Testimony on

Not-For-Profit CO-OPs

By

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(a CO-OP in existence since 1972)

Before
THE CONSUMER OPERATED AND ORIENTED PLAN (CO-OP) ADVISORY BOARD;
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I. History of a not-for-profit CO-OP

Good morning. My name is Cindy Palmer and I am the CEO of Colorado Choice Health Plans, a not-for-profit, community oriented organization that has been operating in rural Colorado for almost 38 years. It is a co-op that got its start with a Federal grant and loan in the early 1970s. When it paid off the loan in 1990 it was one of only 3 plans, started under that program, that was still in existence.

The Plan was started in the San Luis Valley region of Colorado. The San Luis Valley is a geographically isolated area, in south central Colorado, surrounded by mountains and comprised of six counties, all designated either rural or frontier. Three of the counties are in the 10 poorest counties in the State. The Plan was started by the community to provide services to this underserved rural area. It originally operated as both an insurer, with an HMO license, and as a CHC with clinics in the most isolated rural communities. It offered a sliding fee scale and programs for the uninsured, until these programs were taken over by a local clinic that received it's FQHC designation. At that time the Plan moved into the role of insurer only, and sold it's clinic facilities.

The Plan was self managed in these early years, but due to the need to implement new technologies and broader services it entered into a management contract with a company that had the resources to meet these needs. In the mid 1980s the Plan entered into a contract with a larger, non-competing insurer, to provide administrative services. This contract covered almost all operations. The Plan maintained it's own Executive Director and sales operations and was still overseen by it's Community Board.

In 1998 the Executive Director (with eight years tenure) and the Community Board terminated this management agreement and became totally self-managed once again. This decision was made because the Executive Director and the Board felt that the management company was not really focused on the needs of the Plan. Growth was necessary to continue to be a sustainable organization into the future. The Executive Director and the Board were not prepared for what it meant to become fully self-managed. Late in 1999, after suffering significant operating problems and financial losses, that lowered the Statutory Net Worth to $250,000 at a time when the statutory minimum was $1,000,000, the Plan came under Supervisory Order from the Division of Insurance.

I started working with the Plan, in early 2000, as a consultant. Working very closely with the Supervisor that had been appointed by the Insurance Commissioner, we did an assessment of what it would take for the Plan to achieve a turn-around. It very quickly became apparent that after less than eighteen months of self-management, almost every aspect of the Plan needed change. The system they had chosen was not meeting their needs, the product portfolio was limited, product pricing was not sound, what provider contracts were left over from the management company were old, many key providers had cancelled their

contracts, accounts receivable had not been reconciled for some time and there were significant write-offs that were needed, operational standards were not in place and administrative costs were out of control. The project took on the feel of a new start-up but was actually much more critical because there was already a book of business that had to be managed and there was not the luxury of putting things in place before the need to provide services started.

II. Where to start when everything needs done

I believe two of the most important keys to success are the IT systems selected and the contracted provider network. The first thing I did was a vendor search for a system that was affordable for a small Plan and that would offer the flexibility to be able to compete in a marketplace that included some of the largest carriers in the industry. The system we selected is user friendly and has allowed us to be creative with benefit designs and with managing our provider network. It has been a major key to our success, both operationally and competitively.

Technology is continuing to grow at an astounding rate and industry requirements continue to grow (HIPAA 5010, ICD10, Core Certification, etc.). This is the Achilles heel for small companies and must be addressed by any new company.

I believe one of the hardest challenges a start-up will face is getting a provider network in place. During my tenure with the Plan we have had to re-contract our whole network as well as significantly expand our network to be competitive. This is not an easy task as you have nothing to offer the provider. You want rates that are competitive with the big insurers but you have no volume of business to offer a provider. You have no clout and nothing to leverage but your mission. This I understand because I have sat in the offices of Vice Presidents, CFOs and CEOs of some of the biggest hospital systems and physician groups in the State of Colorado and tried (not always successfully) to convince them that it made sense to contract with a small company. You have to believe in your mission and get them to believe that the right thing for them to do is to support your mission. You also need to know what rates you need to be competitive in your marketplace.

Compliance is the next big issue. Compliance can be very burdensome for a small company and it has done nothing but become more complex every year. State and Federal statutes and regulations, PPACA compliance and NCQA accreditation can be overwhelming, both financially and operationally. Accreditation is required to be in the exchanges. Some consideration needs to be given to allowing some phase in time for start-up organizations. How to balance this is going to be a challenge, but I believe there should be some discussion around this.

Focusing on building a strong infrastructure is necessary to enable you to have a foundation to support growth, without compromising your ability to service your customers as you grow.

If you can start with knowledgeable management, a good system, a strong provider network and a strong compliance structure then the main thing left is hiring strong staff and making sure they understand and are committed to your mission.

Reasonable growth within a reasonable time is important. You have to get to some scale in order to support your infrastructure requirements. We have expanded our Plan, over the last few years, from being licensed in the six counties of the San Luis Valley to it's current licensed service area of 23 counties in rural Colorado. We still struggle with growth due to the high cost of health care premiums and the ability to compete with the large insurers. We have a smaller network and under an HMO license we are limited on the amount of out-of-network benefits we can offer. What we do offer are personalized customer service, quick response to customer issues, fast claims turn-around (97% paid in 14 days sustained for the last 7 years) and a commitment to the communities we serve. In my 10 years with the Plan we have had only 7 consumer complaints filed with our regulator and all were found in our favor. We are viewed as both provider friendly and consumer friendly. This is a must for any small plan and critical for a start-up.

III. Lessons to be learned for new Start-Up CO-OPs

I believe the position that the Plan found itself in, after less than 18 months under self-management, shows how quickly an organization that had existed for over 25 years could go out of business due to poor management and poor decision making. The key to a new start-up not only surviving, but even getting up and running efficiently is having people involved in the process that have a true understanding of what needs to be done and how things have to come together. Nothing replaces the value of people who have sound hands-on experience and strong decision making abilities.

I believe the key components are a strong IT system, a competitive provider network, a complete understanding of the compliance requirements and sound, documented infrastructure.

When I came to this Plan, as a consultant, I had several years experience in health-care operations. I had over ten years experience in finance before I moved into the health care industry. During my tenure in health care I worked for larger managed care companies and also worked on the provider side of the industry. I had hands on experience in the areas of finance, strategic planning, health care accounting, product development, actuarial functions, compliance, systems, contracting, medical management, claims

administration and billing and enrollment and it still was a challenge getting all of these areas under control and operating smoothly, in the Plan.

It is hard to say what pieces are the most critical for a start-up to focus on first because all of the pieces have to work for it to get past the start-up stage and to continue as a long-term viable operation. During my years as a consultant I spent a lot of time, on behalf of venture capitalists, working with start-up companies and turn-around companies. During this period a very wise man said to me “there is a lot of money to be spent on starting new companies, what there isn’t, are the people who can make it happen”. I believe that is the biggest challenge to be addressed.

Thank you for your time, for allowing me to testify and for your efforts to make sure that the Plans that are set up under this program will continue to be able to serve the communities that are so much in need of viable alternatives.

If I can be of any service to the Committee please feel free to contact me.