capital requirements; and
    - E. Premium forecast
- All appropriate footnotes (see Section 1.F below for suggestions)
- Projections for the base case, low enrollment and high enrollment scenarios
- A certification statement by an actuary.

**In addition to the pro forma PDF, you must submit a completed Attachment 3 in Excel format.** The Excel file does not have to contain the footnotes and certification statement, but the data in the financial statements must be identical to the data in the PDF.

Please note that the first four sheets of the pro forma Excel template are substantially based on the NAIC Annual Statement, and the first column on those Excel sheets shows the corresponding NAIC line number to assist cross- referencing. Lines that do not appear in the corresponding NAIC Annual Statement section are highlighted in yellow.

### A1. Balance Sheet – Assets: Instructions

The Balance Sheet – Assets must reflect the year-end assets of the CO-OP. The Balance Sheet – Assets should be consistent with and tie to the loan funding and repayment

schedule, other pro forma financials, and the business plan. Please refer to the 2011 *NAIC Health Annual Statement Instructions: Financial Statements – Assets* for guidance on what must be included in each line.

### A2. Balance Sheet – Liabilities, Capital and Surplus: Instructions

The Balance Sheet – Liabilities, Capital and Surplus must reflect the year-end liabilities, capital and surplus of the CO-OP. The Balance Sheet – Liabilities, Capital and Surplus should be consistent with and tie to the loan funding and repayment schedule, other pro forma financials, and the business plan. Please refer to the 2011 *NAIC Health Annual Statement Instructions: Financial Statements - Liabilities, Capital and Surplus* for guidance on what must be included in each line.

### Revenue and Expenses (Income) Statement Instructions

The Income Statement must reflect the annual income or losses of the CO-OP. The Income Statement should be consistent with and tie to the loan funding and repayment schedule, other pro forma financials, and the business plan. Please refer to the 2011 *NAIC Health Annual Statement Instructions: Financial Statements - Statement of Revenue and Expenses* for guidance on what must be included in each line.

### C. Cash Flow Statement Instructions

The Cash Flow Statement must summarize all sources and uses of cash, including but not limited to: the loan awards, any third party financial awards or support, start-up development costs, as well as the on-going business operations of the CO-OP. The Cash Flow Statement should be consistent with and tie to the loan funding and repayment schedule, other pro forma financials, and business plan. Please refer to the 2011 *NAIC Health Annual Statement Instructions: Financial Statements – Cash Flow* for guidance on what should be included in each line.

### D. Regulatory Capital Requirements Forecast Schedule Instructions

The CO-OP must provide an estimate of the annual total regulatory capital requirements associated with each of the base case and alternative enrollment forecasts. The Regulatory Capital Requirement Forecast should tie to the Solvency Loan schedule, as well as to the other pro forma financial statements. Include any assumptions which materially affect the regulatory capital calculation, such as the assumptions used in the managed care credit calculation.

### E. Premium Forecast Instructions

The Premium Forecast must reflect the CO-OP's Average Per Member, Per Month cost,

average member age, and average actuarial value calculation as divided by market, in or outside of the Exchange, distinct geographical region, and Exchange metal level. The Premium Forecasts should be consistent with and tie to the loan funding and repayment schedule, other pro- forma financials, and business plan.

### F. Footnotes to Financial Statements

You may include footnotes for each financial statement submitted to provide clarity regarding the amounts reported. For example, you may include footnotes regarding:

- Medical loss ratio
- Contributions
- Other costs
- Administrative expenses
- Other revenue (if any)
- Other payables/receivables

# Attachment 4: Quarterly Financial Statement or Annual Financial Statement

All CO-OPs are required to submit the Q2 NAIC Quarterly Statement with the August submission and the Annual Financial Statement with the March submission of the Semi-Annual Progress Report.

# Attachment 5: Audited Annual Financial Report (Due annually on June 1)

1. **The CO-OP Has Submitted an Audited Annual Financial Report to the NAIC**

   If applicable, submit to CMS the audited annual financial report that was submitted to the NAIC by June 1. If the CO-OP has not yet submitted an audited annual financial report to the NAIC, follow the instructions in "2" below**.**

2. **The CO-OP Has Not Yet Submitted an Audited Annual Financial Report to the NAIC**

   If the CO-OP has not yet submitted an audited annual financial report to the NAIC, the CO-OP must submit an audited annual financial report using the NAIC Annual Statement template.

## 3.2 Monthly Reporting Guidance

***(Released on May 5, 2015)***

This memo sets forth additional guidance and clarifications regarding the new monthly reporting requirements for CO-OP loan recipients. Pursuant to Sections 10 and 11 of the Loan Agreement, CO-OP loan recipients must submit reports and other data required by CMS to monitor the performance of CO-OP loan recipients. To provide a timely snapshot of each CO-OP loan recipient's capital position and risk profile, CMS requests that each CO-OP submit a few pieces of key data to CMS on a monthly basis. The current requirements for the CO-OP monthly reporting include the following:

1. Active enrolled members – on the individual Marketplace – total and broken down by age:
    a. Age 0-20
    b. Age 21-34
    c. Age 35-44
    d. Age 45-54
    e. Age 55-64
    f. Age 65+
2. Total disenrollment – on the individual Marketplace
3. Active enrolled members – off the individual Marketplace – total and broken down by age:
    a. Age 0-20
    b. Age 21-34
    c. Age 35-44
    d. Age 45-54
    e. Age 55-64
    f. Age 65+
4. Total disenrollment – off the Individual Marketplace
5. Total active enrollment – Small Group
    **a.** Small Group enrollment – on the Marketplace
    b. Small Group enrollment – off the Marketplace
6. Total active enrollment – Large Group
7. Total active members enrolled in QHPs (Individual and SHOP)
8. Total active members enrolled in non-QHPs (Off exchange: Individual, Small and large group)
9. Total overall active enrollment
10. Total overall disenrollment
11. Total projected enrollment for next reporting period
12. Total active enrollment as a % of previously projected (prior month)
13. Total written premiums (gross)
14. Total uncollected premiums and agents' balances in course of collection
15. Total claims incurred (gross)
16. Total claims unpaid
17. Total cash/cash equivalents on-hand

18. Total bonds/other solvency investments
19. Investment Income Receivables
20. Healthcare Receivables
21. Premium Deficiency Reserve (PDR)
22. Capital and Surplus
23. Federal Reinsurance Premiums
24. Commercial Federal Reinsurance Premiums
25. Federal Reinsurance Recoveries
26. Commercial Reinsurance Recoveries
27. Total G&A Expenses
28. Claims Adjustment Expenses
29. Net Investment Income (Loss)
30. Other Income (Loss)
31. Net Income (Loss)
32. DOI Financial Reports

As of February 2014, CO-OP loan recipients were required to begin submitting select enrollment and financial data by the last day of the month. This data should cover the YTD balance as of the last day of the prior month. Specifically, active enrollment data should reflect the number of enrollees **with coverage** in effect as of the last day of the current reporting period. Additionally, financial data reported should be current and **cumulative YTD** as of the last day of the reporting period. In addition, all CO-OPs presently providing data to their State Department of Insurance (DOI) on a monthly basis should provide CMS with a copy of their full submission. Please note that all financial data provided on a monthly basis will be verified against NAIC report submissions to help assess the accuracy and validity of the data being provided to CMS. Thus, CO-OPs should ensure the amounts reported in the monthly reports agree with their reporting to state DOI.

Please note that additional changes have been made to the guidance below for clarification provided on definitions in the February 3, 2015 memo. To assist in providing clarification regarding the new monthly data reporting requirement, the following clarification notes are provided along with an updated Data Dictionary.

- "**Active Enrolled Members**" should solely reflect members presently being provided with coverage. (Note: ASO business should be included in the figures provided.)

- "**Age**" should be provided for all subcategory ranges provided. If a CO-OP has no members presently within a given age range, please enter a zero (0) within the monthly report template.

    - Please ensure that your data submission is not coded with a dash (-) or other null figure as this will result in inaccurate data being recorded for your CO-OP.

- "**Total active members enrolled in QHPs**" should be the total of SHOP and individual members enrolled with Qualified Health plans: # 1 and #5a.

- "**Total active members enrolled in non-QHPs**" should be the total of small group, individual and large group members enrolled with non-Qualified Health plans.

- "**Total overall active enrollment**" should be the total of active enrollments across all markets: # 1, #3, # 5, and #6. Also, this field should equal the total of fields, #7 and #8.

- "**Total overall disenrollment**" should be the total of all disenrollments across all markets: Individual, small group (including SHOP) and large group.

- "**Total Uncollected Premiums and Agents' Balances in Course of Collection**" should not be provided as a negative **(-)** figure. For the purposes of analysis, providing a negative figure will result in inaccurate data being assessed for your CO-OP.

- "**Total Claims Incurred**" should be a cumulative amount for claims incurred (paid and unpaid) during the current year only, consistent with the calculation methodology used for the Statement of Revenue and Expense, Line 16 – Subtotal of hospital and medical from the regulatory filing. This amount **should not** include reinsurance recoveries from federal and commercial reinsurance programs.

- "**Total Claims Unpaid**" should also not be provided as a negative **(-)** figure within the monthly report template. For the purposes of analysis, providing a negative figure will result in inaccurate data being assessed for your CO-OP.

- "**Total administrative expenses incurred**" should not include claims adjustment expenses. Calculation methodology used should be consistent with the methodology used to report the Statement of Revenue and Expense, ***Line 21 - General administrative expenses on the regulatory filings.*** Refer to SSAP No.70 for accounting guidance.

**Purpose:**

This document provides further clarification regarding the specifications of the monthly report measures now required by CMS for all CO-OPs that are offering products. Effective February 2014, CO-OP loan recipients must report the following information for current year-to-date. Please refer to NAIC definitions and reporting standards for additional clarification if needed.

**Data Dictionary:**

| Measure: | Instructions: |
|---|---|
| Age | To determine the appropriate age category of an enrollee, use the age of the enrolled individual at the time of application. |
| On the Marketplace | Report data from qualified health plans sold through the Exchange. |
| Off the Marketplace | Report data from plans not sold through the Exchange. |
| Active Enrolled Members – INDIVIDUAL | Report the number of Individual Market enrolled members with coverage in effect as of the last day of the reporting period. All individuals counted in this column should have paid their first month's premium. |
| Active Enrolled Members – SMALL GROUP | Report the number of Small Group Market enrolled members with coverage in effect as of the last day of the reporting period. All individuals counted in this column should have paid their first month's premium. |
| Active Enrolled Members – LARGE GROUP | Report the number of Large Group Market enrolled members with coverage in effect as of the last day of the reporting period. All individuals counted in this column should have paid their first month's premium. |
| Active Enrolled Members – TOTAL | Report the number of enrolled members with coverage in effect as of the last day of the reporting period. All individuals counted in this column should have paid their first month's premium. |

| | |
|---|---|
| Disenrollment | Report the number of members who have since disenrolled from coverage in effect as of the last day of the reporting period. |
| Total Premiums Written | Report the sum amount of all premiums written during the current year, including: amounts for premium transactions conducted directly with insured; amounts due from agents resulting from various insurance transactions; and premiums receivable from government-insured plans. Refer to SSAP No 6; SSAP No. 61R for accounting guidance.<br><br>Written premium is the contractually determined amount charged to the policy holder for the effective period of the contract. For health contracts without fixed contract periods, premium written will equal the amount collected during the reporting period plus uncollected premiums at the end of period less uncollected premium at the beginning of the period.<br><br>The amount reported on monthly should equal to the cumulative **YTD** total premium written during the current year and **should not** be adjusted for reinsurance ceded or receivables/payables from risk adjustment and risk corridors. Ceded reinsurance should be reported separately. |
| Total Uncollected Premiums and Agents' Balances in Course of Collection | Report the sum amount for all uncollected premiums and agents' balances in course of collection, including: amounts for direct and group billed uncollected premiums; amounts collected but not yet remitted to the home office; and accident and health premiums due and unpaid. |
| Total Claims Incurred (Gross) | The amount reported monthly should equal to the cumulative **YTD** total claims incurred during the current year consistent with the amount reported on **Line 16 of the Statement of Revenue and Expenses** of the Regulatory Filing, and **should not** be adjusted for reinsurance recoveries.<br>. |
| Total Claims Incurred (Gross) | Report the sum of all amounts incurred for member health services and benefits including: hospital and medical benefits; other professional services; outside referrals; emergency room and out-of-area; prescription drugs; and aggregate write-ins for other hospital and medical; and incentive pool, withhold adjustments and bonus amounts. |
| Total Claims Unpaid | The amount reported monthly should be consistent with the amount reported on **Statement of Liabilities, Capital and Surplus, Line 1** – Claims Unpaid, of the Regulatory Filing. |

| | |
|---|---|
| | Report the sum of all amounts for unpaid claims, including: those that have been reported and are in the process of adjustment; percentage withholds from payments made to contracted providers; incurred but not reported losses; recoverable for anticipated coordination of benefits and subrogation. Refer to SSAP No. 55 for accounting guidance. |
| Total Cash/Cash Equivalents And Short-term Investments | The amount reported monthly should be consistent with the amount reported on **Statement of Assets**, **Line 5** – Cash, cash equivalents, and short-term investments, of the Regulatory Filing.<br><br>Report the sum amount reflecting all cash, including petty cash, other un-deposited funds, certificates of deposit in banks or other similar financial institutions with maturity dates of one year or less from the acquisition date and other instruments defined as cash and cash equivalents in accordance with SSAP No. 2, Cash, Drafts, and Short-term Investments. |
| Total Bonds/Stocks/Other Investments | **Bonds** - amount reported on the monthly report should equal to sum of amounts reported on **Asset Statement, Line 1 - Bonds** of the regulatory filing.<br><br>Report the sum amount reflecting all bonds with maturity dates greater than one year from the acquisition date. Bonds are valued and reported in accordance with guidance set forth in SSAP No. 26, Bonds, excluding Loan-backed and Structured Securities; and SSAP No. 43R, Loan-backed and Structured Securities. Record bond acquisitions or disposals on the trade date, not the settlement date. Record private placements on the funding date. Exclude: Interest due and accrued. (Include definition of stocks, and other investments applicable.)<br><br>Stocks - amount reported on the monthly report should equal to sum of amounts reported on **Asset Statement, Line 2.1 – Preferred Stocks and 2.2 – Common Stocks** of the regulatory filing<br><br>Report the amount reported for common stocks and preferred stocks in the value in accordance with guidance set forth in SSAP No. 30, SSAP No. 32, and SSAP No. 97. |
| Investment Income Receivables | Amount reported on monthly report should be consistent with amount reported on **Statement of Assets, Line 14** of the Regulatory Filing. |

| | |
|---|---|
| | Report the cumulative **YTD** income earned on investments but not yet received. |
| Healthcare Receivables | The amount reported monthly should be consistent with the amount reported **Statement of Assets, Line 24** of the Regulatory Filing.<br><br>Report the cumulative **YTD** receivables including pharmaceutical rebate receivable, claim overpayment receivables, loans and advances to providers, capitation arrangement receivables and risk sharing receivables from affiliated and non-affiliated entities. |
| Premium Deficiency Reserve (PDR) | The amount reported monthly should be consistent with the amount reported on **Statement of Liabilities, Capital and Surplus, Line 4** of the Regulatory Filing.<br><br>Report the **YTD** balance of reserves including aggregate reserves for accident and health policies and excluding reserves relating to uninsured plans and the uninsured portion of partially insured plans. |
| Capital and Surplus | The amount reported monthly basis should be consistent with the amount reported on **Statement of Liabilities, Capital and Surplus, Line 14** of the Regulatory Filing;<br><br>Report total of capital and surplus available at the end of reporting period. |
| Federal Reinsurance Premiums | The amount reported monthly should be consistent with the amount reported on **Schedule S and ACA notes** of Regulatory Filing.<br><br>Report the cumulative **YTD** ceded reinsurance premium payable to the ACA transitional Federal reinsurance program. |
| Commercial Reinsurance Premiums | The amount reported monthly should be consistent with the amount reported in **Schedule S** of the Regulatory Filing.<br><br>Report the cumulative **YTD** ceded reinsurance premium paid and payable to the private reinsurance |

| | |
|---|---|
| | program. |
| Federal Reinsurance Recoveries | The amount reported monthly should be consistent with the amount reported on **Schedule S and ACA notes** of the Regulatory Filing.<br><br>Report the cumulative **YTD** amount recoverable from transitional ACA reinsurance program for claims paid and unpaid. |
| Commercial Reinsurance Recoveries | The amount reported monthly should be consistent with the amount reported in **Schedule S** of the Regulatory Filing.<br><br>Report the cumulative **YTD** amounts recovered and recoverable from private reinsurance on paid claims. |
| Total G&A Expenses | The amount reported monthly should be consistent with the amount reported in **Statement of Revenue and Expenses, Line 21** of the Regulatory Filing.<br><br>Report the cumulative **YTD** total of all general and administrative expenses incurred **excluding** all expenses relating to cost containment activities. |
| Claims Adjustment Expenses | The amount reported monthly should be consistent with the amount reported on the **Statement of Revenue and Expenses, Line 20** of the Regulatory Filing.<br><br>Report the cumulative **YTD** total of all expenses incurred in connection with the recording, adjustment and settlement of claims. |

| | |
|---|---|
| Net Investment Income (Loss) | The amount reported monthly should be consistent with the amount reported on **Statement of Revenue and Expenses, Line 25** of the Regulatory Filing.<br><br>Report the cumulative total **YTD** investment income earned from all forms of investments, including investment fees earned relating to uninsured plans. **Include** dividend from subsidiary controlled and affiliated entities, joint ventures, partnership, and limited liability companies less investment expenses, taxes (excluding federal income taxes), licenses, fees, depreciation on real estate and other invested assets. Additionally, **include** investment incomes credited to uninsured plans, and interest on borrowed money. **Exclude** capital gains and losses on investment. |
| Other Income (Loss) | The amount reported monthly should be consistent with the amount reported on **Statement of Revenue and Expenses, Line 29** of the Regulatory Filing.<br><br>Report the cumulative **YTD** total of write-ins listed in schedule details of Write-ins for other income or expenses. |
| Net Income (Loss) | The amount reported monthly should be consistent with the amount reported on **Statement of Revenue and Expenses, Line 32** of the Regulatory Filing.<br><br>Report **YTD** balance of excess or deficiency of total revenue over total expenses adjusted for extraordinary items and less federal taxes as of the end of the reporting period. |
| DOI Financial Reports | Provide copies of any monthly financial reporting submitted to the state DOI. |

# 4. Loan Terms

## *4.1* Core Contract Guidance

***(Released on March 19, 2014)***

The purpose of this memo is to clarify the Centers for Medicare and Medicaid Services (CMS) Consumer Operated and Oriented Plan Program (CO-OP) guidance for core contracts. The CO-OP Program reviews core contracts to assess CO-OP compliance with programmatic requirements, ensure consistency with business plans and loan agreements, evaluate efforts on behalf of the CO-OP to ensure reasonableness relative to available CO-OP loan funds and budgets, and determine any potential conflicts of interest.

| Memorandum Summary |
| --- |
| ➢ For core contracts that tie to the milestone schedule and disbursement of start-up funds, CO-OPs must continue to follow the guidance dated November 14, 2012[3] and submit to CMS for approval prior to execution core contracts and modifications. This includes CO-OPs engaged in start-up activities associated with expanding into a new state. |
| ➢ For core contracts that do not tie to the milestone schedule and disbursement of funds, CO-OPs must submit to CMS for approval prior to execution only contracts with sponsor organizations or related parties, and agreements with C-Suite executives. |

*Core Contract Activities That Do Not Tie To Disbursements:*
CO-OPs must continue to submit to CMS for approval prior to execution core contracts, including modifications, amendments, and newly generated contracts, with sponsor organizations or related parties, and employment agreements of top executives in advance of executing such agreements. “Related parties” refers to any party or entity with which a current principal, director, or employee of the CO-OP has a present or past relationship, such as a principal, director, or employee. CMS must continue to review these agreements as they implicate ongoing programmatic concerns regarding conflicts of interest and excessive or unusual executive compensation.

A CO-OP that had not previously submitted such contracts to CMS for approval and had executed such agreements must provide the executed contracts to the CO-OP Account Manager within 30 days of the date of this memo. Going forward, the CO-OP must submit such contracts to CMS in advance of execution and not execute the agreements until it receives CMS approval.

*Core Contract Activities that Tie to Disbursements*:

[3] See Attachment 1 of this manual for the November 14, 2012 guidance.

CO-OPs must submit to CMS for approval in advance of execution all core contracts and modifications that tie to milestones and disbursements, including those related to expansion activities. For these activities, CO-OPs must adhere to guidance issued on November 14, 2012[4] as explained in "Attachment 4: Instructions for CO-OP Loan Detailed Disbursement Schedule.". Pursuant to this guidance, CO-OPs may not use any federal loan funds for a core contract prior to its review and approval by CMS. After receiving CMS approval, loan funds may be used towards a core contract, as specified in the disbursement schedule. If a CO-OP still engaging in start-up activities has not submitted all core contracts for CMS review and approval, this information must be provided within 30 days of the date of this memo.

[4] See attachment 1

## Attachment 1 - Core Contract and Business Plan Modification Guidelines

***(Released on November 14, 2012. Attached for reference only, superseded by March 14, 2014 guidance)***

The purpose of this memo is to clarify the Centers for Medicare and Medicaid Services CO-OP Program (CMS) guidance for core contract and business plan modifications. Adherence to these guidelines is important to your organization's success and ability to meet the requirements of the CO-OP Program.

| Memorandum Summary |
| --- |
| ➢ Core contracts and modifications to all contracts must be submitted to CMS for approval prior to execution.<br>➢ CO-OPs may not use any CMS funds for a core contract prior to its review and approval by CMS.<br>➢ Business plan modifications must be reviewed and approved by CMS before implementation of the planned changes. |

### *CORE CONTRACT MODIFICATIONS*

**Core contract description:** As explained in "Attachment 4: Instructions for CO-OP Loan Detailed Disbursement Schedule," CMS has identified certain contracts as core to your business activity due to their significant impact on your organization's success. Specifically, CMS had identified six types of contracts as core to your business activity:

1. *Employment Agreements for Top Executive (e.g., CEO, CFO, CIO, President, etc.)*
2. *Facilities*
3. *Third Party Administrator*
4. *Information Technology Services*
5. *Quality Assurance*
6. *Contracts with Sponsors*

**Core contract assessment:** All core contracts and modifications to core contracts require review and approval from CMS prior to their execution. CMS reviews these contracts in part to assess compliance with program requirements; consistency with your business plan and loan agreement; reasonableness relative to loan funds and budget; and conflicts of interests.

**Core contract funding use:** The use of CMS loan funding by your organization for core contracts is not permitted for any purpose until the core contract is approved by CMS. Once a core contract has been approved by CMS, loan funding may be used to fund that core contract consistent with your disbursement schedule. The funding for each core contract that may be

used is limited to the amount designated in the disbursement schedule or approved in writing as part of the core contract review. Any additional funding for a core contract must be approved in writing from CMS.

**Core contract designations in the future:** There may be cases where changes in the scope of a non-core contract can result in a new designation for the contract. Therefore, when making any changes to the scope or funding of any existing contract, your organization must notify CMS. If CMS indicates that the proposed changes have resulted in a new designation of the contract as a core contract, the modification must be reviewed and approved by CMS prior to execution of the modified contract.

### *BUSINESS PLAN MODIFICATIONS*

**Business plan:** The business plan is a major component of the Funding Opportunity Announcement application criteria which permitted approval of your loan award by CMS pursuant to Section 1322 of the Affordable Care Act. Major business plan changes therefore must be approved by CMS to assure consistency and compliance with the key start-up operations and timelines discussed in your application and approved by CMS. Major business plan changes may include but are not limited to fundamental changes in strategic approaches, contract solicitation, and operational timelines. For example, major business plan changes include those which modify or impact your organization's:

- Licensure plan;
- Staffing plan;
- Provider network strategy;
- Enrollment strategy;
- Target market;
- Plan offerings;
- Governance structure;
- Vendor solicitation or contracting;
- Sponsorship;
- Operations timelines; and
- Loan funding and repayment schedule.

CMS authorizations for core funding and business plan modifications become final upon written notification by your Account Manager. If you have questions regarding this guidance, please submit them to the CO-OP Program Mailbox at CO-OPProgram@cms.hhs.gov with the subject line "Core Contract and Business Plan Modification Guidelines."

## 4.2 Start-up Quarterly Disbursement Schedule

***(Released on July 9, 2014)***

This memo sets forth the Start-up Loan disbursement schedule for milestones in calendar years 2015 and 2016. This schedule is an extension of the timetable released in the November 29, 2012 memorandum entitled "Anticipated Delay- Start-up Loan Disbursement Request for Quarter 2 2013 Milestones Processing and New CO-OP Program Loan Disbursements Schedule for Calendar Years 2012-2014.[5] For those CO-OPs with milestones in 2015 – 2016, for example CO-OPs expanding into neighboring states, the attached schedule outlines the quarterly disbursement dates for milestones in calendar years 2015 - 2016. If you have any questions regarding this memorandum, please contact your Account Manager.

[5] See Attachment 1 of this manual for the November 29, 2012 memorandum.

## Attachment I. CO-OP Program Loan Disbursements Schedule
## For Milestones in Calendar Years 2015 – 2016

| Funding Request for … | Documentation Due Date | Documents Required | Anticipated Disbursement Date |
|---|---|---|---|
| **Quarter 1 2015 Milestones** | July 31, 2014<br><br>August 15, 2014 | ➢ Quarterly Disbursement Request<br>➢ Documentation of Quarter 2 2014 Completed Milestones<br>➢ Quarter 2 2014 Quarterly Financial Report<br>➢ Semi-Annual Progress Report for Quarter 1 2014 & Quarter 2 2014 | September 19, 2014 |
| **Quarter 2 2015 Milestones** | October 31, 2014<br><br>November 15, 2014 | ➢ Quarterly Disbursement Request<br>➢ Documentation of Quarter 3 2014 Completed Milestones<br>➢ Quarter 3 2014 Quarterly Financial Report | December 19, 2014 |
| **Quarter 3 2015 Milestones** | February 2, 2015<br><br>March 1, 2015 | ➢ Quarterly Disbursement Request<br>➢ Documentation of Quarter 4 2014 Completed Milestones<br>➢ Quarter 4 2014 Quarterly Financial Report or 2014 NAIC Annual Report<br>➢ Semi-Annual Progress Report for Quarter 3 2014 & Quarter 4 2014 | March 20, 2015 |
| **Quarter 4 2015 Milestones** | April 30, 2015<br><br>May 15, 2015 | ➢ Quarterly Disbursement Request<br>➢ Documentation of Quarter 1 2015 Completed Milestones<br>➢ Quarter 1 2015 Quarterly Financial Report | June 19, 2015 |
| **Quarter 1 2016 Milestones** | July 31, 2015<br><br>August 15, 2015 | ➢ Quarterly Disbursement Request<br>➢ Documentation of Quarter 2 2014 Completed Milestones<br>➢ Quarter 2 2014 Quarterly Financial Report<br>➢ Semi-Annual Progress Report for | September 18, 2015 |

| Funding Request for … | Documentation Due Date | Documents Required | Anticipated Disbursement Date |
|---|---|---|---|
| | | Quarter 1 2014 & Quarter 2 2014 | |
| **Quarter 2 2016 Milestones** | November 2, 2015<br><br>November 15, 2015 | ➢ Quarterly Disbursement Request<br>➢ Documentation of Quarter 3 2014 Completed Milestones<br>➢ Quarter 3 2014 Quarterly Financial Report | December 18, 2015 |
| **Quarter 3 2016 Milestones** | February 1, 2016<br><br>March 1, 2016 | ➢ Quarterly Disbursement Request<br>➢ Documentation of Quarter 4 2014 Completed Milestones<br>➢ Quarter 4 2014 Quarterly Financial Report or 2015 NAIC Annual Report<br>➢ Semi-Annual Progress Report for Quarter 3 2014 & Quarter 4 2014 | March 18, 2016 |
| **Quarter 4 2016 Milestones** | May 2, 2016<br><br>May 15, 2016 | ➢ Quarterly Disbursement Request<br>➢ Documentation of Quarter 1 2015 Completed Milestones<br>➢ Quarter 1 2015 Quarterly Financial Report | June 17, 2016 |

***Please note the review and approval of a revised disbursement schedule and any associated disbursement request requires additional time to process. In this case, the anticipated disbursement date may be further extended.**

## Attachment 1- Anticipated Delay - Start-Up Loan Disbursement Request for Quarter 2 2013 Milestones Processing and New CO-OP Program Loan Disbursements Schedule for Calendar Years 2012 – 2014

***(Released November 29, 2012. Attached for reference only, superseded by July 9, 2014 guidance.)***

| Memorandum Contents Summary |
| --- |
| ▪ Start-Up Loan Disbursement Quarter 2 2013 Delay Notification |
| ▪ New CO-OP Program Loan Disbursements Schedule for Calendar Years 2012 – 2014 with Revised Anticipated Disbursement Dates |

### Start-Up Loan Disbursement Quarter 2 2013 Delay Notification

The purpose of this memo is to notify your organization of the occurrence of an expected two-week delay in the processing of your request for the CO-OP Program Start-up Loan Disbursement for Quarter 2 2013 Milestones. Our original anticipated disbursement date was December 5, 2012. The new anticipated date for disbursements is December 21, 2012. ***Please note: This memo only applies to CO-OPs expecting to receive a disbursement on December 5, 2012 as discussed with their Account Manager.***

### New CO-OP Program Loan Disbursements Schedule for Calendar Years 2012 - 2014

In our efforts to improve upon our disbursement request process, we have updated the CO-OP Program Disbursements Schedule for Calendar Years 2012 – 2014 with revised anticipated disbursement dates. The updated schedule shown below reflects more pragmatic timetabling required to review and process from start-to-finish Start-up Loan disbursements program wide. This update includes an adjusted window for reviewing and processing revised disbursement schedule requests and subsequent reconciliations by CMS.

It is the CO-OP Program's strong desire to ensure your organization has enough operating capital on hand to carry out daily business functions. Therefore, to the extent that this expected delay in the processing of your disbursement request will cause a significant concern to the management of your organization, please contact your Account Manager.

## CO-OP Program Loan Disbursements Schedule
## For Calendar Years 2012 – 2014 *(Revised 11/28/12)*

| Funding Request for … | Documentation Due Date | Documents Required | Anticipated Disbursement Date* |
|---|---|---|---|
| **Quarter 2 2013 Milestones** | November 12, 2012 | ➢ Quarterly Disbursement Request<br>➢ Project Plan | December 21, 2012 |
| **Quarter 3 2013 Milestones** | January 31, 2013<br><br>February 15, 2013 | ➢ Quarterly Disbursement Request<br>➢ Documentation of Quarter 4 2012 Completed Milestones<br>➢ Semi-Annual Progress Report for Quarter 3 2012 & Quarter 4 2012 | March 22, 2013 |
| **Quarter 4 2013 Milestones** | April 30, 2013<br><br>May 15, 2013 | ➢ Quarterly Disbursement Request<br>➢ Documentation of Quarter 1 2013 Completed Milestones<br>➢ Quarter 1 2013 Quarterly Financial Report | June 21, 2013 |
| **Quarter 1 2014 Milestones** | July 31, 2013<br><br>August 15, 2013 | ➢ Quarterly Disbursement Request<br>➢ Documentation of Quarter 2 2013 Completed Milestones<br>➢ Quarter 2 2013 Quarterly Financial Report<br>➢ Semi-Annual Progress Report for Quarter 1 2013 & Quarter 2 2013 | September 20, 2013 |
| **Quarter 2 2014 Milestones** | October 31, 2013<br><br>November 15, 2013 | ➢ Quarterly Disbursement Request<br>➢ Documentation of Quarter 3 2013 Completed Milestones<br>➢ Quarter 3 2013 Quarterly Financial Report | December 20, 2013 |
| **Quarter 3 2014 Milestones** | January 31, 2014<br><br>February 15, 2013 | ➢ Quarterly Disbursement Request<br>➢ Documentation of Quarter 4 2013 Completed Milestones<br>➢ Quarter 4 2013 Quarterly Financial Report<br>➢ Semi-Annual Progress Report for Quarter 3 2013 & Quarter 4 2013 | March 21, 2014 |

| Funding Request for … | Documentation Due Date | Documents Required | Anticipated Disbursement Date* |
|---|---|---|---|
| | | | |
| **Quarter 4 2014 Milestones** | April 30, 2014<br><br><br><br>May 15, 2013 | ➢ Quarterly Disbursement Request<br>➢ Documentation of Quarter 1 2014 Completed Milestones<br>➢ Quarter 1 2014 Quarterly Financial Report | June 20, 2014 |

***Please note the review and approval of a revised disbursement schedule and any associated disbursement request requires additional time to process. In this case, the anticipated disbursement date may be further extended.**

## 4.3 Guidance on Risk Based Capital Requirements

***(Released on December 9, 2014)***

This memorandum provides clarification on the approach to oversight by the Center for Medicare & Medicaid Services (CMS) with regard to the RBC requirements in the CO-OP Loan Agreement.

**Overview**

Section 7.2 (b) of the CO-OP Loan Agreement with CMS states that the surplus reserves held by the CO-OP cannot be more than 10% below the RBC level stated in the Business Plan for the applicable year at any time. Currently, the CO-OP Loan Agreement requires a CO-OP to maintain a surplus level of 500% Risk-Based Capital (RBC). If a CO-OP falls more than 10% below this level or 450% RBC, the CO-OP is out of compliance with section 7.2(b) of the Loan Agreement.

RBC is a method of measuring the minimum amount of capital appropriate for an issuer to support its overall business operations in consideration of its size and risk. RBC is not intended to be a stand-alone tool in determining the financial solvency of a CO-OP loan recipient; rather it is one of many tools that CMS uses to evaluate CO-OP financial risk. Given the limited access that CO-OP loan recipients have to external capital sources, CMS recognizes that there may be instances where allowing a CO-OP loan recipient's surplus level to temporarily fall below the 500% RBC level, but to a level that is acceptable to its State regulator may be appropriate, and could significantly increase the long term viability and sustainability of the CO-OP loan recipient. CO-OPs will remain subject to the full regulatory oversight of their state DOI, including any applicable RBC action levels.

**Loan Agreement Parameters**

Per Section 12.1 of the Loan Agreement, CMS may permit a CO-OP loan recipient to enter an Improvement Period if CMS has determined that the CO-OP loan recipient has not complied with CO-OP Program requirements and if CMS believes that the violation is nonetheless resolvable. Section 12.2 states that the CO-OP loan recipient may be placed under the requirements of an Improvement Plan, which may consist of one, several, or all of the following: Warning Notice; Corrective Action Plan; Enhanced Oversight Plan; Technical Assistance; or Discontinuance of Loan Disbursements.

Furthermore, Section 15.1 sets forth cases where non-compliance with CO-OP Program requirements may become an Event of Default, including: if CMS does not believe that the violation is resolvable and advises the CO-OP loan recipient in writing that the violation constitutes an Event of Default; if the CO-OP loan recipient has been given an opportunity to

correct non-compliance through an Improvement Plan and has failed to correct the failure and comply with the Improvement Plan; or if CMS determines that the CO-OP loan recipient ceases to be solvent.

**CO-OP Notification Requirements**

If the RBC level for a CO-OP loan recipient drops, or is projected within the next 180 days to drop, below the Loan Agreement required level, the CO-OP loan recipient should notify CMS as soon as possible and no later than 10 business days from the date of the occurrence. Furthermore, within 30 days of the initial notification, the CO-OP should submit to CMS an RBC plan which must:

1. Identify and explain the conditions which contribute to the RBC dropping below the Loan Agreement required level;
2. Contain proposals of corrective actions and corresponding milestones which the CO-OP intends to take and would expect to result in the return to the Loan Agreement required RBC level;
3. Provide life of loan financial projections that correspond to the corrective action plan scenario;
4. Identify and explain key assumptions related to the projections and describe the sensitivity of the projections to those assumptions;
5. Identify the quality of, and problems associated with, the CO-OP's business, including, but not limited to assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance, if any, in each case.

**CMS Evaluation & Notification**

CMS will evaluate such scenarios on a case-by-case basis to determine whether the CO-OP should be placed on an Improvement Plan or notified of an Event of Default, and will advise the CO-OP as to its determination in writing.

CMS evaluation of non-compliance with the RBC level required in the loan agreement will include, but is not limited to, the following criteria:

- Reasonableness, completeness, and anticipated impact of the proposed plan and the likelihood it will result in the CO-OP returning to the RBC levels required by the Loan Agreement and being able to repay CMS loans.
- Reviews for programmatic and regulatory compliance in other areas.
- Reviews for CO-OP experience and performance in its current market

If CMS determines that the CO-OP should be placed on an improvement plan, it may expand or refine the corrective actions described in the original submission and require increased reporting through an enhanced oversight plan.

Please contact your CO-OP Program Account Manager if you have any questions regarding the information contained in this memorandum.

## 4.4 Draft Guidance on Executive Compensation

***(New Guidance Released for Comment)***

The purpose of this memorandum is to provide draft guidance to a Consumer Operated and Oriented Plan's (CO-OP) management and board of directors on the process by which executive compensation should be determined by a CO-OP's board of directors. Additionally, this draft guidance describes the process that the Centers for Medicare & Medicaid Services' (CMS) will use to review a CO-OP's compensation practices and documentation.

### Background

CMS is charged with overseeing the operations and governance of the CO-OPs established under section 1322 of the Affordable Care Act. The Affordable Care Act specifies, among other things, that the CO-OP Program foster the creation of qualified non-profit health insurance issuers to offer qualified health plans in the individual and small group markets in the states in which they are licensed to offer such plans.[6] To assist CO-OPs with meeting start-up costs and state solvency requirements, section 1322 provides loan funding to eligible entities to help establish and maintain these new plans.

A CO-OP's status as a non-profit health insurance issuer under section 501(c)(29) of the Internal Revenue Code of 1986 is contingent upon compliance with the terms of the loan or grant made to the organization. Furthermore, CO-OPs, as qualified non-profit health insurance issuers, are required to use profits to lower premiums, improve benefits, or for other programs intended to improve the quality of health care delivered to their members.[7]

Since CO-OPs are 501(c)(29) corporations, and are regarded as non-profit by the Internal Revenue Service (IRS), executive compensation and benefits are subject to existing IRS regulations governing excess benefits transactions, and excessive compensation is subject to intermediate sanctions.[8] Consistent with IRS guidance, CO-OPs can take certain steps to establish a "rebuttable presumption" that their executive compensation arrangements are reasonable.[9]

In addition to IRS requirements, since the CO-OPs are funded predominantly with federal funds, the CO-OPs are bound by their Loan Agreement with CMS, which prohibits the use of loan funds to pay excessive executive compensation.[10]

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6Patient Protection and Affordable Care Act, 2010, Sec 1322(a) (2)

7 Patient Protection and Affordable Care Act, 2010, Sec 1322(c) (4)

8 http://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/Intermediate-Sanctions-Excess-Benefit-Transactions

9 http://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/Rebuttable-Presumption-Intermediate-Sanctions

10 Section 3.6 of the Loan Agreement,

Listed below is an overview of the process that CMS recommends a CO-OP's board of directors use to determine executive compensation. The process is described in greater detail in the Appendix. Following this process does not guarantee that the board of directors will arrive at executive pay decisions that CMS will determines are reasonable, but it indicates that the board of directors made a good faith effort to manage executive pay appropriately and followed common practices.

## Executive Compensation Process Overview

- A CO-OP's board of directors should formulate and adopt a mission statement that is consistent with relevant law.
- A CO-OP's board of directors or compensation committee of the board should formulate and adopt a statement of compensation philosophy that will govern the compensation of executives, and if appropriate, the staff of the organization.
- A CO-OP's board of directors or compensation committee of the board should identify comparable organizations against which to benchmark its own proposed compensation practices.
- A CO-OP's board of directors or compensation committee of the board should identify compensation resources it will use in planning and structuring pay for its executives. Where appropriate, it may delegate some of this responsibility to an outside compensation consultant.
- A CO-OP's board of directors or compensation committee of the board should use resources to develop pay ranges intended to set lower limits, upper limits, and target pay for executives.
- A CO-OP's board of directors or compensation committee of the board should determine whether variable pay is appropriate for executives, and if so, set criteria for budgeting them and targets for their use.
- A CO-OP's board of directors or compensation committee of the board should determine whether it is appropriate for certain executives to have perquisites such as a car and/or expense account and ensure that those perquisites are adopted to assist the organization's effort to achieve its mission. In addition to perquisites, a CO-OP's board of directors or compensation committee of the board should take care in the use of other forms of compensation to ensure that their use is limited to ways of fulfilling the mission of the organization. The preference or convenience of the executive should have little weight in

the decision to use these additional types of compensation.

- A CO-OP's board of directors or compensation committee of the board should develop performance review standards and metrics that will be used in assessing the performance of executives and planning increases to their pay or planning payouts of variable pay.
- A CO-OP's board of directors or compensation committee of the board should establish a method for determining base pay increase and variable pay budgets, taking into account ability to pay, practice of comparable organizations, and compensation philosophy.
- A CO-OP's board of director or compensation committee of the board should document all the process and elements listed above in a form that they can readily be reviewed by auditors, stakeholders, and regulators.

### CMS Review of CO-OP Compensation Practices and Documentation

CMS will conduct annual reviews of compensation data and documentation. In addition, if CMS has issues or concerns, we may request additional reviews or audits of compensation data and documentation. CMS's review of compensation data and documentation will compare CO-OP pay practices predominantly with other non-profit organizations of similar size and scope in the health insurance, healthcare, and human services arenas.

In addition to pay levels, variable pay programs and other forms of compensation described below will be subject to evaluation. In cases where base pay or pay practices appear to differ from established common practices, CMS may inquire as to the pay philosophy, comparable organizations, and pay resources used by the CO-OP board or its compensation committee as a basis for establishing such practices. CMS's expectation is that there will be a rational scaling of compensation to the size of the CO-OP, measured by premiums, covered lives, or other appropriate measures of service. CMS is prepared to engage a CO-OP board when there is a question about the suitability of compensation for the executives of that CO-OP.

## Appendix 1

This appendix describes in greater detail a process that CMS recommends a CO-OP's board of directors or compensation committee of the Board of Directors adopt to determine executive compensation. The information listed here represents CMS's expectation regarding how a CO-OP's board of directors should determine executive compensation.

### Mission Statement

The mission statement is the foundational document of the CO-OP. It states what services it aspires to provide, to what population of consumers or insureds, to what extent, and with what intended outcome for a given population. The structure of the CO-OP, its staffing, and its compensation philosophy and methodology are the means for accomplishing the mission statement. Since providing affordable health insurance to a proportion of a state or regional population is likely to be part of the mission statement, keeping the CO-OP's costs, including compensation, reasonable is pertinent to that mission. The mission is the yardstick by which CO-OP activity and spending is measured.

### Compensation Committee

Virtually all publicly traded companies and most large non-profits delegate responsibility for planning and managing executive compensation to a subset of its board members, a compensation committee. Therefore, a CO-OP's board of directors, at its discretion, may delegate its responsibility for planning and managing executive compensation to a compensation committee. Members of the compensation committee are chosen for their relevant expertise, perspective and judgment, and perceived ability to be independent and fair. They are assigned detailed work that would consume too much of the full board's time. However, their recommendations should be voted upon by the full board and final decisions should represent a consensus of all board members.

### Compensation Philosophy

One of the first responsibilities of a CO-OP's board of directors or compensation committee of the board is to formulate a compensation philosophy. A compensation philosophy sets forth which other organizations the organization regards as comparable, and whether it wants to match, pay somewhat more than, or somewhat less than the average pay of those organizations for comparable positions. The statement of compensation philosophy can also state that particular functions of the CO-OP are regarded as having critical importance to the organization at this stage in its lifecycle, and this may require paying marginally more to executives (and staff) who possess the skills to perform those functions.

## Comparable Organizations

Comparable organizations are those from which the CO-OP recruits talent and to which the CO-OP loses talent. Choosing the organizations the CO-OP regards as comparable will have a substantial effect on the compensation levels the organization will target and with which it will compete.

The main function of the CO-OP, providing health insurance, is found in both for-profit corporations and non-profit organizations, and the CO-OP's mission, providing a social good in a local community, is similar to that of other non-profit organizations. Thus, the comparable organizations chosen will probably be a composite of both corporations and non-profits.

Non-profits in the state or multi-state region that provide health insurance, health services, and social welfare benefits may be regarded as comparable for compensation purposes. For-profit corporations offering health insurance may be considered as comparable organizations as well, although substantial care should be taken in using their compensation data, which may be considerably higher, as their missions may differ from those of comparable non-profit organizations.

An important factor in using the compensation data of comparable organizations is their scale. It is an axiom of executive compensation that compensation levels follow scale. The CEO of a $1 billion corporation will be paid more, perhaps considerably more, than that of a $100 million organization. Comparable organizations may include those somewhat smaller than the CO-OP, those of comparable size, and those that are somewhat larger. Organizations that are 2 or 5 times the size of the CO-OP, measured by revenues, premiums, or insured lives, can be useful comparators, but only if their contribution to pay structures is scaled down by weighting as shown in the section on Pay Ranges.

## Compensation Resources

A CO-OP's board of directors or the compensation committee of the board will need considerable resources to accomplish its task. It will need operating measures of the CO-OP provided by management, an understanding of the organization's finances, and input from the executives as to their interests, concerns, and plans for the coming year. Although the chief executive officer (CEO) may express an interest in compensation for executives for whom there is difficulty recruiting or retaining, the CEO should not play a role in the committee's deliberations. A CO-OPs board of directors or compensation committee of the board will need compensation data of the organizations in the region or the state that are regarded as comparable, usually in the form of third-party compensation surveys. For compensation surveys to be regarded as reliable, they should be conducted by a disinterested third party, contain no self-reported data, and should present aggregated data in the form of averages or

percentile values. Surveys that report salary or bonus information of individual incumbents should not be used. Compensation data can be acquired from the tax returns (Form 990) of individual non-profit organizations, but these data should be aggregated and used in the form of averages and/or percentile figures.

In addition to the scale of the organizations for which pay data is being considered, their industry group and region of the country (or national data) are relevant considerations. These factors can also be assessed and given greater or lesser weight as shown in the Pay Range example below.

## Compensation Consultant

The ability to acquire the relevant data and organize it in a way that conforms to sound practice may exceed the abilities of the board members and the board's compensation committee. For this reason, most boards engage an expert consultant or team to assist them with this effort. Professional compensation consultants have access to multiple compensation surveys and can acquire specific information relevant to the comparable organizations the committee has identified. They perform technical, data-intensive work that produces a product that the committee can adopt and recommend to the full board for a vote.

It is important that compensation consultants clearly report to the board, and not to senior management. Board members, or compensation committee members, should provide compensation consultants with the board's compensation philosophy and assessment of whether the board intends to take a conservative, moderate, or aggressive approach to compensating the CO-OP's executives. Additionally, compensation consultants should tailor their findings and recommendations to that philosophy.

## Pay Ranges

A pay structure represents pay policy quantitatively, in the form of a table that includes the minimum base pay level for a job or job family, the maximum base pay level for a job or job family, and a mid-point or control point. The control point may or may not be an arithmetic mid-point between the minimum and maximum values. The control point represents (1) the base salary a fully competent, fully successful incumbent would be paid and (2) the median of salaries paid to comparable staff in organizations that the compensation committee identifies as competitors for talent or comparable in terms of mission, scope, industry, and size. The spread (i.e., distance from minimum to maximum) is typically 50 percent to 70 percent. A pay range for a CEO and Vice Presidents could look like this:

The key element in the pay range is the control point. It represents the salary the board would pay a fully competent executive; this is often at the 40$^{th}$, 50$^{th}$, or 60$^{th}$ percentile value in the

range of pay for similar positions in organizations to which the CO-OP compares itself. The control point is derived from data acquired from multiple compensation surveys and may include aggregated data acquired from form 990s from non-profits the CO-OP regards as comparable. Data from different sources that are given different weight can be combined in a manner such as the following**:**

***Table 1 CEO Compensation-Weighted Averages from Different Industries***

***(Table is for illustrative purposes only. CMS does not endorse the values in this table.)***

| Survey | Average Budget/Revenues | 25%tile | 50%tile | 40%tile (interpolated) |
|---|---|---|---|---|
| Non Profit Health Care | $150 M | $220,000 | $280,000 | $256,000 |
| Non-Profit Insurance | $200 M | $240,000 | $300,000 | $276,000 |
| For Profit Health Insurance | $3 B | $360,000 | $550,000 | $474,000 |
| Non-Profit Human Services | $60 M | $160,000 | $210,000 | $190,000 |

| | Average Budget/ Revenues | Weight | Weight % | Weighted 50%tile | Weighted 40%tile |
|---|---|---|---|---|---|
| Non Profit Health Care | $150 M | 6 | 50% | $140,000 | $128,000 |
| Non-Profit Insurance | $200 M | 2 | 17% | $50,000 | $46,000 |
| For Profit Health Insurance | $3 B | 2 | 17% | $91,667 | $79,000 |
| Non-Profit | $60 M | 2 | 17% | | |

| | | | | | |
|---|---|---|---|---|---|
| **Human Services** | | | | **$35,000** | **$31,667** |
| **Total** | | | | **$316,667** | **$284,467** |

In the above example, data from four different industry groups are used in effort to aggregate pay data to form the control point for the CEO position. The data from for-profit insurance companies reflect much larger companies, whose CEOs are paid considerably more. The example also reflects smaller non-profit human services organizations whose CEOs are paid considerably less. By assigning these disparate organizations the same weight, that is 2 out of 12, or 17 percent, it is possible to include the big corporation data without allowing it to skew the data from the smaller organizations. The non-profit health care organizations that are of a size similar to the CO-OP, are assigned the greatest weight, and contribute the most to the final figures.

Both the 50$^{th}$ percentile and 40$^{th}$ percentile (interpolated) figures are presented. The lower figure might be adopted by a CO-OP's board of directors or compensation committee of the board as a further measure to mitigate the effect of including the higher figure from the for-profit insurance companies, or could reflect a measured approach to compensation that reflects the compensation philosophy and is deemed more consistent with the CO-OP's mission.

## Variable Pay

Variable Pay is variously regarded as bonus, performance pay, or pay-at-risk, which can vary from year to year, and is generally paid as a lump sum after the results of the program year or fiscal year are known. Its payment is generally based entirely or mainly on the achievement of quantitative goals established at the beginning of the year by the compensation committee or the board at large. As the CO-OPs are new entities, the timeframe for the goal may be short, and oriented to getting the organization established. It may be pensionable or not. It is generally expressed as a target of a certain percent of base pay. In a non-profit, this target should be lower than the bonus targets for executives in for-profit organizations. In a CO-OP, the compensation philosophy may dictate that the bonus opportunities differ for different executive positions, with the CEO receiving a larger bonus target.

## Perquisites

Perquisites – additional benefits such as car allowance and expense account – should be kept to a minimum given the mission of the organization and the source of its original funding. When given, the mission of the organization should be a bigger consideration than the convenience of

the executive. Normally, the aggregate value of these should not exceed 10 percent of base salary for the CEO and 5 percent of base salary for the other executives.

## Other Forms of Compensation

Hiring bonuses, retention pay, deferred compensation, off-cycle increases, and other such measures are considered other forms of compensation. These compensation tools are available to CO-OP boards to address specific situations when they are trying to attract or retain key executive talent. Situations that may suggest using these additional tools could include a period of winding down an organization that is merging with another or going out of business. Routine or frequent use of these or other additional compensation tools are strongly discouraged, and their use must be documented and communicated to CMS.

## Performance Review Standards

A CO-OP's board of directors or the compensation committee of the board should establish standards and criteria it will use in evaluating executive performance and planning increases to base pay. Holding a meeting and agreeing that executives had "done a good job" is not a sufficient means of exercising a fiduciary duty to assure that executive compensation is not excessive. Exercising some discretion in executing the pay program is unavoidable, but that discretion should be limited by standards and metrics that are established in advance.

## Base Pay Increase and Variable Pay Budgets

Similar to a base pay increase budget, a budget for variable pay, which reflects the organization's ability to pay and the likelihood that strategic goals will be achieved, should be developed during the year. Criteria for goal attainment that represent minimum and maximum success should be developed and documented at the beginning of the year. Goals should be expressed entirely, or primarily, in quantitative form so that discretion in judging their level of achievement is minimized. The budget for variable pay for eligible executives should not exceed 15 percent of the base pay of the eligible executives in aggregate, even if the targets for different executive levels may differ (e.g., CEO, 20 percent of salary; vice presidents, 10 percent of salary).

## 5. Reserved for Governance Requirements

## 6. Reserved for Program Monitoring

## 7. Reserved for Loan Agreement Administration