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State Government Relations, Health & Long-term Care
(revised)

Before Commissioner Gennet Purcell of the Department of Insurance, Securities, and Banking (DISB), District of Columbia

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Commissioner Purcell, distinguished panel members, good afternoon. My name is JoAnn Lamphere, and I serve as Director of AARP's State Government Relations Health and Long-term Care team. I am honored to testify on behalf of AARP's 91,000 members in the District of Columbia, who are concerned about excess reserve funds held by CareFirst's DC Affiliate, Group Hospitalization and Medical Services, Inc. (GHMSI) and its inadequate community health reinvestment, particularly for at-risk populations. AARP appreciates your leadership and the opportunity to participate in this hearing.

AARP believes that it is important for the District of Columbia and the Department of Insurance, Securities, and Banking (DISB) to ensure that CareFirst/GHMSI is fulfilling its public mission – to provide quality, affordable, and accessible products and services to its customers and the community. We believe such reasonable standards can be accomplished by CareFirst/GHMSI in a viable and invigorated way.

From information publicly available, it appears the amount of reserves that CareFirst/GHMSI holds in its possession is unreasonably large. Some stakeholders estimate that an excess surplus of approximately $687 million is currently being held by this not-for-profit organization. If you determine that this surplus is considered excessive, we recommend a portion of these excess funds be used to (1) invest in proven health initiatives to improve the overall health of the District's population; (2) provide affordable coverage choices for the District's "uninsurable" adults; and (3) constrain rising health premiums for current policyholders who are struggling under rate increases. Resources are needed more than ever to assist struggling residents in the District, especially during this economic downturn.

AARP has advocated for many years on both the state and national levels to expand the availability of affordable health coverage and increase access to quality health care. Being able to secure affordable coverage and care is an ever growing worry for many adults in the District and across the United States. Each day in the District of Columbia, approximately 40 residents

lose their health insurance. An estimated 13 percent of adult residents of the District are uninsured[1]. The very high cost of insurance is one of the reasons the District has so many residents who forgo necessary health coverage and care. Public health coverage and health care reinvestment initiatives, as well as assurances of reasonable premium levels, would significantly help DC residents.

It is striking the effort CareFirst is making to defend both its level of reserves and community investments. The objectives of "benefit for subscribers" and "community reinvestment" need not be considered in opposition to one another. CareFirst seems hampered by a 20th century perspective that cannot envision how to meet 21st century community health needs. Meeting its community benefit obligations is a deeper engagement than "charitable contributions" and "giving to worthy causes." Many health insurance companies across the USA have learned how to: commit passionately to filling in the cracks and service needs of a broken health care system; invest in health prevention and education, especially for at-risk populations; design decision supports for providers to help them deliver better evidence-based care; and actually adopt communities and work in partnership with them to achieve improved health. In addition to serving a community need, these innovations can often benefit investing companies' bottom lines. Most of us here value the innovation that the private sector can deliver. It is proper that private sector innovation and creativity is harnessed by government for the social good. While this hearing is focused on financial accounting details, we should not lose sight of the overall community objectives that the Medical Insurance Empowerment Act sought to achieve.

We believe that CareFirst should be required to devote more resources (both financial and organizational) to the health and coverage needs of the Washington area community to the maximum extent feasible. There is a substantial amount of unmet need for health care in the District of Columbia. According to the CDC, nearly 40% of District seniors did not receive a flu vaccine[2]. Serious multiple chronic conditions, such as AIDS/HIV, heart disease and diabetes, are crippling the well-being of older DC residents. Through a greater investment into evidence-based community health programs by CareFirst/GHMSI, improved assurances of health care and coverage can be provided to members of our local community.

In summary, should the Commissioner deem CareFirst's surplus to be excessive, we believe that a portion of these excess funds be used to support community health programs in order to improve the overall health of DC's residents. AARP strongly supports community health reinvestment initiatives, particularly for at-risk populations -- such as those with chronic health conditions. The unmet health needs of the District of Columbia are great. With its significant resources, CareFirst/GHMSI should be expected to invigorate its commitment to improving the health of people in the District of Columbia.

On behalf of AARP's 91,000 members in the District of Columbia, I thank you once again for the opportunity to address you today. We look forward to working with you on this issue in the months and years ahead.

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[1] Kaiser Family Foundation State Health Facts, 2007.

[2] Behavioral Risk Factor Surveillance System Survey Data. US Department of Health and Human Services, Centers for Disease Control and Prevention, 2007.