

**Council of the District of Columbia
Committee on Public Services and Consumer Affairs**

NOV 20 AM 10:21
OFFICE OF THE
SECRETARY

Report

1350 Pennsylvania Avenue, N.W., Washington, DC 20004

To: Members of the Council of the District of Columbia

From: Mary M. Cheh, Chairperson *MC*
Committee on Public Services and Consumer Affairs

Date: October 17, 2008

Subject: Bill 17-934, the "Medical Insurance Empowerment Amendment Act of 2008"

The Committee on Public Services and Consumer Affairs, to which B17-934, the "Medical Insurance Empowerment Amendment Act of 2008," reports favorably on the legislation and recommends its adoption by the Council of the District of Columbia.

CONTENTS

Statement of Purpose and Effect _____ Page 2

Legislative History _____ Page 2

Background/Committee Reasoning _____ Page 3

Section-by-Section Analysis _____ Page 14

Summary of Public Hearing _____ Page 15

Fiscal Impact _____ Page 22

Analysis of Impact on Existing Law _____ Page 22

Committee Action _____ Page 23

List of Attachments _____ Page 23

STATEMENT OF PURPOSE AND EFFECT

The purpose of B17-934, the "Medical Insurance Empowerment Amendment Act of 2008," is to provide a framework to ensure that non-profit hospital and medical services corporations pursue their public health mission. B17-934 would require the Mayor to determine the percentage of annual premium revenues that non-profit hospital and medical services corporations must spend on community health reinvestment, to establish a sufficient surplus operating range for non-profit hospital and medical services corporations, and to require non-profit hospital and medical services corporations to justify the accumulation of surplus in excess of the upper limit of that range, or divest themselves of the excess surplus through community health investment. The bill would also require non-profit hospital and medical services corporations to continue to offer the open enrollment program to each subscriber as long as the subscriber renews his or her coverage under the program; to set affordability and adequacy standards for the open enrollment program; and to require non-profit hospital and medical services corporations to advertise the availability of the open enrollment program. The legislation would prohibit non-profit hospital and medical services corporations from converting to for-profit status.

LEGISLATIVE HISTORY

- September 16, 2008 Introduction of B17-934 by Councilmembers Cheh, Alexander, Barry, Bowser, Brown, Catania, Graham, Mendelson, Thomas, and Wells, and Chairman Gray
- September 19, 2008 Referral of B17-934 to the Committee on Public Services and Consumer Affairs
- September 26, 2008 Notice of Intent to Act on B17-934 is published in the *District of Columbia Register*
- September 26, 2008 Notice of Public Hearing on B17-934 is published in the *District of Columbia Register*
- October 10, 2008 Public Hearing on B17-934 held by the Committee on Public Services and Consumer Affairs
- October 17, 2008 Consideration and vote on B17-934 by the Committee on Public Services and Consumer Affairs

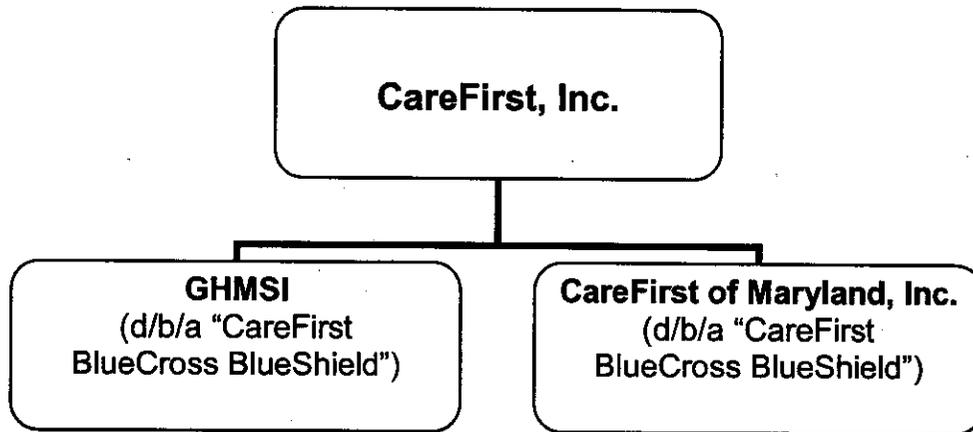
BACKGROUND/COMMITTEE REASONING

A. Background

The central problem addressed by Bill 17-934 is the lack of a framework to ensure that the District's only non-profit hospital and medical services corporation meets its obligations to community health reinvestment.

1. CareFirst's Role in Public Health

Group Hospitalization and Medical Services, Inc. ("GHMSI"), a non-profit entity domiciled in the District of Columbia, is the only non-profit hospital and medical services corporation¹ in the District. Its sole member and parent company is CareFirst, Inc., and it is affiliated with CareFirst of Maryland, Inc. ("CFMI"). Both GHMSI and CareFirst of Maryland, Inc. do business as "CareFirst BlueCross Blue Shield."² The relationship is set forth in the following organizational chart³:



GHMSI participates in the insurance markets of the District of Columbia, northern Virginia, and Maryland. CFMI markets products in all of Maryland.

¹ The Hospital and Medical Services Corporation Regulatory Act of 1996 is codified as Chapter 35, "Hospital and Medical Services Corporations Regulation," of Title 31 of the District of Columbia Official Code and defines a "corporation," for purposes of the statute, as "a nonstock, nonprofit corporation which is subject to regulation and licensing under this chapter and which offers subscriber contracts as part of a hospital service plan, a medical service plan, or both." D.C. Official Code § 31-3501.

² This report uses the term "CareFirst" in a broad sense to refer to GHMSI, CFMI, and CareFirst, Inc., collectively. When necessary, the report uses the terms "GHMSI," "CFMI," and "CareFirst, Inc." to refer to the respective entities.

³ This chart excludes a substantial number of CareFirst companies, including CareFirst BlueChoice, a for-profit health maintenance organization ("HMO") and subsidiary of CFMI.

GHMSI's predecessor, Group Hospitalization, Inc., was chartered as a "charitable and benevolent institution" by act of Congress on August 11, 1939.⁴ The charter was amended in 1984 to reflect the merger of Group Hospitalization with Medical Services, Inc., creating the entity known as GHMSI.⁵

Congress amended the charter again in 1993, this time to make GHMSI subject to District regulation.⁶ In 1997, Congress again acted to amend the charter to allow GHMSI to have a non-profit corporate member⁷ – CareFirst Inc., which was established as the holding company for both GHMSI and CFMI.⁸ This amendment cleared the way for GHMSI to pursue licensing by the Blue Cross Blue Shield Association ("BCBSA"). GHMSI and CFMI began doing business as "CareFirst BlueCross BlueShield" in 1998.

CareFirst BlueCross BlueShield performed very well in its first year of operation, 1998. GHMSI and CFMI totaled \$3.9 billion in revenues, 2.5 million subscribers, \$75.7 million in net income, and reserves of \$472 million.

In 2002, CareFirst and WellPoint Health Networks, Inc. ("WellPoint") applied for a merger. The corporate transaction, which would require the approval of both the Maryland Insurance Administration ("MIA") and the District's Department of Insurance and Securities Regulation (now known as the Department of Insurance, Securities, and Banking or "DISB"), would result in the acquisition of CareFirst by WellPoint and the conversion of CareFirst to for-profit status.

Following a lengthy process in which over 100 hours of testimony were taken and 85,000 pages of documents were reviewed,⁹ Maryland Insurance Commissioner Steven B. Larsen concluded in 2003 that it was "clear that this proposed transaction is not in the public interest."¹⁰ Commissioner Larsen noted that the CareFirst board of directors' "decision to allow [the transfer of \$68 million to corporate officers as part of the original proposed transaction], and its subsequent defense of that transfer, is inexcusable."¹¹ In rejecting the merger application, he also cited "the Board's failure to recognize and abide by the corporate mission of the organization . . . and its failure to consider how a conversion might impact its ability to further that corporate mission."¹² It is evident that

⁴ See Pub. L. No. 395, 53 Stat. 1412 (1939).

⁵ See Pub. L. No. 98-493, 98 Stat. 2272 (1984).

⁶ See Pub. L. No. 103-127, § 138, 107 Stat. 1336, 1349 (1993).

⁷ A "member" of a non-profit institution is roughly equivalent to a "shareholder" of a for-profit corporation. See, e.g., D.C. Official Code § 29-301.02 (defining "member" as "one having membership rights in a" non-profit corporation).

⁸ See Pub. L. No. 105-149, 111 Stat. 2684 (1997).

⁹ MARYLAND INSURANCE ADMINISTRATION, REPORT OF THE MARYLAND INSURANCE ADMINISTRATION, STEVEN B. LARSEN, COMMISSIONER, REGARDING THE PROPOSED CONVERSION OF CAREFIRST, INC. TO FOR-PROFIT STATUS AND ACQUISITION BY WELLPOINT HEALTH NETWORKS, INC. 2 (2003).

¹⁰ *Id.* at 198.

¹¹ *Id.* at 175.

¹² *Id.* at 200.

Commissioner Larsen had serious reservations about CareFirst's credibility.¹³ The Commissioner emphasized that, despite CareFirst's non-profit mission, "the weight of the evidence supports the conclusion that the enrichment of the executive team was, if not the primary motivation, an important motivation . . . in selecting the prevailing bidder."¹⁴ In essence, the Commissioner concluded that the board had effectively lost sight of its mission.

Since the MIA's rejection of the proposed for-profit conversion and executive windfall, CareFirst has continued to grow in size and financial security. This growth is reflected in the steady annual increases in GHMSI's surplus (that is, the value of its assets minus its liabilities). The following table shows GHMSI's surplus levels over the last five years:¹⁵

<i>Year</i>	<i>GHMSI Surplus</i>
2003	\$392 million
2004	\$501 million
2005	\$561 million
2006	\$663 million
2007	\$754 million

As of 2nd quarter 2008, GHMSI's surplus had reached \$761 million.

Another method of calculating the financial health of an insurance company involves a risk-based capital ("RBC") ratio. The ratio is computed by comparing the insurer's total adjusted RBC (also known as "TAC," equivalent to the surplus¹⁶) to authorized control level RBC ("ACL").¹⁷ A low ratio of TAC to ACL represents a high risk of insolvency. When a company's TAC falls to 200% of ACL, the National Association of Insurance Commissioners ("NAIC") recommends that the state insurance regulator place the insurer under regulatory control. The District's insurance laws codify the NAIC recommendations in this regard.¹⁸

¹³*Id.* ("In some cases, CareFirst has in fact misrepresented the nature of the offers from the two bidders. This also calls into question the veracity of other information provided to the MIA in connection with these applications.")

¹⁴*Id.*

¹⁵ Figures in the table are available in GHMSI's annual financial statements submitted to DISB. Dollar values are rounded to the nearest million.

¹⁶ *SEE DC APPLESEED CENTER, CAREFIRST: MEETING ITS CHARITABLE OBLIGATION TO CITIZENS OF THE NATIONAL CAPITAL AREA III-44 (2004)*. The Appleseed report explains that "[f]or health companies, TAC is usually equal to reported surplus plus other types of capital held. This typically includes capital stock if the insurer is a stock company, as well as surplus notes." GHMSI is not a stock company and has no capital stock or surplus notes.

¹⁷ Authorized control level is a benchmark determined in accordance with instructions developed by the National Association of Insurance Commissioners.

¹⁸ *See D.C. Official Code §31-2001.*

In addition to meeting statutory the minimum, GHMSI must meet the contractual minimum established by BCBSA as a condition of licensure. The BCBSA requires its licensees to carry a minimum RBC ratio of 375%. According to the Maryland Healthcare Commission, “[m]ost insurance carriers in the United States hold surpluses in the range of 250 to 400 percent [of ACL] even at the low point in the underwriting cycle.”¹⁹

By any measure, GHMSI’s RBC ratio is high. The following table illustrates GHMSI’s RBC ratio over the last five years:

<i>Year</i>	GHMSI RBC Ratio
2003	787%
2004	951%
2005	893%
2006	955%
2007	916%

GHMSI’s 2007 ratio of 916% is more than 4½ times the statutory regulatory standard and almost 2½ times the BCBSA requirement. GHMSI’s RBC ratio outpaces those of its affiliates, CFMI (808%) and CareFirst BlueChoice (824%), as well as its regional competitors, Optimum Choice (691%), Kaiser Foundation MidAtlantic (594%), Aetna Health Maryland (545%) and United Healthcare MidAtlantic (430%), and has done so for at least the last five years.

Despite the sustained health of its finances, GHMSI’s contributions to community health have not kept pace. While the company gives to a number of deserving community health programs, some of which are described in the “Summary of Public Hearing” *infra*, its community health investments have tapered off.

In 2005, former DISB Commissioner Lawrence Mirel wrote that, “[b]ased upon its financial health, including its significant surplus and net income level, and the breadth of its operations in the District, we believe that GHMSI should be engaging in charitable activity significantly beyond its current activities.”²⁰ He added that, “although GHMSI may meet its legal obligation to engage in charitable activity solely through the provision of health insurance in its service area, GHMSI has *an additional responsibility* – separate

¹⁹ MARYLAND HEALTH CARE COMMISSION, HEALTH INSURANCE PREMIUMS, THE UNDERWRITING CYCLE, AND CARRIER SURPLUSES 2 (March 2005). The “underwriting cycle” is simply “a repeating pattern of gains and losses within the insurance industry. As the cycle plays out, expected trends and the associated premium increases tend to go above or below the actual rate of change in underlying health care costs.” MILLIMAN USA, HEALTH INSURANCE UNDERWRITING CYCLE EFFECT OF HEALTH PLAN PREMIUMS AND PROFITABILITY 1 (April 10, 2003).

²⁰ DISTRICT OF COLUMBIA DEPARTMENT OF INSURANCE, SECURITIES, AND BANKING, IN THE MATTER OF: INQUIRY INTO THE CHARITABLE OBLIGATIONS OF GHMSI/CAREFIRST IN THE DISTRICT OF COLUMBIA 19 (2005).

and apart from the bare legal obligation set forth in its charter – *to engage in charitable activities in the District . . . which advance the public health.*²¹

The conclusions of Commissioner Mirel dovetail with those of former Attorney General Robert Spagnoletti, who wrote in 2005 that

[a]s a “charitable and benevolent institution” that seeks to serve a public health mission, GHMSI has an obligation to use its profits and excess surplus to serve the purpose of promoting health in its service area. GHMSI’s board may choose to fulfill this obligation in various ways, such as devoting surplus resources to (1) improving the quality, benefits, affordability, or accessibility of its non-profit health plans, (2) providing health plan benefits or other services to the poor at no charge, and/or (3) funding health-related activities that are conducted by other charitable organizations.²²

Attorney General Spagnoletti followed that statement with another several months later:

OAG’s conclusion is that GHMSI has a legal obligation to devote its entire operation to serving, directly or indirectly, the charitable, public health purposes for which it was chartered. . . .

Until GHMSI acknowledges its obligation as a “charitable and benevolent institution” to operate for the benefit of the public, one cannot presume that its corporate decisions are based on a board determination as to how best to fulfill the corporation’s charitable purposes. . . .

[T]he accumulation and maintenance of a surplus is essential if a charitable health insurer is to have the financial solvency necessary to fulfill its public health mission over the long term. But the insurer would be acting contrary to its charitable obligation if it made the accumulation of “surplus” an end in itself, or sought to accumulate surplus for a purpose that was not reasonably related to the company’s public health mission. The stronger its current financial position and more secure its future prospects given its current surplus level, the less likely it is that the company has a *bona fide* need, consistent with its public health mission, to accumulate additional surplus.²³

²¹ *Id.* at 22. (Emphasis added.)

²² Memorandum from Robert J. Spagnoletti, Attorney General, to Robert Bobb, City Administrator 8 (March 4, 2005).

²³ Memorandum from Robert J. Spagnoletti, Attorney General, to Robert Bobb, City Administrator 1-2 (August 4, 2005).

The positive reaction of GHMSI to the opinions of Commissioner Mirel and Attorney General Spagnoletti was short-lived. The company gave \$51 million to charitable activities in 2006 but just \$15 million in 2007, while increasing its surplus by over \$200 million. CareFirst has stated that it intends to give \$40 million in charitable donations in 2008, but this figure is potentially misleading, as it includes giving by both GHMSI and CFMI, which has its own surplus of \$514 million. It is unclear how much GHMSI plans to contribute to community health programs in its service area.

2. Community Health in the District of Columbia

The RAND Corporation's 2008 study of health and healthcare in the District²⁴ reveals a number of major issues facing District residents:

- More than 25% of adults have hypertension.
- More than half of adult residents are overweight or obese.
- Despite an overall high level of health insurance coverage, 20% of District residents reported no usual *source* of care.
- Rates of emergency department visits for conditions that could have been handled in a primary-care setting are rising.²⁶

The RAND report also highlights a variety of troubling statistics specifically regarding children's health:

- 36% of children between the ages of 6-12 are overweight.
- 9% of District children were reported to have a dental health problem.
- 12% have asthma.

The study also presents data pointing to geographical discrepancies in health and healthcare:

- Wards 7 and 8 have higher rates of chronic disease, poor health status, and premature mortality than the rest of the District.
- Ward 5's rates of hypertension and overweight/obesity exceed the District average.
- Breast and prostate cancer rates are highest in Wards 4 and 8.
- The cervical cancer rate is highest in Ward 7.
- Ward 6 has the highest rate of colon cancer.
- Nearly 1 in 5 children in Ward 7 have asthma.

The report noted that the "availability of providers for vulnerable populations was difficult to measure," but cited residents' assessment that they have "limited options for

²⁴ Nicole Lurie et al., *Assessing Health and Health Care in the District of Columbia: Phase 2 Report* iv (RAND, Working Paper No. WR-579, 2008).

²⁶ *Id.* at 3-4.

places to go where they could receive high-quality care.”²⁷ In fact, “[c]urrent ambulatory care capacity is a key factor underlying the problems District residents have accessing care; however, problems with ambulatory care are diverse and extend well beyond just the capacity of the system.”²⁸

Even the RAND report, which identifies this wide variety of problems, does not fully capture the healthcare issues confronting the District, which faces, among other ills, the worst HIV/AIDS rate in the nation. It is clear, that District residents are fighting an uphill battle in elevating the quality and expectancy of their lives. This struggle is not simply rooted in the number of uninsured residents (approximately 11% of the population), but also in lack of access to adequate primary care, specialist services, preventative care, and health and wellness education.

B. Barriers

There is a deep uncertainty surrounding CareFirst’s degree of dedication to its charitable public health mission. The best way to dispel that uncertainty is to enact legislation establishing a framework to ensure that CareFirst meets its public health obligation to the community.

While some parties have suggested that the board of directors is now committed to keeping GHMSI on track toward its public health mission,²⁹ the board has lost sight of its mission before. Commissioner Larsen’s rejection of the proposed merger with WellPoint in 2003 made that adequately clear, but recent events – particularly the issue of former chief executive officer (“CEO”) William Jews’s severance compensation – have generated heightened skepticism.

William Jews was tapped as the new president and CEO of CareFirst in 1993. By all accounts, he contributed significantly to the improvement of the company’s performance, which had suffered in prior years.³⁰ His tenure was not, however, exemplary, and his departure led to stern criticism of CareFirst’s lack of focus on its non-profit mission by its Maryland regulator.

MIA Commissioner Tyler found that Mr. Jews’s “record of executive leadership was a decidedly mixed one” and that Mr. Jews cannot “avoid responsibility for the enormous troubles and public wrath visited upon the company” during his tenure (particularly in regard to the failed conversion attempt).³¹ The Commissioner also found that it was an “established fact that under [Mr. Jews’s] leadership the company strayed significantly from its . . . nonprofit, public purpose mission.”³²

²⁷ *Id.* at 6-7.

²⁸ *Id.* at 13.

²⁹ *See., e.g.,* testimony of Barbara Lang at the October 10, 2008 hearing on Bill 17-934, *infra* p. 17.

³⁰ *See Ins. Comm’r for Md. v. CareFirst, Inc.*, Statement of Reasons in Support of Final Order 16, MIA-2007-10-027 (July 14, 2008) [hereinafter MIA Statement of Reasons].

³¹ *Id.* at 16-17.

³² *Id.* at 18.

The reason for the MIA's review of Mr. Jews's record was CareFirst's proposal to pay him nearly \$18 million following his termination in 2006. Commissioner Tyler held that the proposed payment was not "fair and reasonable" and that portions of it would not be "for work actually performed" by the former CEO.³³ The Commissioner ruled that the golden parachute payment was unlawful and ordered that it be scaled down to approximately \$9 million.³⁴

Commissioner Tyler was less than pleased with the board of directors' failure to evaluate Mr. Jews' prior performance in setting his compensation. He wrote that

the board had little understanding of its role or obligations, starting with its obligations to the [Maryland] General Assembly. Rather than evaluating the CEO, this board of a specially chartered nonprofit health insurer spent time . . . complaining about the "quality" of the Maryland legislature. Those complainants are notable both for their arrogance and their irrelevance because, to state the obvious, the General Assembly directs the CareFirst board, not *vice versa*.³⁵

Once again, the board had effectively lost sight of its mission.

CareFirst has also been unable to meet its own expectations for community reinvestment. The Open Enrollment program is a prime example. As part of its response to Commissioner Mirel's 2005 ruling (and at his request), CareFirst filed a report on its charitable donations with DISB. In that report, CareFirst discussed its participation in the Open Enrollment program and its expectations for the program in the following years.

District law requires that non-profit hospital and medical services corporations offer an Open Enrollment program as a way of enhancing the options for health insurance for those who must purchase insurance on the individual market.³⁶ While many residents receive insurance through their employers or through public programs such as Medicaid or the DC Alliance, the remainder must purchase their coverage individually. Health insurance purchased on this individual market is individually underwritten and tends to be expensive; in some cases, applicants are simply denied coverage because of their medical histories. The statutorily-mandated Open Enrollment program is intended to stabilize – and lower – those high costs and make insurance available to all. The Open Enrollment plan must "provide for the issuance of . . . subscriber contracts without imposition by the corporation of underwriting criteria whereby coverage is denied . . . because of an individual's age, health history, medical history, employment status, or, if employed, industry or job classification."³⁷ In order to reduce the rates charged to enrollees, CareFirst is required to pay into a rate stabilization fund operated by the

³³ *Ins. Comm'r for Md. v. CareFirst, Inc.*, Final Order 1-2, MIA-2007-10-027 (July 14, 2008).

³⁴ *Id.* at 2.

³⁵ MIA Statement of Reasons, *supra* note 30, at 25.

³⁶ D.C. Official Code § 31-3514.

³⁷ D.C. Official Code § 31-3514(c).

company. The corporation is allowed a tax deduction (capped at \$550,000) for the money it places in the fund.³⁸

In its 2005 report, CareFirst wrote to Commissioner Mirel that

[e]nrollment in the program has increased from 255 members in December of 2004 to 319 members as of June 2005 – a 25 percent increase. Although similar open enrollment products offered in other states have typically met with limited success, our goal is to increase OE enrollment to 1,155 by the end of 2005 and to 4,755 by the end of 2009 – which would represent roughly 6 percent of the District’s uninsured market.³⁹

The company met *none* of those goals. At the end of 2007, there were roughly 1,100 enrollees in the program, and the national healthcare advocacy organization Families USA was complaining to GHMSI about the “barriers consumers face in accessing information on CareFirst’s open enrollment insurance option.”⁴⁰

The Committee concludes that CareFirst’s history of straying from its public health mission, combined with unmet expectations and a lack of a clear framework for accountability to its mission, call for a legislative response.

C. Legislative Action: Description

Bill 17-934 would amend the Hospital and Medical Services Corporation Regulatory Act of 1996 in three key ways.

The first is a requirement that GHMSI engage in community health reinvestment. “Community health reinvestment” is defined in the bill as health coverage for low-income, uninsured, or underinsured persons; operating subsidies for public health provider programs; and other community healthcare-related expenditures reasonably approved by the Mayor.⁴¹ Under the legislation, the Mayor would conduct a thorough review before issuing an annual order to the corporation to expend a specified percentage of its gross premium revenues on community health reinvestment. The annual review would allow the Mayor to establish an appropriate figure that is consistent with financial soundness and efficiency.

The Mayor would also make an annual determination of the appropriate surplus range for GHMSI. Again, this range would be determined after a thorough review and set to be consistent with financial soundness and efficiency.

³⁸ D.C. Official Code § 31-3514(j)(1).

³⁹ Letter from CareFirst BlueCross BlueShield to Lawrence H. Mirel, Commissioner, DISB 11 (Sept. 1, 2005).

⁴⁰ Letter from David Tian and Cheryl Fish-Parcham, Families USA, to Chester Burrell and Natalie O. Ludaway, CareFirst BlueCross BlueShield (June 25, 2008).

⁴¹ It is expected that the Mayor will delegate his responsibilities under the legislation to DISB, the agency that regulates insurance companies in the District.

If the corporation fails to meet the specified percentage of revenues, or if its surplus exceeds the maximum established by the Mayor, it has the opportunity to demonstrate, by clear and convincing evidence, that the failure was appropriate under the circumstances. If the corporation does not make that showing, it may not increase its premium rates for 12 months, and it must implement a plan to divest the appropriate amount and allocate it toward community health reinvestment. The Mayor is given the authority to issue appropriate orders for the enforcement of the act.

Part two of the legislation deals with the Open Enrollment program. Under current law, CareFirst is permitted to terminate the program as of December 31, 2010.⁴² Bill 17-934 would require CareFirst to maintain the program indefinitely. The program must be offered to each subscriber as long as she renews her coverage under the program.

The bill also sets the following affordability and adequacy criteria for the program:

- Annual premiums shall not exceed 125% of the standard individual market rates.
- Deductibles and co-pays shall not exceed the standard commercial policy available to employers in the District.
- No lifetime or annual caps on benefits.
- No exclusions or riders applied to applicants with pre-existing medical conditions.

The third key change made by Bill 17-934 is a ban on conversion to a for-profit entity or mutual insurance company. GHMSI has maintained that it has no interest in converting to for-profit status. When directly asked at the October 10, 2008 hearing, CEO Chet Burrell reiterated this stance. Other states, such as New Jersey, Arizona, and New Mexico, prohibit their non-profit hospital and medical services corporations from converting.⁴³ This provision provides assurance that GHMSI will remain focused on its public health mission and forecloses the possibility of another conversion fiasco.

D. Legislative Action: Analysis

Bill 17-934 establishes a framework for GHMSI to meet its public health mission. The legislation prescribes standards for the executive branch to follow in determining whether GHMSI is accumulating too high a surplus or spending too little on community health benefits.

⁴² D.C. Official Code § 31-3514(k)(3).

⁴³ See N.J. Stat. Ann. § 17:48A-2.; N.M. Stat. Ann. § 59A-47-4; Ariz. Rev. Stat. Ann. §§ 10-1003(1-2), 10-2302(1-2). Following the failure of CareFirst's conversion attempt in 2003, Maryland enacted a 5-year ban on conversion, which has since expired. See Md. House Bill 1179 § 7 (2003).

The Committee emphasizes that these standards are flexible.⁴⁴ Rather than designate a specific percentage of premium revenues that must go to community health reinvestment or a specific cap on surplus, the legislation would require the Mayor to revisit the figures every year. The Mayor must also take into account the need to keep the company financially sound and efficient. The intent of the legislation is that the company maintain reserves adequate to pay its subscribers' claims, fund capital improvements, meet contingencies, and remain a healthy participant in the market. This flexibility will allow the operation of the framework to adjust to the underwriting cycle and any incidents which may have an impact on GHMSI's financial viability in the future. It is in the public interest for GHMSI to continue in its role as a robust non-profit health insurer, and nothing in this bill compromises that objective. It is *excess* funds that will go to community health reinvestments.

Because GHMSI plays that important role in its *entire* service area, the committee print for Bill 17-934 includes a new provision requiring the Mayor to give due consideration to the interests of the other jurisdictions within the service area. The bill also consistently refers to community health reinvestments for the entire service area. GHMSI's current giving is not restricted to the District; nor should it be. The Committee expects that GHMSI will continue to engage in charitable activity in the District, northern Virginia, and Maryland. Community health reinvestments *anywhere* in GHMSI's service area would be credited against its obligation.

Finally, the bill also removes the permissive sunset for open enrollment. By setting affordability and adequacy standards for the program, Bill 17-934 ensures that the product will be a meaningful piece of the healthcare coverage offered to District residents. Requirements for advertising the program help to make sure that residents will actually be aware of the program. Most importantly, the open enrollment provisions of Bill 17-934 will guarantee the availability of relatively affordable health insurance to those unable to secure coverage from their employers or public programs.

E. Cost-Benefit Analysis

This is not the first time that the Council has considered establishing a framework for ensuring that CareFirst meets its obligations to the public health. Similar legislation (Bill 16-190) was introduced by Councilmember Graham in 2005 but was not brought forth to the full Council. Community activists, particularly the DC Appleseed Center, have continued to press CareFirst to increase its charitable activity or, at least, consent to some independent oversight of its surplus and community health reinvestment practices.

⁴⁴ Bill 17-934 may be contrasted in this regard with the agreement that Pennsylvania entered into with its non-profit health plans. The Pennsylvania agreement "committed the Plans to annually contributing 1.6 percent of their health care premiums plus 1 percent of their Medicare and Medicaid premiums, less certain state taxes, . . . to support community health programs." CAROL PRYOR & CATHERINE DUNHAM, THE ACCESS PROJECT, THE PENNSYLVANIA COMMUNITY HEALTH REINVESTMENT AGREEMENT: ESTABLISHING NON-PROFIT INSURERS' COMMUNITY BENEFIT OBLIGATIONS 3 (2006).

Despite negotiations convened by the chairperson of this Committee, no such agreement was reached.

Bill 17-934 represents a chance to achieve a measure of finality on this issue, with a neutral party – the Mayor and, by delegation, DISB – following legislatively-prescribed standards to determine the appropriate surplus and community health reinvestment levels for GHMSI, consistent with financial soundness and efficiency. The health needs of the community are acute and extensive and would be well-served by a non-profit hospital and medical services corporation that is held accountable to its non-profit, public health mission.

For the reasons listed above, the Committee has determined that the enactment of Bill 17-934 by the Council would greatly benefit District residents.

SECTION-BY-SECTION ANALYSIS⁴⁵

Section 1 provides the long and short title of Bill 17-934.

Section 2 amends the Hospital and Medical Services Corporation Regulatory Act of 1996 as follows:

Subsection (a) defines the term “community health reinvestment.”

Subsection (b) requires the corporation to comply with the Risk-Based Capital Act of 1996 by filing an annual risk-based capital report with the Mayor.

Subsection (c) contains findings and requires the Mayor to issue an annual order to the corporation to expend a specified percentage of its gross premium revenues on community health reinvestment. The subsection further establishes a rebuttable presumption when the corporation fails to meet this percentage that it is not engaging in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency.

Subsection (d) requires the Mayor to make an annual determination of the appropriate surplus range for GHMSI, consistent with financial soundness and efficiency. The subsection also establishes a rebuttable presumption when a corporation exceeds this permissible surplus range that it is not engaging in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency.

This subsection also requires the Mayor to determine annually whether the corporation has satisfied its community health reinvestment obligation. If he determines that it has not, the corporation has 90 days to file a report justifying its failure by clear and convincing evidence, as well as a plan to divest itself of excess surplus and spend the specified percentage of revenues in the event the Mayor rejects the proposed justification.

⁴⁵ This analysis addresses the committee print of Bill 17-934.

If the corporation fails to meet its burden of justification, the Mayor must reject for 12 months all premium rate increases ought by the corporation and issue such orders as are necessary to enforce the legislation.

Subsection (e) requires the Mayor to order an annual audit of the rate stabilization fund for open enrollment; requires the corporation to continue to offer the open enrollment program indefinitely; establishes affordability and adequacy criteria for the program; and mandates advertisement of the program.

Subsection (f) prohibits the corporation from converting to a for-profit entity.

Subsection (g) prohibits the corporation from converting to a mutual insurance company.

Subsection (h) requires the Mayor to issue rules to implement the legislation; requires the corporation to furnish such information to the Mayor as he may require; and requires the Mayor to take into account the needs and interests of other jurisdictions in the corporation's service area when implementing the legislation.

Section 3 adopts the fiscal impact statement included in this report.

Section 4 states that the bill shall take effect following the approval of the Council and the standard periods of Mayoral and Congressional review.

SUMMARY OF PUBLIC HEARING

On Friday, October 10, 2008, the Committee on Public Services and Consumer Affairs held a hearing on Bill 17-934, the "Medical Insurance Empowerment Amendment Act of 2008." **Councilmember Mary M. Cheh**, chairperson of the Committee, called the hearing to order at 9:00 a.m. in room 120 of the John A. Wilson Building.

Chairperson Cheh provided background on the question of CareFirst's community obligations. She then explained the structure and goals of Bill 17-934. Chairperson Cheh acknowledged that CareFirst does currently give to the community and that many of the programs it supports are deserving and effective. She noted, however, that CareFirst should have nothing to fear from the bill if, as it asserts, it is already giving sufficiently to community health investment.

Councilmember David Catania made an opening statement, noting at the outset that the subject matter of Bill 17-934 intersects the responsibilities of the Committee on Health, which he chairs. Councilmember Catania detailed his concerns with the leadership of CareFirst, including the pecuniary gain that executives were to receive under the company's original plan for conversion to for-profit status. He also explained his experience in negotiating with CareFirst to arrive at the original proposal for the

Healthy DC program. Those negotiations led to an apparent agreement between CareFirst and his office, until CareFirst decided at the last minute to pull out of the deal. Councilmember Catania noted that the more that CareFirst adds to its reserves, the more attractive a target it becomes for conversion to for-profit status.

Chester "Chet" Burrell, President and CEO of CareFirst BlueCross BlueShield, testified in opposition to the legislation.⁴⁶ Mr. Burrell stated that CareFirst already gives generously to the community, more so than all other commercial insurers in the region. He added that it seems self-evident that the principal obligation of CareFirst is to work for the benefit of its policyholders. Mr. Burrell stated that he accepted his job at CareFirst because he saw the potential role that CareFirst could play in addressing the unmet health care needs of the community.

Mr. Burrell stated that CareFirst has no intention of converting to a for-profit company. He added that CareFirst follows its public-health mission and voiced his personal support for a legislative ban on conversion by CareFirst to for-profit status.⁴⁷

Mr. Burrell testified that CareFirst BlueCross BlueShield's risk-based capital would be between 700-750% by the end of the 2008, in part because of the nationwide economic downturn and in part because of a widespread trend of rising healthcare costs. Councilmember Cheh asked whether the ratio was dropping in response to the Council's consideration of Bill 17-934 and suggested that, while the legislation has not been enacted, we may be seeing its effects already. Mr. Burrell stated that CareFirst does not manipulate its surplus and that any change is a result of the business process.

Councilmember Cheh asked Mr. Burrell whether he considered Bill 17-934 to be qualitatively different from extant laws governing insurance, as the industry is already highly regulated. Mr. Burrell responded that he believed this legislation to be different. He contrasted the bill's framework to the authority granted to the Insurance Commissioner of Maryland, who has the ability to review a company's reserves and, if he concludes that they are excessive, can return the excess to policyholders by rate reduction. Councilmember Cheh stated that her concern was whether insurance departments in other jurisdictions review companies' surpluses. Mr. Burrell stated that some states do look at excess surplus.

Mr. Burrell stated that CareFirst does not offer a Medicaid product in the District. In response to questioning by Councilmember Catania, Mr. Burrell testified that he would be happy to discuss with the Councilmember the possibility of providing \$4 million to fill the "doughnut hole" in Medicare Part D.⁴⁸ Councilmember Catania asked if Mr. Burrell

⁴⁶ Witnesses Burrell, Lang, Gleason, Smith, Chollet, and Calia provided their testimony under oath.

⁴⁷ Due in part to Mr. Burrell's testimony, the Committee Print of Bill 17-934 includes provisions, not included in the introduced version, that would prohibit a non-profit medical and hospital services corporation from converting to for-profit status.

⁴⁸ An explanation of the Medicare Part D "doughnut hole" is provided in HENRY J. KAISER FAMILY FOUNDATION, THE MEDICARE PART D COVERAGE GAP: COSTS AND CONSEQUENCES IN 2007 i (2008) ("A unique feature of the Medicare Part D drug benefit is the so-called "doughnut hole", the gap in coverage in which Part D enrollees are required to pay the full cost of their drugs until they qualify for catastrophic

could point to the last time that CareFirst filed for a premium rate increase that was ultimately rejected by DISB. Mr. Burrell said that he could not but noted that DISB has the power to reject proposed increases.

Councilmember Cheh asked why CareFirst had not met its target enrollment rates for Open Enrollment program. Mr. Burrell responded that CareFirst had hoped for wider industry participation in the program, so that CareFirst would not be alone in contributing to covering the target population. Councilmember Cheh remarked that CareFirst has a history of making assurances that it is ultimately unable to meet.

Barbara Lang, President and CEO of the DC Chamber of Commerce, testified in opposition to the bill. Ms. Lang recognized that Bill 17-934 has been narrowly drafted to apply to one corporate entity in the District (namely, CareFirst)⁴⁹, but she voiced concern that the legislation could encroach upon a board of director's duty to steer a company. Ms. Lang stated that the bill could set a public policy precedent for governmental interference with the management of for-profit and not-for-profit companies. She added that no one could have foreseen the recent failure of companies such as AIG and Bear Stearns, which emphasizes how hard it would be for the Mayor to "draw down" GHMSI's reserves without damaging the company's financial health.

Councilmember Cheh noted that comparing this legislation to the collapse of major financial companies is not appropriate, as the federal government had to bail out greed, excess, and lack of good leadership by the executives and boards of those companies. She pointed out that Bill 17-934 would not draw down reserves; rather, it establishes a framework. Ms. Lang responded that she respectfully disagreed as to that analysis of recent corporate failures, and that the point of her testimony was that, in her view, Bill 17-934 usurps the corporate board's role and duty. She added that all companies need reserves to get through hard times. Councilmember Cheh agreed that companies need reserves and suggested that Bill 17-934 was wholly consistent with that necessity.

Sharon Gleason, Director of Development for the Girl Scout Council of the Nation's Capital, testified in opposition to any attempt to harm CareFirst's finances, because of its charitable giving. Ms. Gleason testified that CareFirst supports the Girl Scouts' Grow Strong program, which has served 2000 girls in the metropolitan area since 2007. Ms. Gleason detailed the Girl Scouts' efforts, with CareFirst's financial support, to help District girls develop. In response to a question from Councilmember Catania, Ms. Gleason testified that she was unaware that CareFirst has not provided a Medicaid product in a generation.

coverage. In 2007, the first full year of enrollment in Part D plans for many beneficiaries, the coverage gap began when a beneficiary incurred \$2,400 in total drug spending and ended after out-of-pocket spending reached \$3,850, equivalent to \$5,451 in total drug spending. Once through the gap, beneficiaries become eligible for catastrophic coverage where most of the costs of . . . drugs are covered.”)

⁴⁹ The Committee notes that Bill 17-934 addresses not a single entity *per se*, but rather a class of one, as GHMSI is the only non-profit hospital and medical services corporation that has been granted a certificate of authority under the Hospital and Medical Services Corporation Regulatory Act of 1996. Were another corporation to fall under the ambit of that act, it too would be subject to the provisions of Bill 17-934.

Walter Smith, Executive Director of the DC Appleseed Center, testified in support of the legislation. He listed four reasons why his organization supports Bill 17-934: 1) it puts in place a “fair, transparent process to ensure that GHMSI meets its public health mission”; 2) such a process is “particularly appropriate” given the uncertainty of public officials regarding whether CareFirst is meeting its obligation to the public; 3) GHMSI’s failure to meet its obligations would have a substantial, negative impact on the community; and 4) the framework established by the legislation protects the public’s interest in the company and is in keeping with actions taken by other jurisdictions.

Mr. Smith stated that, in implementing the bill, the Mayor would take all potential effects on CareFirst’s finances into account as part of the requirement to be consistent with financial soundness and efficiency. He testified that Bill 17-934 could be positive for local businesses, as their employees’ healthcare costs would be lowered as a result of enhanced community health reinvestment.

Deborah Chollet, Senior Fellow at Mathematica Policy Research, Inc., testified in support of Bill 17-934.⁵⁰ Ms. Chollet, an economist, described the financial situation of GHMSI. She noted in particular that GHMSI’s surplus continues to exceed that of its competitors in the metropolitan area; that there is precedent for this legislation in Pennsylvania, which entered into an agreement with its Blue Cross Blue Shield plans to give 1.6% of their gross premiums to community benefits; and that GHMSI could afford to spend more on community health reinvestments. Ms. Chollet stated that, based on her analysis, the gap between what CareFirst gives and what it could (and should) be giving is “enormous.” She added that Bill 17-934 provides flexibility where the Pennsylvania agreement is rigid, and that this bill benefits from that flexibility.

Ms. Chollet noted that there is any number of needs to which community health reinvestments could be applied, offering electronic medical records, quality of care, cost of care, health education, and preparedness as examples.

Kurt Calia, Partner at Covington and Burling LLP, testified in support of the legislation. Mr. Calia provided an overview of the legal foundation for the bill. He noted that the Bill 17-934 finds ample basis in GHMSI’s charter, in the ability of the District to govern its own affairs, and in relevant case law concerning charitable and benevolent entities. Mr. Calia reiterated that GHMSI has obligations as a charitable and benevolent institutions and that the company refuses to acknowledge these obligations. He added that the business community could see many of its healthcare concerns resolved by increased giving by CareFirst to preventative care and other community health reinvestments.

Mr. Calia explained that even if CareFirst’s obligations were only to its present and future subscribers, that group is nearly synonymous with the community at large.

⁵⁰ Ms. Chollet indicated that her testimony reflects her own opinions and not those of her employer.

JoAnn Lamphere, Director of State Government Relations for Health and Long-Term Care at AARP, testified in support of Bill 17-934. Ms. Lamphere stated that AARP endorses the reinvestment of excess surplus in community health reinvestment. Her organization particularly lauds the continuation of Open Enrollment and the establishment of adequacy and affordability criteria for the program. Ms. Lamphere noted that Bill 17-934 would provide improved assurances of health coverage and care to needful members of the community.

Cheryl Fish-Parcham, Deputy Director of Health Policy for Families USA, testified in support of the legislation. Ms. Fish-Parcham explained that she receives calls from residents of states that have no program similar to Open Enrollment, and that these residents face direct medical costs that are “totally impossible” for them to handle. Ms. Fish-Parcham stated that CareFirst began information about the Open Enrollment program on the Internet in August of 2008 and that Bill 17-934’s requirement that the program continue to be advertised will increase awareness of its availability. She noted that the current \$1500 annual drug cap in the Open Enrollment plan is woefully insufficient to meet the needs of the high-risk individuals who tend to purchase coverage under the program. She added that states that keep premiums within the caps imposed by Bill 17-934 (such as Maryland and Minnesota) do a better job of covering high-risk individuals. Ms. Fish-Parcham concluded by pointing to the many unmet health care needs in the District, some of which could be fulfilled by greater community health reinvestment by GHMSI.

Robert F. Van Dyke, an employee of RealMed, a healthcare technology company, testified in opposition to the legislation. Mr. Van Dyke testified that CareFirst has demonstrated its commitment to the community. He stated that he supports the need to increase access to health care but is worried that this bill could cause lead to higher premium costs. Mr. Van Dyke noted that his concerns were based less on questions about the structure of the legislation and more in the need to share costs among all insurers.

Sharon Baskerville, CEO of the District of Columbia Primary Care Association (“DCPCA”), testified in support of the legislation. Ms. Baskerville stated that her organization, which represents clinics throughout the District, recognized the legislation as “a strong bill in the right direction” but had questions about its implementation. In particular, she was concerned about the government’s ability to effectively manage investments – including community health reinvestments – for District residents.⁵¹ Ms. Baskerville testified that she believes it is “critical” to have legislation to put an end to the question of CareFirst’s community obligations. She pointed out how difficult it is for a clinic or community health program to raise funds and that District residents “should not have to depend on their healthcare based on how good a fundraiser I am.”

Vera Waltman Mayer, Senior Advocate for IONA Senior Services and Coordinator for the DC Coalition on Long Term Care, testified in support of Bill 17-934.

⁵¹ Chairperson Cheh clarified that this bill does not authorize the Mayor to receive or invest any funds; instead, CareFirst would be required to spend down the money itself. The government would simply ensure that the funds are spent on actual community health reinvestments.

Ms. Mayer stated that CareFirst could be of great assistance in meeting the health needs of the District. She described the difficulty that home care workers face in obtaining affordable health insurance and the ripple effect that their clients must deal with as a result. Because persons without insurance often wait until an emergency to seek medical care, their conditions require longer, more involved treatments, and a home care worker cannot take care of his or her clients when he or she is receiving such treatment. Ms. Mayer concluded by explaining that GHMSI could contribute to the availability of affordable health insurance by supporting the Alliance or Healthy DC.

Theodore A. Burkett, a private citizen, appeared with Ms. Mayer and testified about his experience as a CareFirst subscriber. Formerly covered by CareFirst in connection with his employment, Mr. Burkett was laid off when the store at which he worked was closed. He stated that he was forced to switch to an individual policy with high co-payments and benefit caps that does him more financial harm than good. While he pays over \$7000 in premiums annually, CareFirst contributes no more than \$5000 to his medical bills.

Margot Aronson, Vice President for Legislation and Advocacy at the Greater Washington Society for Clinical Social Work, testified in support of the legislation. Ms. Aronson stated that social workers see first-hand the impact of lack of access to affordable healthcare and mental health care in the District. She added that Bill 17-934 would provide "clear direction" for CareFirst to meet its obligations as a charitable and benevolent institution. Ms. Aronson noted that the Open Enrollment program should be affordable, with reasonable deductibles and no pre-existing condition exclusions. She also urged the Council to consider addressing the problem of low reimbursement rates for mental health providers; providers are leaving CareFirst's network because they cannot afford to practice at CareFirst's rates.

Kim Alphonso, a private citizen, testified about the healthcare needs of her family, which includes a child with special needs. Ms. Alphonso praised CareFirst for providing the best coverage she has had and asked the Committee not to "make CareFirst's revenue an additional source for DC's budget."⁵²

Father Mario Dorsonville, of the Spanish Catholic Center, Catholic Charities, testified to his organization's experience in working with CareFirst. Father Dorsonville stated that CareFirst has been an important partner for the Center's medical and dental clinics, providing \$100,000 a year in support.

Paul Alegero, representing the Boys and Girls Club of Greater Washington, testified in opposition to the legislation. He noted that CareFirst supports the Boys and Girls Club's efforts to fight the District's high teen pregnancy rate.

⁵² Chairperson Cheh pointed out that the bill would not appropriate any of CareFirst's funds for government use.

Wayne McOwen, representing the District of Columbia Insurance Federation (“DCIF”), testified in opposition to the legislation.⁵³ Mr. McOwen stated that Bill 17-934 is onerous and unnecessary, since DISB already has authority to regulate premiums. He opined that the bill would abandon traditional solvency analyses to set arbitrary limits on insurers’ reserves. Mr. McOwen testified that satisfactory processes are already in place to provide protections for consumers.

Alan Nessman, Special Counsel with the Practice Directorate of the American Psychological Association (“APA”), testified in support of Bill 17-934.⁵⁴ Mr. Nessman stated that his organization’s support is based on its extensive experience with the mental health needs of the District as well as the APA’s experience with CareFirst in particular. He urged the distribution of a portion of any community health reinvestment to mental health needs. Mr. Nessman testified that CareFirst could help provide mental health coverage in the DC Alliance; coordinate data about mental health needs and services in order to better target services; or coordinate services more effectively between the providers and other persons serving the District’s mental health needs. Mr. Nessman voiced support for the legislation’s Open Enrollment provisions and the addition of a prohibition of pre-existing condition exclusions.

James F. Brown, Director of Health Services at The Actors Fund, testified in support of the legislation. Mr. Brown explained that Bill 17-934 would speak directly to the needs of the artists that seek assistance from The Actors Fund. Mr. Brown noted that the rate of lack of health insurance among artists is twice the national average and that many rely on programs such as Open Enrollment for coverage. He testified that it is essential for community health reinvestments to expand coverage and maintain a widespread community health system.

Janice Williams, Executive Vice President of Programming for the YMCA of Metropolitan Washington, testified to CareFirst’s financial support of YMCA programs. Ms. Williams noted that District’s childhood obesity statistics are troubling and that CareFirst helps fund the YMCA’s efforts to engage children in more exercise. She noted that CareFirst employees often volunteer their time in furtherance of the YMCA’s work.

Gabrielle Urghart, Executive Director of the American Heart Association (“AHA”), Greater Washington Region, testified to CareFirst’s financial contributions to the AHA’s work. She noted that CareFirst asks for results from the programs they support and added that CareFirst employees are engaged in community volunteering.

Jeff Franco, Executive Director of City Year Washington, DC, testified to CareFirst’s support of City Year’s efforts to fight HIV in the District. He expressed his gratitude to CareFirst for its contributions to City Year’s work.

⁵³ Mr. McOwen indicated that DCIF is a trade association of which GHMSI is a significant member.

⁵⁴ Mr. Nessman indicated that he was presenting the testimony of Katherine Nordal, the Executive Director for Professional Practice at the APA.

Stephen J. Ackerman, a self-employed writer testifying on behalf of the DC Chapter of the Nation Writers Union, Local 1981 of the United Auto Workers, testified in support of the legislation. Mr. Ackerman described his difficult experiences trying to obtain health insurance as an individual. He noted that the Open Enrollment provisions of Bill 17-934 would be a positive step toward addressing the problems of the individual market.

Colleen Dermody, Vice President of Witeck-Combs Communications, a small business with a staff of 5, testified to her satisfaction with CareFirst as an insurer. Ms. Dermody requested that the Committee consider the needs of subscribers first, though she acknowledged the positive nature of community health reinvestment.

Irwin Royster, Director for Community Outreach at Planned Parenthood of Metropolitan Washington DC, Inc., testified to CareFirst's support of Planned Parenthood's efforts to provide free health services for at-risk teens.

Doreen Hodges, Executive Director of Family Voices of the District of Columbia, Inc. and a mother of special-needs children, testified in support of Bill 17-934. Ms. Hodges noted that the legislation could assist many families with special-needs individuals. She offered the concept of a "catastrophic relief fund," which would provide support for families bearing the burden of high costs associated with special-needs children, as an example of an appropriate community health reinvestment.

Chairperson Cheh thanked the witnesses for their testimony, and called the hearing to a close at 1:40 p.m.

FISCAL IMPACT

The Committee on Public Services and Consumer Affairs finds that approval of Bill 17-934 will have no fiscal impact. A fiscal impact statement has been requested from the Office of the Chief Financial Officer and will be delivered by second reading.

ANALYSIS OF IMPACT ON EXISTING LAW

Bill 17-934 would have a minimal impact on existing law. The bill would authorize the Mayor to establish appropriate operating surplus ranges for non-profit hospital and medical service corporations, direct excess surplus to be invested in the health of the community, and order a percentage of premiums to be spent on community health reinvestment. Bill 17-934 would also set adequacy and affordability criteria for open enrollment, remove the permissive sunset for open enrollment, and prohibit non-profit hospital and medical services corporations from converting to for-profit status.

COMMITTEE ACTION

On Friday, October 10, 2008, the Committee on Public Services and Consumer Affairs met to consider the Committee Print and Committee Report on Bill 17-934. Chairperson Cheh convened a quorum with Councilmembers Brown and Wells joining her in attendance.

Chairperson Cheh moved for approval of the Committee Print and Report on Bill 17-934, with leave for staff and the General Counsel to make technical corrections and conforming changes. The Committee Print and Report on Bill 17-934 were approved by voice vote, 3-0.

LIST OF ATTACHMENTS

- (A) Bill 17-934, as introduced
- (B) Notice of Intent to Act, published in the *District of Columbia Register*
- (C) Public Hearing Notice, published in the *District of Columbia Register*
- (D) Public Hearing Agenda and Witness List
- (E) Committee Print of Bill 17-934
- (F) Fiscal Impact Statement on Bill 17-934
- (G) Testimony submitted to the Committee

ATTACHMENT A

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44

Chairman Vincent Gray

Councilmember Kwame Brown

Councilmember Phil Mendelson

Councilmember Jim Graham

Councilmember Muriel Bowser

Councilmember Marion Barry

Councilmember Mary M. Cheh

Councilmember Tommy Wells

Councilmember Harry Thomas, Jr.

Councilmember Yvette Alexander

Councilmember David Catania

A BILL

IN THE COUNCIL OF THE DISTRICT OF COLUMBIA

Councilmember Mary M. Cheh introduced the following bill which was referred to the
Committee on _____.

To amend the Hospital and Medical Services Corporation Regulatory Act of 1996 to require the
Mayor to determine the percentage of annual premium revenues that hospital and medical
services corporations must spend on community health reinvestment; to define what
activities constitute community health reinvestment; to require the Mayor to establish the
sufficient surplus operating range for hospital and medical services corporations; to
require hospital and medical services corporations to justify the accumulation of surplus
in excess of the upper limit of that range, or divest themselves of the excess surplus
through community health investment; to require hospital and medical services
corporations to continue to offer the open enrollment program to each subscriber as long
as the subscriber renews his or her coverage under the program; to set affordability and
adequacy standards for the open enrollment program; and to require hospital and medical
services corporations to advertise the availability of the open enrollment program.

1 BE IT ENACTED BY THE COUNCIL OF THE DISTRICT OF COLUMBIA, That this
2 act may be cited as the “Medical Insurance Empowerment Amendment Act of 2008”.

3 Sec. 2. The Hospital and Medical Services Corporation Regulatory Act of 1996, effective
4 April 9, 1997 (D.C. Law 11-245; D.C. Official Code § 31-3501 *et seq.*), is amended as follows:

5 (a) Section 2 (D.C. Official Code § 31-3501) is amended as follows:

6 (1) Redesignate the existing paragraph (1) as paragraph (1A).

7 (2) Add a new paragraph (1) to read as follows:

8 “(1) “Community health reinvestment” means expenditures for:

9 “(a) Health coverage programs for low-income and/or underinsured and
10 uninsured persons, including the DC Healthcare Alliance, Healthy DC, and Medicaid, and any
11 other program to provide affordable and accessible insurance for individuals, including those
12 with health problems;

13 “(b) Other programs or means of subsidizing or providing healthcare
14 coverage and/or healthcare services to persons who are determined under applicable and
15 recognized standards to be unable to pay for such coverage or services or to be without access to
16 affordable healthcare services or coverage, including rate subsidies for HIPAA and HCTC, rate
17 subsidies for programs for individuals paid by any Blue Plan that have not been collected from
18 group premiums, and operating subsidies for public health provider programs; and

19 “(c) Other community healthcare-related expenditures approved by the
20 Mayor, which approval shall not be unreasonably withheld.”

21 (b) Section 4(a) (D.C. Official Code § 31-3503(a)) is amended by adding a new
22 paragraph (21A) to read as follows:

1 “(21A) The “Risk-Based Capital Act of 1996,” effective April 9, 1997 (D.C. Law
2 11-233; D.C. Official Code § 31-2001 *et seq.*), requiring insurers to file with the Mayor annual
3 risk-based capital reports.”

4 (c) Section 5 (D.C. Official Code § 31-3504) is amended as follows:

5 (1) Redesignate existing subsection (a) as subsection (a-1)

6 (2) Add a new subsection (a) to read as follows:

7 “(a) The Council finds and declares the following with respect to the corporation
8 that is governed by this chapter and whose charter declares it to be a benevolent and charitable
9 institution and authorizes it to cooperate, consolidate, or contract with individuals or groups or
10 organizations interesting in promoting and safeguarding the public health:

11 (1) that the corporation has a public health mission, which it must fulfill
12 by engaging in community health reinvestment in its service area to the maximum feasible extent
13 consistent with financial soundness and efficiency;

14 (2) that the corporation should not be permitted free rein to accumulate
15 surplus to cover any and all catastrophic events no matter how remote or unforeseeable;

16 (3) that the surplus at or above the level authorized by this chapter should
17 establish a presumption that the corporation is not fulfilling its public health obligation by
18 engaging in community health reinvestment to the maximum feasible extent consistent with
19 financial soundness and efficiency;

20 (4) that the corporation, unlike corporations that utilize owner-supplied
21 funds, does not provide a return on equity; and

22 (5) that, for all the foregoing reasons, it is critical that the Mayor specify a
23 percentage of gross premiums from all sources that must be devoted to community health

1 reinvestment, monitor the corporation's accumulated surplus level, and determine an upper limit
2 on the permissible surplus level for the corporation."

3 (3) Add a new subsection (d) to read as follows:

4 " (d)(1) Within 120 days of the effective date of the Medical Insurance
5 Empowerment Amendment Act of 2008, and annually thereafter, the Mayor shall issue an order
6 requiring the corporation annually to expend a specified percentage of its gross premium
7 revenues from all sources toward community health reinvestment, in accordance with the
8 corporation's obligation to engage in community health reinvestment to the maximum feasible
9 extent consistent with financial soundness and efficiency."

10 " (2) There shall be a presumption that a corporation expending less than the
11 specified percentage of its gross premium revenues from all sources toward community health
12 reinvestment is not engaging in community health reinvestment to the maximum feasible extent
13 consistent with financial soundness and efficiency. That presumption can be rebutted only by
14 the corporation's demonstration to the Mayor, by clear and convincing evidence, that the
15 corporation's expenditure of less than the specified percentage of its gross premium revenues
16 from all sources toward community health reinvestment set by the Mayor is appropriate under
17 the circumstances, taking into account that the corporation has a community health reinvestment
18 obligation."

19 (d) Section 7 (D.C. Official Code § 31-3506) is amended by adding new subsections (e),

20 (f), and (g) to read as follows:

21 " (e)(1) In addition to the order requiring the corporation to devote a specified
22 percentage of its gross premium revenue from all sources toward community health reinvestment
23 as required by section 5, within 120 days of the effective date of the Medical Insurance

1 Empowerment Amendment Act of 2008, the Mayor shall issue a determination setting forth the
2 appropriate sufficient operating surplus range for the corporation, net of the percentage of gross
3 premiums mandated by subsection 7(d), in accordance with the corporation's obligation to
4 engage in community health reinvestment to the maximum feasible extent consistent with
5 financial soundness and efficiency.

6 “(2) There shall be a presumption that a corporation operating at a surplus level
7 greater than the upper level of the sufficient operating surplus range is not engaging in
8 community health reinvestment to the maximum feasible extent consistent with financial
9 soundness and efficiency. That presumption can be rebutted only by the corporation's
10 demonstration to the Mayor, by clear and convincing evidence, that the corporation's operation
11 at a surplus level greater than the upper level of the sufficient operating surplus range set by the
12 Mayor is appropriate under the circumstances, taking into account that the corporation has a
13 community health reinvestment obligation.

14 “(f) The Mayor shall determine on an annual basis whether the corporation has
15 satisfied its community health reinvestment obligation by meeting the specified percentage and
16 by operating within the sufficient operating range. If the Mayor determines that the corporation
17 has not met the specified percentage or that the corporation's surplus exceeds the upper bound of
18 its sufficient operating range, the corporation shall file, within 90 days of the Mayor's
19 determination:

20 “(1) A report with the Mayor providing clear and convincing evidence that would
21 justify its surplus level or its failure to meet the specified percentage; and

22 “(2) A plan with the Mayor explaining how the corporation will satisfy the
23 specified percentage and divest itself of its surplus for purposes of community health

1 reinvestment, with divestiture to occur in a manner and within a period of time considered
2 reasonable by the Mayor, such plan to be implemented by the corporation in the event that it is
3 determined by the Mayor that the corporation has not met its burden to justify by clear and
4 convincing evidence its failure to meet the specified percentage and its surplus level.

5 “(g) If the corporation fails to meet its burden to justify by clear and convincing
6 evidence its surplus level or its failure to meet the specified percentage, the Mayor shall deny for
7 12 months all premium rate increases sought by the corporation pursuant to D.C. Official Code §
8 31-3508 and may issue such orders as are necessary to enforce the purposes of this act.”

9 (e) Section 15 (D.C. Official Code § 31-3514) is amended as follows:

10 (1) Subsection (j), paragraph (2) is amended by striking the phrase “may order an
11 independent” and replacing it with “shall order annually an independent”.

12 (2) Subsection (k) is amended to read as follows:

13 “(k) A corporation shall continue to offer the program to each subscriber as long
14 as the subscriber renews his or her coverage under the program.”

15 (3) Add a new subsection (m) to read as follows:

16 “(m) The open enrollment program shall maintain the following affordability and
17 adequacy criteria for individual participants:

18 “(1) Annual premium costs shall not exceed 125% of standard individual
19 market rates and shall be determined once every 12 months;

20 “(2) Cost sharing, deductibles, and co-insurance shall not exceed the
21 standard commercial policy available to employers in the District of Columbia;

22 “(3) Open enrollment subscriber contracts shall not contain service
23 limitations, life-time, or annual benefit maximums;

1 “(4) Open enrollment subscriber contracts and contract forms shall be
2 subject to section 9 of the Hospital and Medical Services Corporation Regulatory Act of 1996,
3 approved April 9, 1997 (Law 11-245; D.C. Official Code § 31-3508).”

4 (4) Add new subsection (n) to read as follows:

5 “(n) A corporation shall prominently advertise the availability of its open
6 enrollment subscriber contracts continuously on the Internet and at least quarterly in a newspaper
7 or newspapers of general circulation throughout the District. The content and format of such
8 advertising shall be filed with the Mayor no less than 30 days before its appearance in a
9 newspaper or on the Internet.”

10 (f) Section 25 (D.C. Official Code § 31-3524) is amended as follows:

11 (1) Designate the existing text as subsection (a).

12 (2) New subsections (b) and (c) are added to read as follows:

13 “(b) The Mayor, pursuant to Title 1 of the District of Columbia
14 Administrative Procedure Act, approved October 221, 1968 (82 Stat. 1204; D.C. Official Code §
15 2-501 *et seq.*), shall issue rules to implement the provisions of the Medical Insurance
16 Empowerment Amendment Act of 2008.

17 “(c) A corporation shall make available to the Mayor such information as
18 may be required to permit the Mayor to verify the corporation’s community health reinvestment
19 and, if appropriate, its compliance with a plan to meet the specified percentage and divest excess
20 surplus. When evaluating any such plan, the Mayor may retain attorneys, appraisers,
21 independent actuaries, independent certified public accountants, or other professionals, the cost
22 of which shall be borne by the corporation.”

23 Sec. 3. Fiscal impact statement.

1 The Council adopts the fiscal impact statement in the committee report as the fiscal
2 impact statement required by section 602(c)(3) of the District of Columbia Home Rule Act,
3 approved December 24, 1973 (87 Stat. 813; D.C. Official Code § 1-206.02(c)(3)).

4 Sec. 4. Effective date.

5 This act shall take effect following approval by the Mayor (or in the event of veto by the
6 Mayor, action by the Council to override the veto), a 30-day period of Congressional review as
7 provided in section 602(c)(1) of the District of Columbia Home Rule Act, approved December
8 24, 1973 (87 Stat. 813; D.C. Official Code § 1-206.02(c)(1)), and publication in the District of
9 Columbia.

ATTACHMENT B

COUNCIL OF THE DISTRICT OF COLUMBIA

PROPOSED LEGISLATION

BILLS

- B17-931 New Town Boundary Amendment Act of 2008

Intro. 09-16-08 by Councilmembers Thomas, Jr., Brown and Barry and referred to the Committee on Economic Development
- B17-932 Sunday Service Parking Act of 2008

Intro. 09-16-08 by Councilmember Thomas, Jr., and referred to the Committee on Public Works and the Environment
- B17-933 Dr. Purvis J. Williams Auditorium Designation Act of 2008

Intro. 09-16-08 by Councilmembers Thomas, Jr., Brown and Barry and referred to the Committee of the Whole
- B17-934 Medical Insurance Empowerment Amendment Act of 2008

Intro. 09-16-08 by Councilmembers Cheh, Brown, Mendelson, Graham, Bowser, Barry, Wells, Thomas, Jr., Alexander, Catania and Chairman Gray and referred to the Committee on Public Services and Consumer Affairs
- B17-935 Water and Sewer Authority Equitable Ratemaking Amendment Act of 2008

Intro. 09-16-08 by Councilmember Graham and referred to the Committee on Public Works and the Environment
- B17-936 Lead Hazard Prevention and Elimination Act of 2008

Intro. 09-16-08 by Councilmember Graham and referred to the Committee on Public Works and the Environment with comments from the Committee on Public Services and Consumer Affairs and the Committee on Health
- B17-937 Public Space Hazardous Tree Amendment Act of 2008

Intro. 09-16-08 by Councilmember Graham and referred to the Committee on Public Works and the Environment

ATTACHMENT C

Council of the District of Columbia
Committee on Public Services and Consumer Affairs
Notice of Public Hearing

1350 Pennsylvania Avenue, N.W. Washington, D.C. 20004

**COUNCILMEMBER MARY CHEH, CHAIRPERSON
COMMITTEE ON PUBLIC SERVICES AND CONSUMER AFFAIRS**

ANNOUNCES A PUBLIC HEARING ON

Bill 17-934, the "Medical Insurance Empowerment Amendment Act of 2008"

**Friday, October 10, 2008
9:00 A.M.**

**John A. Wilson Building
1350 Pennsylvania Avenue, N.W.
Room 120**

On Friday, October 10, 2008, Councilmember Mary M. Cheh, Chairperson of the Committee on Public Services and Consumer Affairs, will hold a public hearing on Bill 17-934, the "Medical Insurance Empowerment Amendment Act of 2008." Bill 17-934 would amend the law governing CareFirst BlueCross BlueShield, the District's largest health insurer, by empowering the Mayor to take steps to ensure that CareFirst pursues its public health mission. The bill would also set adequacy and affordability standards for the Open Enrollment program and require its indefinite extension. The public hearing will begin at 9:00 a.m. in Room 120 of the John A. Wilson Building, 1350 Pennsylvania Avenue, N.W.

The Committee invites the public to testify or to submit written testimony, which will be made a part of the official record. Anyone wishing to testify at the hearing should contact Aukima Benjamin at 724-8062 or via email at abenjamin@dccouncil.us. All public witnesses will be permitted three (3) minutes for oral presentation, and all witnesses representing groups or organizations will have five (5) minutes.

If you are unable to testify at the hearing, written statements are encouraged and will be made a part of the official record. Copies of written statements should be submitted either to the Committee on Public Services and Consumer Affairs, or to Ms. Cynthia Brock-Smith, Secretary to the Council, Room 5 of the John A. Wilson Building, 1350 Pennsylvania Avenue, N.W., Washington, D.C. 20004. The record will close at the end of the business day on Tuesday, October 14, 2008.

ATTACHMENT D

**Council of the District of Columbia
Committee on Public Services and Consumer Affairs
Agenda and Witness List
1350 Pennsylvania Avenue, N.W. Washington, D.C. 20004**

**COUNCILMEMBER MARY CHEH, CHAIRPERSON
COMMITTEE ON PUBLIC SERVICES AND CONSUMER AFFAIRS**

PUBLIC HEARING

Bill 17-934, the "Medical Insurance Empowerment Amendment Act of 2008"

**Friday, October 10, 2008
9:00 A.M.**

**John A. Wilson Building
1350 Pennsylvania Avenue, N.W.
Room 120**

Panel 1:

Chet Burrell, CareFirst BlueCross BlueShield
Barbara Lang, DC Chamber of Commerce
Sharon Gleason, Girl Scouts

Panel 2:

Walter Smith, DC Appleseed Center for Law and Justice
Kurt Calia, Covington and Burling LLP
Deborah Chollet, Mathematica Policy Research, Inc.

Panel 3:

Robert F. Van Dyke, private citizen
Cheryl Fish-Parcham, Families USA
Rachel, private citizen
JoAnn Lamphere, AARP

Panel 4:

Sharon Baskerville, DC Primary Care Association
Vera Waltman Mayer, DC Coalition on Long Term Care
Theodore A. Burkett, private citizen

Panel 5:

Margot Aronson, Greater Washington Society for Clinical Social Work
Julius Ware, President, Ward 7 Business and Professional Association
Kim Alphonso, Columbia Lighthouse for the Blind

Panel 6:

Fr Mario Dorsonville, Spanish Catholic Center
Alan Nessman, American Psychological Association
Paul Alegero, Boys and Girls Club of Washington DC

Panel 7:

Wayne McOwen, District of Columbia Insurance Federation
Vince Keane, Unity Healthcare
James F. Brown, Director of Health Services, The Actors Fund of America

Panel 8:

Samuel Jordan, Health Care Now!
Rolando Andrew, Lung Association
Donnie Shaw, YMCA

Panel 9:

Gabrielle Urghart, AHA
Jeff Franco, City Year
Stephen J. Ackerman, National Writers Union-DC, UAW Local 1981

Panel 10:

Colleen Dermody, Witeck Combs Communications
Irwin Royster, Planned Parenthood Metropolitan Washington

ATTACHMENT E

5
6
7 **A BILL**
8
9

10 **IN THE COUNCIL OF THE DISTRICT OF COLUMBIA**
11
12
13

14
15
16 To amend the Hospital and Medical Services Corporation Regulatory Act of 1996 to require the
17 Mayor to determine the percentage of annual premium revenues that hospital and medical
18 services corporations must spend on community health reinvestment, to define what
19 activities constitute community health reinvestment, to require the Mayor to establish the
20 sufficient surplus operating range for hospital and medical services corporations, to
21 require hospital and medical services corporations to justify the accumulation of surplus
22 in excess of the upper limit of that range, or divest themselves of the excess surplus
23 through community health investment, to require hospital and medical services
24 corporations to continue to offer the open enrollment program to each subscriber as long
25 as the subscriber renews his or her coverage under the program, to set affordability and
26 adequacy standards for the open enrollment program, to require hospital and medical
27 services corporations to advertise the availability of the open enrollment program, and to
28 prohibit hospital and medical services corporations from converting to for-profit entities.

29 **BE IT ENACTED BY THE COUNCIL OF THE DISTRICT OF COLUMBIA, That this**
30

31 act may be cited as the "Medical Insurance Empowerment Amendment Act of 2008".

32 **Sec. 2. The Hospital and Medical Services Corporation Regulatory Act of 1996, effective**
33 **April 9, 1997 (D.C. Law 11-245; D.C. Official Code § 31-3501 *et seq.*), is amended as follows:**

34 **(a) Section 2 (D.C. Official Code § 31-3501) is amended as follows:**

35 **(1) Existing paragraph (1) is redesignated as paragraph (1A).**

36 **(2) A new paragraph (1) is added to read as follows:**

37 **"(1) "Community health reinvestment" means expenditures benefiting a**

38 **corporation's service area for:**

1 “(a) Health coverage programs for low-income and/or underinsured and
2 uninsured persons, including the DC Healthcare Alliance, Healthy DC, and Medicaid, and any
3 other comparable program in a corporation’s service area to provide affordable and accessible
4 insurance for individuals, including those with health problems;

5 “(b) Other programs or means of subsidizing or providing healthcare
6 coverage and/or healthcare services to persons residing in a corporation’s service area who are
7 determined under applicable and recognized standards to be unable to pay for such coverage or
8 services or to be without access to affordable healthcare services or coverage, including rate
9 subsidies for plans offered pursuant to the Health Insurance Portability and Accountability Act of
10 1996, approved August 21, 1996 (Pub. L. 104-191; 110 Stat. 1936), rate subsidies for programs
11 for individuals paid by any Blue Cross Blue Shield-affiliated healthcare plan that have not been
12 collected from group premiums, and operating subsidies for public health provider programs;
13 and

14 “(c) Other community healthcare-related expenditures in the corporation’s
15 service area as approved by the Mayor, which approval shall not be unreasonably withheld.”.

16 (b) Section 4(a) (D.C. Official Code § 31-3503(a)) is amended as follows:

17 (1) Paragraph (25) is amended by striking the phrase “; and” and inserting a
18 semicolon in its place.

19 (2) Paragraph (26) is amended by striking the period and inserting the phrase “;
20 and” in its place.

21 (3) A new paragraph (27) is added to read as follows:

1 “(27) The Risk-Based Capital Act of 1996, effective April 9, 1997 (D.C. Law 11-
2 233; D.C. Official Code § 31-2001 *et seq.*), requiring insurers to file with the Mayor annual risk-
3 based capital reports.”.

4 (c) A new section 6a is added to read as follows:

5 “(a) The Council finds and declares the following with respect to a corporation
6 that is governed by this act and whose charter declares it to be a benevolent and charitable
7 institution and authorizes it to cooperate, consolidate, or contract with individuals or groups or
8 organizations interesting in promoting and safeguarding the public health:

9 (1) A corporation has a public health mission, which it must fulfill by
10 engaging in community health reinvestment in its service area to the maximum feasible extent
11 consistent with financial soundness and efficiency;

12 (2) A corporation should not be permitted free rein to accumulate surplus
13 to cover any and all catastrophic events no matter how remote or unforeseeable;

14 (3) The surplus at or above the level authorized by this act should
15 establish a presumption that the corporation is not fulfilling its public health obligation by
16 engaging in community health reinvestment in its service area to the maximum feasible extent
17 consistent with financial soundness and efficiency;

18 (4) A corporation, unlike corporations that utilize owner-supplied funds,
19 does not provide a return on equity;

20 (5) For all the foregoing reasons, it is critical that the Mayor specify a
21 percentage of gross premiums from all sources that must be devoted to community health
22 reinvestment in its service area, monitor a corporation’s accumulated surplus level, and
23 determine an upper limit on the permissible surplus level for the corporation; and

1 (6) It is critical that the Mayor shall take all reasonable steps to ensure
2 that a corporation's community health reinvestment expenditures benefit actual and potential
3 subscribers in its service area."

4 “(b) A corporation shall engage in community health reinvestment in its service
5 area to the maximum feasible extent consistent with financial soundness and efficiency.

6 “(c)(1) Within 120 days after the effective date of the Medical Insurance
7 Empowerment Amendment Act of 2008, passed on 2nd reading on _____, 2008 (Enrolled version
8 of Bill 17-934), and annually thereafter, the Mayor shall issue an order requiring a corporation
9 annually to expend a specified percentage of its gross premium revenue from all sources toward
10 community health reinvestment in its service area, in accordance with the corporation's
11 obligation to engage in community health reinvestment in its service area to the maximum
12 feasible extent consistent with financial soundness and efficiency.

13 “(2) There shall be a presumption that a corporation expending less than the
14 specified percentage of its gross premium revenue from all sources toward community health
15 reinvestment in its service area is not engaging in community health reinvestment in its service
16 area to the maximum feasible extent consistent with financial soundness and efficiency. The
17 presumption shall be rebutted only by the corporation's demonstration to the Mayor, by clear and
18 convincing evidence, that the corporation's expenditure of less than the specified percentage of
19 its gross premium revenues from all sources toward community health reinvestment set by the
20 Mayor pursuant to paragraph (1) of this subsection is appropriate under the circumstances, taking
21 into account the obligation of the corporation to engage in community health reinvestment in its
22 service area to the maximum feasible extent consistent with financial soundness and efficiency.”.

1 (d) Section 7 (D.C. Official Code § 31-3506) is amended by adding new subsections (e),
2 (f), and (g) to read as follows:

3 “(e)(1) In addition to the order requiring a corporation to devote a specified
4 percentage of its gross premium revenue from all sources toward community health reinvestment
5 in its service area as required by section 6a(c)(1), within 120 days of the effective date of the
6 Medical Insurance Empowerment Amendment Act of 2008, passed on 2nd reading on _____,
7 2008 (Enrolled version of Bill 17-934) the Mayor shall issue a determination setting forth the
8 appropriate sufficient operating surplus range for the corporation, net of the percentage of gross
9 premiums mandated by subsection 7(d), in accordance with the corporation’s obligation to
10 engage in community health reinvestment in its service area to the maximum feasible extent
11 consistent with financial soundness and efficiency.

12 “(2) There shall be a presumption that a corporation operating at a surplus level
13 greater than the upper level of the sufficient operating surplus range is not engaging in
14 community health reinvestment in its service area to the maximum feasible extent consistent
15 with financial soundness and efficiency. The presumption shall be rebutted only by the
16 corporation’s demonstration to the Mayor, by clear and convincing evidence, that the
17 corporation’s operation at a surplus level greater than the upper level of the sufficient operating
18 surplus range set by the Mayor is appropriate under the circumstances, taking into account the
19 obligation of the corporation to engage in community health reinvestment in its service area to
20 the maximum feasible extent consistent with financial soundness and efficiency.

21 “(f) The Mayor shall determine on an annual basis whether a corporation has
22 satisfied its community health reinvestment obligation by meeting the specified percentage and
23 by operating within the sufficient operating range. If the Mayor determines that the corporation

1 has not met the specified percentage or that the corporation's surplus exceeds the upper bound of
2 its sufficient operating range, the corporation shall file, within 90 days of the Mayor's
3 determination:

4 “(1) A report with the Mayor providing clear and convincing evidence
5 that would justify its surplus level or its failure to meet the specified percentage; and

6 “(2) A plan with the Mayor explaining how the corporation will satisfy
7 the specified percentage and divest itself of its surplus for purposes of community health
8 reinvestment in its service area, with divestiture to occur in a manner and within a period of time
9 considered reasonable by the Mayor, such plan to be implemented by the corporation if that it is
10 determined by the Mayor that the corporation has not met its burden to justify by clear and
11 convincing evidence its failure to meet the specified percentage and its surplus level.

12 “(g) If the corporation fails to meet its burden to justify by clear and convincing
13 evidence its surplus level or its failure to meet the specified percentage, the Mayor shall deny for
14 12 months all premium rate increases sought by the corporation pursuant to section 9 and may
15 issue such orders as are necessary to enforce the purposes of this act.”

16 (e) Section 15 (D.C. Official Code § 31-3514) is amended as follows:

17 (1) Subsection (j)(2) is amended by striking the phrase “may order an
18 independent” and inserting the phrase “shall order annually an independent” in its place.

19 (2) Subsection (k) is amended to read as follows:

20 “(k) A corporation shall continue to offer the program to each subscriber as long
21 as the subscriber renews his or her coverage under the program.”

22 (3) New subsections (m) and (n) are added to read as follows:

1 “(m) The open enrollment program shall maintain the following affordability and
2 adequacy criteria for individual participants:

3 “(1) Annual premium costs shall not exceed 125% of standard individual
4 market rates and shall be determined once every 12 months;

5 “(2) Cost sharing, deductibles, and co-insurance shall not exceed the
6 standard commercial policy available to employers in the District of Columbia;

7 “(3) Subscriber contracts shall not contain service limitations, lifetime, or
8 annual benefit maximums;

9 “(4) Subscriber contracts and contract forms shall be subject to section 9;
10 and

11 “(5) Subscriber contracts and contract forms shall not contain exclusions
12 or riders for pre-existing conditions.

13 “(n) A corporation shall prominently advertise the availability of its open
14 enrollment subscriber contracts continuously on the Internet and at least quarterly in a newspaper
15 of general circulation throughout the District. The content and format of the advertising shall be
16 filed with the Mayor no less than 30 days before its appearance in a newspaper or on the
17 Internet.”.

18 (f) Section 16 (D.C. Official Code § 31-3515) is amended to read as follows:

19 “Sec. 16. Conversion to a for-profit entity.

20 “A corporation issued a certificate of authority under this act shall not be converted into a
21 stock corporation, partnership, limited liability company, or other business entity organized for
22 profit.”.

23 (g) Section 17 (D.C. Official Code § 31-3516) is amended to read as follows:

1 "Sec. 17. Conversion to a mutual company.

2 "A corporation issued a certificate of authority under this act shall not be converted into a
3 mutual insurance company."

4 (h) Section 25 (D.C. Official Code § 31-3524) is amended as follows:

5 (1) Designate the existing text as subsection (a) and replace the word "may" with
6 the word "shall".

7 (2) New subsections (b) and (c) are added to read as follows:

8 "(b) A corporation shall make available to the Mayor such information as
9 may be required to permit the Mayor to verify the corporation's community health reinvestment
10 and, if appropriate, its compliance with a plan to meet the specified percentage and divest excess
11 surplus. When evaluating any such plan, the Mayor may retain attorneys, appraisers,
12 independent actuaries, independent certified public accountants, or other professionals, the cost
13 of which shall be borne by the corporation.

14 "(c) In implementing the provisions of Medical Insurance Empowerment
15 Amendment Act of 2008, passed on 2nd reading on _____, 2008 (Enrolled version of Bill 17-
16 934) the Mayor shall consider the interests and needs of the jurisdictions in the corporation's
17 service area."

18 Sec. 3. Fiscal impact statement.

19 The Council adopts the fiscal impact statement in the committee report as the fiscal
20 impact statement required by section 602(c)(3) of the District of Columbia Home Rule Act,
21 approved December 24, 1973 (87 Stat. 813; D.C. Official Code § 1-206.02(c)(3)).

22 Sec. 4. Effective date.

1 This act shall take effect following approval by the Mayor (or in the event of veto by the
2 Mayor, action by the Council to override the veto), a 30-day period of Congressional review as
3 provided in section 602(c)(1) of the District of Columbia Home Rule Act, approved December
4 24, 1973 (87 Stat. 813; D.C. Official Code § 1-206.02(c)(1)), and publication in the District of
5 Columbia.

ATTACHMENT F

**[Fiscal Impact Statement pending from
Office of the Chief Financial Officer]**

ATTACHMENT G

TESTIMONY OF CHET BURRELL
PRESIDENT AND CHIEF EXECUTIVE OFFICER
CAREFIRST BLUECROSS BLUESHIELD
Hearing on Medical Insurance Empowerment Act of 2008 (Bill 17-0934)
October 10, 2008

Good morning, Chairperson Cheh and members of the Committee. My name is Chet Burrell. I appear before you today in my role as President and Chief Executive Officer of CareFirst BlueCross BlueShield, a not-for-profit health care company which provides health insurance products and administrative services to 3.3 million members through our two operating affiliates serving Maryland and the National Capital Area which is comprised of the District, Northern Virginia and portions of Maryland. Thank you for allowing me to testify on this proposal.

In about six weeks, I will mark my first anniversary at CareFirst. To say the least, it's been an exciting and, in many respects, a tumultuous year. Virtually my entire career has been in health care, beginning some 35 years ago when I managed the State of New York's mammoth Medicaid program. As such, I understand well the many challenges you face as public servants as you seek to provide access to quality and affordable health care for your neediest constituents. I also spent years running several not-for-profit Blues Plans before trying my hand in launching various start-up health companies. I accepted the CareFirst job in large part because I saw the potential that a regional, not-for-profit health insurer like CareFirst could play in addressing the unmet health care needs of the community.

In fact, within days of my arrival, I had the first of many meetings with your colleague, Councilmember Catania, eager to see if CareFirst and the District could forge a partnership to provide health coverage for the estimated 22,000 uninsured District residents who don't qualify for the District's existing Medicaid or Healthcare Alliance programs. Without going into the entire history of what occurred with the Healthy DC Plan, let me note that CareFirst had committed to administer the program on behalf of the District at cost and to contribute an additional \$5 million annually to subsidize premiums to make coverage as affordable as possible. For the public record, I want to reiterate that CareFirst stands by the commitments it made toward the success of an appropriately designed Healthy DC initiative. But, in making that commitment, it is not possible for any insurer, especially a not-for-profit entity such as ours, to absorb the unknowable, unlimited and uncontrollable risks of the Healthy DC program as it ultimately was shaped.

All of which brings us to the bill that is before us today that seeks to define CareFirst's community role as a not-for-profit health services company. First, let me say that I deeply believe in the importance of this role as do our Boards of Directors. But, I have been struck by the persistent degree of misinformation and lack of understanding about that role. It seems self-evident that our principal obligation is to work for the benefit of our policyholders by providing the greatest possible value and service to those who pay the bills. Congress chartered GHMSI, our affiliate serving the National Capital Area, and defined its purpose. The clear intent of Congress (as affirmed by the previous D.C. Insurance Commissioner and Attorney General), was that GHMSI would operate specifically for the benefit of its policyholders, rather than for the public at large.

At the heart of the proposed Medical Insurance Empowerment Act are provisions that would require CareFirst to 1) redistribute a portion of premium revenues paid by policyholders to the District for community health programs and 2) cap the financial reserves we use to protect policyholders, requiring CareFirst to relinquish any reserves that the District determines exceed those set levels. We believe strongly that the proposed legislation is not only contrary to our Federal Charter but reflects a fundamental misunderstanding of the realities of the competitive health insurance marketplace and what CareFirst already contributes to the District and its residents. We do business in one of the nation's most intensely competitive markets, competing against well-financed, for-profit carriers who have ready access to public capital and a national market. As a regional insurer, we cannot spread our risks across the broad geographic territory that a national carrier can. We cannot raise capital by selling shares as our

for-profit competitors can. We operate at an extremely low margin. (Our underwriting margin averages only about 2 percent annually.)

We benefit our members by "being there" for them when they need us most in paying their claims. For this, we hold on our members' behalf capital reserves that were built from the premiums and fees paid by those members over the years to ensure that their health care needs are met. CareFirst must maintain sufficient reserves to meet legal and regulatory requirements; underwrite capital improvements to improve services to our members; and pay members' claims no matter what the circumstance. The proposed legislation uses the term "surplus" to refer to CareFirst's reserves. CareFirst does not have "surplus" cash; rather, the reserves CareFirst holds amount to less than \$800 per insured member, or a fraction of the cost of a day's stay in the hospital. Investment returns earned on these reserves are important in helping us moderate the premiums policyholders pay.

Among their most important fiduciary duties, our Boards – comprised of respected leaders that include a former D.C. Council Chair, a former superintendent of D.C. public schools and others who are as concerned about this community as any member of the Council – set targets for the level of our reserves based on expert third party advice. Any and all earnings on these reserves go strictly to benefit our members and help stabilize and moderate premium rates, which is only appropriate since those reserves are built on the premiums and fees our policyholders paid. The tumultuous state of the economy and the events of the last few weeks painfully demonstrate the importance of ensuring that companies are financially solvent. When many of the most well-known names in American finance have suffered devastating economic blows due to a lack of sufficient capital, and a major metropolitan area continues to cope with the aftermath of a massive hurricane, this bill's intent to require CareFirst to reduce its level of reserves is not only unwise but is irresponsible.

A basic premise of the proposed legislation is that CareFirst should contribute more to the community at large. I submit that we already give generously. In the past three years, CareFirst has contributed more than \$100 million to over 300 worthy community groups throughout our market service area and we expect to give another \$40 million in 2008 to such organizations. All other commercial insurers in the region combined do not equal this level of giving. We are extremely pleased to be able to contribute. And, we intend to continue this policy and expand it as our resources allow. But, our ability to do this requires that we remain competitive and viable in our marketplace. The cost of this giving is borne directly by our policyholders, who have a right to expect wise stewardship of their premium and fee dollars as well as effective efforts on our part to keep costs as low as possible.

In fact, the greatest irony with this proposal should it become law is its impact on the premiums your constituents will pay for their health coverage from CareFirst. At a time when health care costs are rising at two to three times the rate of wages, many of the individuals and small employers who contract with CareFirst for their health insurance already are struggling. By effectively imposing an additional "tax" on CareFirst's reserves and the premiums paid by its policyholders, this legislation will likely lead to even higher premiums, forcing many employers to reduce or discontinue coverage altogether. Hit hardest by this will be the almost 20,000 District residents with Individual Market policies and more than 4,500 small employer groups that we insure in the District.

CF believes this proposed legislation is contrary to the express language of the Federal Charter, the clear intent of Congress, and the interests of our policyholders (both in the District and in surrounding areas). With that said, we recognize the concerns that the Council has expressed and stand ready to continue discussions for addressing those issues. For example, we believe that the approach taken in the neighboring State of Maryland for our premium tax and community benefit obligations, as well as for tracking appropriate levels of reserves, offers a workable model for the District of Columbia. In summary, CareFirst fully acknowledges – indeed, we embrace – our role as a not-for-profit health services company. But, this legislation is unnecessary and inappropriate and should be rejected.

Thank you.



The Voice of Business in DC

CHAMBER of COMMERCE

**Testimony of
Barbara Lang, President & CEO of DC Chamber of Commerce
Before the Committee on Public Services and Consumer Affairs
Bill 17-934, the "Medical Insurance Empowerment Amendment Act of
2008"
Friday, October 10, 2008**

GOOD MORNING, CHAIRMAN CHEH AND MEMBERS OF THE COMMITTEE ON PUBLIC SERVICES AND CONSUMER AFFAIRS. I AM BARBARA LANG, PRESIDENT AND CEO OF THE DC CHAMBER OF COMMERCE, THE WASHINGTON DC METRO REGION'S LARGEST BUSINESS ORGANIZATION. I WOULD LIKE TO THANK YOU FOR ALLOWING ME TO TESTIFY ON BILL 17-934, THE MEDICAL INSURANCE EMPOWERMENT AMENDMENT ACT OF 2008.

THE DC CHAMBER OF COMMERCE WOULD LIKE TO EXPRESS ITS PUBLIC POLICY RESERVATIONS ABOUT BILL 17-934. OUR CONCERNS ARE SIMILAR TO THOSE EXPRESSED AT A HEARING ON OCTOBER 3, 2005, WHEN WE TESTIFIED BEFORE COUNCILMEMBER GRAHAM ON

SIMILARLY TITLED AND PURPOSED LEGISLATION. WE WOULD LIKE TO SUBMIT THAT TESTIMONY ONCE AGAIN FOR THE RECORD IN ADDITION TO MY TESTIMONY TODAY.

IN EXPRESSING OUR CONCERNS, THE CHAMBER RECOGNIZES THAT BILL 17-934 HAS BEEN NARROWLY DRAFTED SO THAT IT WOULD ONLY APPLY TO ONE CORPORATE ENTITY OPERATING IN THE DISTRICT OF COLUMBIA. DESPITE ITS LIMITED APPLICATION, THE PUBLIC POLICY STATEMENTS OF THE BILL'S PROVISIONS COULD HAVE A SIGNIFICANT IMPACT ON NON-PROFITS AND FOR-PROFITS OPERATING IN THE DISTRICT OF COLUMBIA.

AS DRAFTED, THE MEDICAL EMPOWERMENT AMENDMENT ACT OF 2008 WOULD USURP THE ROLE AND RESPONSIBILITIES OF A CORPORATE BOARD OF DIRECTORS AND ITS SENIOR MANAGERS, REPLACE THE BUSINESS JUDGMENT AND ACUMEN OF THE COMPANY'S MANAGEMENT TEAM WITH THAT OF THE MAYOR, AND FORCE THE COMPANY TO RID ITSELF OF ITS RESERVES. BECAUSE OF THE

SWEEPING NATURE OF THE BILL'S PROVISIONS, THE PUBLIC POLICY IMPLICATIONS SHOULD BE FULLY VETTED AND DISCUSSED BEFORE ENACTMENT.

A CORPORATE BOARD OF DIRECTORS IS TYPICALLY CHARGED WITH THE FOLLOWING MAJOR DUTIES: PROVIDING CONTINUITY FOR AN ORGANIZATION, SELECTING AND APPOINTING A CHIEF EXECUTIVE OFFICER, GOVERNING THE ORGANIZATION BY BROAD POLICIES AND OBJECTIVES, ACQUIRING SUFFICIENT RESOURCES FOR THE ORGANIZATION'S OPERATIONS, AND PROVIDING FISCAL ACCOUNTABILITY. IN ADDITION TO THESE DUTIES, A BOARD OF DIRECTORS HAS SPECIFIC RESPONSIBILITIES SUCH AS DETERMINING THE ORGANIZATION'S MISSION AND PURPOSE, ENSURING EFFECTIVE ORGANIZATIONAL PLANNING, ENSURING ADEQUATE RESOURCES, AND MANAGING THOSE RESOURCES EFFECTIVELY.

THIS LEGISLATION COULD ENCROACH UPON A BOARD OF DIRECTORS' DUTY TO ACQUIRE SUFFICIENT RESOURCES AND PROVIDE FISCAL

ACCOUNTABILITY. IT COULD ALSO ENCROACH ON A BOARD'S RESPONSIBILITY TO ENSURE THE ADEQUACY AND EFFECTIVE MANAGEMENT OF AN ORGANIZATION'S RESOURCES. SPECIFICALLY, SECTION 5 SUGGESTS THAT A CORPORATION SHOULD NOT ACCUMULATE RESERVES BECAUSE THE EVENTS THAT WOULD NECESSITATE THE USE OF THOSE RESERVES SEEM REMOTE OR UNFORESEEABLE TO THE LEGISLATIVE OR EXECUTIVE BRANCH OF GOVERNMENT. WHILE THIS STATEMENT MAY SEEM LIKE A LAUDABLE CONCEPT WITH NO HARMFUL IMPLICATIONS, ITS PROHIBITION COULD HAVE SERIOUS RAMIFICATIONS.

SIX MONTHS TO A YEAR AGO, NO ONE SAW THE COLLAPSE OF THE UNITED STATES' FINANCIAL MARKET. NO ONE WOULD HAVE EVER THOUGHT THAT THAT BEAR STEARNS, LEHMAN BROTHERS, AND MERRIL LYNCH, GOLIATHS OF THE INVESTMENT BANKING WORLD, WOULD CRUMBLE AND SUFFER FINANCIAL RUIN. BUT IN FACT, THAT IS EXACTLY WHERE WE ARE TODAY. A YEAR AGO, HAD YOU ASKED OUR FEDERALLY ELECTED OFFICIALS WHETHER THEY WOULD BE VOTING TO

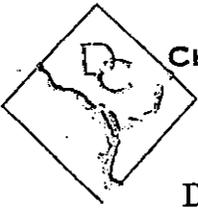
PROVIDE OVER \$700 BILLION TO SAVE WALL STREET, THEY WOULD HAVE SAID THOSE EVENTS WERE UNLIKELY, REMOTE AND UNFORESEEABLE. A CORPORATION ACCUMULATING RESERVES, VERY SIMILAR IN FACT TO RESERVES THE DISTRICT IS CONGRESSIONALLY MANDATED TO MAINTAIN, MIGHT HAVE HELPED THESE CORPORATIONS STAY AFLOAT RATHER THAN REQUIRING THE FEDERAL GOVERNMENT TO BUY THEIR CORPORATE DEBT.

THIS LEGISLATION WOULD ALSO SEEK TO HAVE THE MAYOR DETERMINE WHAT THE APPROPRIATE RESERVE LEVELS ARE FOR A CORPORATION. BY SECOND GUESSING AND REPLACING THE BUSINESS JUDGMENT OF THE BOARD OF DIRECTORS AND SENIOR MANAGEMENT TEAM WITH THAT OF THE EXECUTIVE BRANCH OF GOVERNMENT, THE LEGISLATION DOES NOT INSPIRE CONFIDENCE WITHIN THE BUSINESS COMMUNITY. IN FACT, IT SAYS TO US THAT OUR CORPORATE DECISIONS CAN BE UNDONE BY LEGISLATION OR OVERRULED BY THE MAYOR.

FURTHER ERODING THE BUSINESS COMMUNITY'S SENSE OF CONFIDENCE IS A GOVERNMENT FORCING A CORPORATION TO DIVEST ITSELF OF RESERVES AND THEN SUBSEQUENTLY DIRECTING WHERE AND HOW THOSE RESERVES WILL BE SPENT. ONCE AGAIN, THE CHAMBER RECOGNIZES THAT THIS LEGISLATION IS DIRECTED AT A PARTICULAR NON-PROFIT BUT THERE IS NOTHING THAT PROHIBITS THE COUNCIL FROM EXPANDING THE BILL'S PROVISIONS, THROUGH AMENDMENTS, TO FOR-PROFITS AND OTHER THAT HAVE RESERVES THE GOVERNMENT BELIEVES ARE UNNECESSARY AND EXCESSIVE. ONCE AGAIN, THE PUBLIC POLICY PRECEDENT THAT THIS LEGISLATION COULD SET IS OF CONCERN TO THE CHAMBER.

THE CHAMBER REALIZES THAT IT IS A VERY UNPOPULAR TIME AND POSITION TO SUGGEST THAT THE GOVERNMENT SHOULD RESPECT THE DECISIONS OF A CORPORATE BOARD OF DIRECTORS IN LIGHT OF CURRENT EVENTS AND THE ECONOMY BUT IT IS THE CHAMBER'S ROLE IS TO BE AN ADVOCATE FOR OUR MEMBERSHIP AND REPRESENT THEIR VIEWS BEFORE GOVERNMENTAL OFFICIALS. THE DC CHAMBER OF

COMMERCE IS COMMITTED TO HAVING A POSITIVE IMPACT ON THE QUALITY OF LIFE IN THE DISTRICT OF COLUMBIA AND WE BELIEVE THAT THE DISTRICT SHOULD BE ONE OF THE BEST PLACES TO LIVE, WORK, PLAY, AND DO BUSINESS. THANK YOU AGAIN, FOR ALLOWING ME TO TESTIFY AND I WILL BE HAPPY TO ANSWER ANY QUESTIONS.



CHAMBER OF COMMERCE

**TESTIMONY OF BARBARA B. LANG
PRESIDENT AND CHIEF EXECUTIVE OFFICER
DISTRICT OF COLUMBIA CHAMBER OF COMMERCE
Hearing on the Medical Insurance Empowerment Act of 2005
October 3, 2005**

Good morning Chairman Graham and members of the Committee. My name is Barbara Lang and I am President and Chief Executive Officer of the District of Columbia Chamber of Commerce. Thank you very much for the opportunity to testify on this proposed legislation, which states that the charitable obligations on the District of Columbia's BlueCross BlueShield CareFirst Program shall be a "legal obligation" rather than a community or social one.

We oppose this legislation as it undermines the authority of the company's board of trustees and its senior management and unfairly takes a portion of the premiums paid by subscribers – many of whom struggle to provide health insurance for their employees. This is not a business-friendly proposal. It sends the wrong message to the business community.

CareFirst is a valued member of the District of Columbia business community. They are a Circles Partner of the DC Chamber and work with us on identifying ways to provide benefits for small and medium sized businesses. In fact, CareFirst is the insurance provider for the DC Chamber staff. CareFirst is a respected organization that contributes to the business community and many charitable causes. They have worked with organizations including the United Way, Whitman Walker Clinic, La Clinica del Pueblo, and the Alzheimer's Association. The company continues to develop initiatives that improve and expand health care in the District of Columbia. The CareFirst Board, which includes a number of distinguished leaders of this community, earlier this year announced its CareFirst commitment program which will bring millions more in charitable contributions to the Washington metropolitan area.

We recognize that organizations like Appleseed do important work in the community. However, we are concerned about their assessment of the CareFirst situation and their impact on the available financial reserves. It is important that these reserves be

managed carefully by CareFirst, and specifically its local affiliate GHMSI, to the benefit of healthcare subscribers including the DC Chamber of Commerce. Prudent fiscal management is not inconsistent with the mission of a non-profit organization. While it is important to contribute to the public good, it is also important that CareFirst and its Board of Directors use their expertise to determine how to best allocate resources.

Using a large portion of these reserves to pay for unproven public health initiatives is not necessarily the best of course of action. These reserves -- which are the premiums paid by individuals, employees or employers -- belong to these subscribers. It does not belong to the District Government. If DC should be the target of another terrorist act such as the anthrax scare or a CSX hazardous materials spill, CareFirst members would be impacted. If the reserves are diverted CareFirst might be unable to offer needed security to their customers. Thousands of subscribers have the right to expect that their premiums will be used to pay for their own health care -- and not have them diverted for other purposes, no matter how noble.

Determining the adequacy of reserves is an analysis that the Board of Trustees, in concert with the Commissioner of Insurance, can make and should make. That is the current law. We in the business community applaud the fact that the local CareFirst affiliate, GHMSI, has methodically improved its finances from bankruptcy in 1992 to today's substantial reserves. Now that the company is on sound financial footing, we ask the Council to consider CareFirst's previous good works and its commitment to increasing those deeds and contributing even more to the Washington, DC community. The DC Chamber implores the District Government to see CareFirst as we do -- as a partner striving to improve the delivery of health care for the uninsured and underinsured citizens of our great city. Our success is intertwined -- we must continue to ensure equality and good fortunes for all.

Thank you for the opportunity to share these comments.



**Testimony of Walter Smith, Executive Director
DC Appleseed Center for Law and Justice**

**Before the Council of the District of Columbia
Committee on Public Services and Consumer Affairs**

October 10, 2008

I am Walter Smith, Executive Director of the DC Appleseed Center. With me are Deborah Chollet from Mathematica Policy Research, and Kurt Calia from Covington & Burling. For essentially four reasons, we strongly support "The Medical Insurance Empowerment Amendment Act of 2008."

1. The Reasons We Support The Bill

First, this bill puts in place a fair, transparent process to ensure that GHMSI meets its public health mission, while at the same time remaining a strong, competitive company. The public is served by a company that does both those things, and the process this bill establishes will help ensure that the company in fact does both.

Second, such a process is particularly appropriate given that every public official addressing GHMSI's performance in the last few years, including the Insurance Commissioners in both Maryland and DC, as well as the Attorneys General in both Maryland and DC, have called into question whether the company is in fact meeting its obligation to the public. Moreover, as Deborah Chollet addresses in her testimony, by every available, objective measure, GHMSI's level of surplus appears to be excessive. If so, it should be reduced to meet its public healthcare obligation.

Third, if in fact GHMSI has not been meeting its obligation to the public, the impact on healthcare in the National Capital area is likely quite substantial. By our calculation, conservatively speaking, GHMSI should have spent between \$50 and \$100 million in each of the last four years on community health benefits, when in fact it has spent only a fraction of that amount.

Finally, establishing a process whereby GHMSI can be a strong viable company and also increase its spending on community health care needs not only protects the public's interest in the company, but it is in keeping with actions taken in other jurisdictions, including Pennsylvania.

My colleagues, Kurt Calia and Deborah Chollet, will more fully discuss the basis of GHMSI's obligations to the community and its ability to meet those obligations. I discuss below more fully the reasons why DC Appleseed strongly supports the bill. But first I want to specifically address CareFirst's stated objections to the bill.

2. CareFirst's Objections To The Bill Are Unfounded

In a statement released to the press and appearing on its website, CareFirst has laid out essentially five objections to the bill. All of them are unfounded.

First, the company contends that the bill "would amount to an additional tax on the premiums of CareFirst BlueCross BlueShield (CareFirst) members, would likely lead to higher health care costs, and an increase in the ranks of the District's uninsured." This contention completely misperceives both the intention and the effect of the bill. The bill does no more than put in place a process for determining whether, given the premiums GHMSI is currently assessing, it has available profits and excess surplus it could commit to community benefits while still maintaining its financial stability and competitive strength. As Kurt Calia explains in his testimony, if the Mayor determines that in fact there are such available profits and surplus, it would necessarily include a determination that those funds could be committed to additional community benefits *without raising rates*. The only way that such a Mayoral determination could lead to increased rates by GHMSI would be if the company improperly attempted to undercut the Mayor's determination through raising rates to replace surplus the Mayor had already determined to be excessive. In other words, the only way the process established by this bill could lead to higher rates for policy holders would be if the company fails to faithfully abide by the process.

Second, the company asserts that in fact "we do not hold 'surplus'" at all because "CareFirst holds reserves which amount to less than \$1000 per member...." The company then says, in any case, "any CareFirst 'surplus'" must be "used first and foremost for the benefit of our members." First of all, as further explained in Deborah Chollet's testimony, it is disingenuous for CareFirst to contend that it has no surplus. As her testimony shows, by every fair, objective measure, GHMSI holds reserves well beyond those of its competitors, well beyond the standard set by the National Association of Insurance Commissioners, well beyond the standard set by the BlueCross BlueShield Association, well beyond national averages for all insurance companies, and even well beyond the reserves of the other entities included within CareFirst itself. And while we agree with CareFirst that it of course has to have reserves adequate to cover claims of its members, the whole point of the process established by this bill is to determine whether GHMSI has more than enough revenues to cover those claims and have surplus left over that could be addressed to its mission of meeting unmet health care needs in the National Capital area.

Third, the company contends that "in the past three years, CareFirst has given over \$100 million dollars to worthy community organizations and causes and we expect to give approximately \$40 million dollars this year alone to such organizations." There are two responses to this contention. It contradicts the company's previous claims that it has no surplus and must devote all of its reserves to its policyholders. In addition, we are aware, as is the Council, that the company has been spending money during the last few years on community benefits. But again, the point of the Bill is to determine whether the company has been spending *all it should be spending*, consistent with remaining financially strong and competitive.

Fourth, CareFirst contends that “the proposed legislation seeks to make CareFirst’s reserves a new revenue source for the District’s budget despite the fact that the overwhelming majority of CareFirst’s subscribers who have paid into our reserves are not residents of the District, but instead live in Northern Virginia and Prince Georges and Montgomery Counties in Maryland.” This statement ignores the fact that the overwhelming majority of GHMSI’s subscribers live or work in the District. More importantly, *none* of the new dollars that this bill might require GHMSI to commit to community benefits would be paid to the District government or become part of the “District budget.” Rather, all such dollars would go directly towards benefiting current or future subscribers within GHMSI’s service area – which includes Prince Georges and Montgomery counties and Northern Virginia as well as the District.

Finally, CareFirst contends that “the tumultuous state of the economy and the events of the last few days painfully demonstrate the importance of ensuring that companies are financially solvent.” No one denies that. Indeed, this bill makes clear that GHMSI’s financial strength must be maintained, and if the company in fact can afford no further community benefits and maintain that financial strength, it will have an opportunity to show that through the process established in that bill. However, as further discussed below, there are compelling reasons to believe that once the process is put in place it will demonstrate that in fact GHMSI can and should be committing significant further dollars to health care needs in the District, Northern Virginia, and Prince Georges and Montgomery Counties.

3. DC Appleseed’s December 2004 Report

In December 2004, DC Appleseed issued a report explaining why we thought GHMSI was not meeting its obligation to citizens of the National Capital area. That report showed, through an opinion from Covington & Burling, that GHMSI has a legal obligation under its federal charter and District law to commit the maximum possible amount of its revenues and surplus toward serving the healthcare needs of current and future subscribers as well as the communities in which they live. The only limitation on that obligation is that in committing that maximum amount the company should maintain its competitive and financial stability. Our report also showed, through an economic and financial analysis performed by Mathematica that GHMSI was falling well short of meeting that obligation. Specifically, the report showed that in 2004 GHMSI could conservatively have provided approximately \$50 million in community benefits when in fact it provided only around \$1 million.

Since our 2004 report was issued, there have been significant developments that we believe demonstrate a critical need for the legislation currently under consideration by the Council.

4. The Attorney General’s Opinions

First, on March 9, 2005, the Attorney General issued a memorandum to the City Administrator explaining GHMSI’s legal obligations. In that memorandum, the Attorney General firmly supported the key legal points we made in our report, although he did not agree with all the details of our report. Specifically, he agreed that:

- (1) “under both District and common law, GHMSI’s assets belong to the public” and “unlike a for profit company GHMSI exists to serve the public” (p. 4);
- (2) under its charter, “GHMSI must operate as a charitable and benevolent institution, consistent with operating for the benefit of its present and future subscribers” and it must “devote its entire operation, directly or indirectly, to serving the purposes for which it was chartered” (p. 2);
- (3) this means that it must act “in a manner that is consistent with the larger ‘charitable’ purpose of promoting better health in GHMSI’s service area” (p. 8); and
- (4) it furthermore means that “GHMSI has an obligation to use its profits and excess surplus to serve the purpose of promoting health in its service area” (p. 8).

Significantly, the Attorney General also gave clear examples of the kinds of things GHMSI could and should be doing to meet this stated obligation. These included: increasing the quality of or benefits in its health plans without increasing rates; providing discounts for subscribers with limited incomes; providing health-related education for subscribers or the general public in its service area; and supporting other organizations that promote health in its service area (pp. 7-8).

The Attorney General elaborated on GHMSI’s surplus in a second memorandum dated August 4, 2005. There, the Attorney General emphasized that the accumulation of surplus is appropriate only “as the *means* of advancing” GHMSI’s mission of promoting public health. (p. 2). The Attorney General also warned that GHMSI “would be acting contrary to its charitable obligation if it made the accumulation of ‘surplus’ an end in itself, or sought to accumulate surplus for a purpose that was not reasonably related to the company’s public health mission.” (p. 2).

Furthermore, the Attorney General stated, “Whether or not GHMSI is, in fact, operating consistently with the charitable, public health mission calls for heightened scrutiny, given the company’s stated position that GHMSI’s sole mission is ‘to operate for the benefit of its subscribers’ and ‘not for the benefit of the public at large.’” (p. 2).

Bill 17-0934 effectively addresses the issues set forth by the Attorney General. It provides for the heightened scrutiny to ensure that GHMSI operates according to its public health mission. It defines the types of community health investments, consistent with the Attorney General’s memo that GHMSI should engage in to satisfy its mission. And finally, the bill creates a fair, transparent, and objective means to determine the appropriate amount to be contributed by the company to public health activities.

5. The Insurance Commissioner’s Hearing and Opinion

After the release of the Attorney General’s first opinion, Insurance Commissioner Larry Mirel held a hearing (on March 24, 2005) to inquire whether GHMSI is in fact meeting its obligations to the community.

Following the hearing, on May 15, 2005, Commissioner Mirel issued a report making findings that are critical to the legislation being considered today. First, he found that “the public health needs of the District of Columbia are extensive and diverse.” (p. 12). Second, he found that “not only does GHMSI have the authority to engage in charitable activity outside the provision of health insurance; it has the responsibility to engage in such activity.” (p. 11). In fact, he determined that “it seems clear that the general purpose of the organization was intended to be the furtherance of the public health.” (p. 12).

Third, he found that GHMSI “can and should do more to promote and safeguard the public health of the residents of the District of Columbia” (p. 2). He added that “the ability of CareFirst and GHMSI to do more for the community than it is doing currently is beyond doubt” (p.19). Fourth, he determined that GHMSI could “reduce its surplus level without negatively impacting financial strength and viability, and the Department believes that could be achieved by increasing financial contributions to organizations, activities, or joint efforts that will advance the public health in the District of Columbia.” (p. 21).

And yet, in the two years following Commissioner Mirel’s recommendation, the company reduced its charitable activities by two thirds, from \$51 million in 2005 to \$15 million in 2006 and in 2007, and increased its surplus by over \$200 million.

Unfortunately, however, from our viewpoint, Commissioner Mirel disputed whether GHMSI had a legal obligation to do any of the things he identified. He said: “GHMSI may satisfy the charitable obligation under its charter solely by providing health insurance in its service area” (p. 10). This, we believe, is directly contrary to the language of GHMSI’s charter, inconsistent with GHMSI’s role as a charitable and benevolent nonprofit, and contradicts findings in the Attorney General’s opinion.

While the Commissioner confirmed our view that GHMSI can and should be spending more on community healthcare needs, his opinion cast doubt on GHMSI’s legal obligations. With Bill 17-0934, the Council can clarify both that obligation and CareFirst’s public health mission.

6. GHMSI’s Community Benefits Plan

According to information provided by GHMSI, in 2005 it spent \$51 million on community healthcare needs in the National Capital area. This was the year in which both the D.C. Attorney General and the D.C. Insurance Commissioner determined that the company could and should be committing more funds to those community healthcare needs. And yet, the amount that GHMSI claims as community benefit contributions in the National Capital area declined drastically from \$51 million in 2005 to only \$14.9 million in both 2006 and 2007.

Moreover, while GHMSI has decreased its community benefit spending since 2005, its surplus has *increased* 34 percent—from \$561 million in 2005 to \$754 million in 2007. GHMSI’s surplus in excess of the minimum capital standard recommended by the national BlueCross BlueShield Association (BCBS) increased 37%—from \$326 million to \$445 million between 2005 and 2007. Furthermore, GHMSI characteristically has held greater capital relative to

regulatory or BCBS minimums than either of CareFirst's Maryland companies. In 2007, GHMSI's reserves were 915% of risk-based capital, while CareFirst of Maryland held 807% and CareFirst BlueChoice held 824% — all more than four times the regulatory minimum and more than twice what BCBS recommends.

Most of CareFirst's claimed community benefit spending in 2005 (\$33.9 million) was the alleged value of the company voluntarily constraining rate increases that year. Despite requests to do so, however, CareFirst has consistently refused to offer evidence showing that slowing premiums that year was in fact a community benefit and not a reaction to the market or a strategy to increase market-share.

There are in fact indications that the claimed \$33.9 million in rate relief was in fact not charitable but a business-related action. First, the asserted rate relief was consistent with the rate relief occurring in the market as a whole. As the Washington Post reported (Sept 15, 2005, p. D2), while health insurance premiums rose 9.2% that year, that represented a slowdown from the increases of 11.2% in 2004 and 13.9% in 2003. Second, there is no indication that the asserted rate relief is of the kind that the Attorney General identified as qualifying for community benefits, *i.e.*, relief targeted at persons of low income who otherwise could not afford insurance. And third, it seems to us significant that GHMSI itself describes the claimed rate relief in its own September 1 filing as a "Business Strategy." (p. 4).

Of course we do not fault GHMSI for engaging in prudent business strategies. We want it to do so; but we also want it to meet its charitable obligations to the residents of the National Capital area.

Bill 17-0934 achieves this purpose in two important ways. First, it makes clear that GHMSI has a public health mission which "it must fulfill by engaging in community health reinvestment." Second, it defines exactly what does, and what does not constitute a community benefit in a manner that is consistent with the findings of the DC Attorney General.

7. The Pennsylvania Model

The circumstances facing DC now with regard to GHMSI are almost identical to the situation faced by government officials in Pennsylvania with regard to the Blue Cross Blue Shield Plans in Pennsylvania. There, as here, significant questions were raised whether the Blues were accumulating excessive surpluses at the expense of charitable obligations; and there, as here, the Blues responded either that they had no charitable obligation, or that the surpluses were necessary for certain contingencies, such as terrorism. (See Carol Pryor & Catherine Dunham, *The Access Project, The Pennsylvania Community Health Reinvestment Agreement: Establishing Non-Profit Insurers' Community Benefit Obligations* 2-6 (August 2006), available at <http://www.statecoverage.net/pdf/monograph0806.pdf>).

In response, the Pennsylvania legislature commissioned a study by the Lewin Group that resulted in an agreement between the state insurance commissioner and the Blues defining both the amount of money that the Blues should spend on community benefits and what activities

would qualify as community benefits. In addition, the Pennsylvania Insurance Commissioner conducted a hearing examining whether the Blues' surplus was excessive and therefore inconsistent with the public interest.

The most recent report from the Pennsylvania Insurance Department (for 2007) shows that three of the four Blues there still have a surplus high enough that the Department limits the amount that they can raise their rates.

The bill before the Committee parallels the features of the Pennsylvania program. The current bill, as in Pennsylvania's program, requires an annual independent assessment of the surplus to determine whether or not there is an excess; provides for the expenditure of excess surplus on community health benefits; and clearly delineates what qualifies as a community health benefit.

In short, far from a being bold experiment, the proposal before the Council is based upon a proven model where excess surpluses are redirected to address the urgent health needs of the community.

8. Maryland Insurance Commissioner's Ruling

In July 2008, the Maryland Insurance Commission overruled a proposed \$18 million severance package for former CareFirst CEO, Bill Jews. Maryland regulators concluded this package is an unlawful departure from the company's mission, in that it was offered as a reward for maximizing profits, not promoting community health. (See Maryland Insurance Administration's Prehearing Statement, *Md. Ins. Admin. v. CareFirst, Inc.*, MIA No. 2007-10-027 6-7 (Mar. 31, 2008); Maryland Insurance Administration's Expert Report, *Md. Ins. Admin. v. CareFirst, Inc.*, MIA No. 2007-10-027 33-47 (Mar. 31, 2008)).

In his final order, Commissioner Tyler affirmed that CareFirst has a "special statutory mission and that, "CareFirst's emphasis on financial performance was at the expense of attention to its public purpose mission." (See Maryland Insurance Administration's Final Order, *Md. Ins. Admin. v. CareFirst, Inc.*, MIA No. 2007-10-027 3, 23 (July 14, 2008)).

As was the case with this recent ruling, Bill 17-0934 provides a regulatory framework that is both fair and transparent to ensure that CareFirst's actions are in keeping with its public health mission.

9. CareFirst/GHMSI's Positions Regarding its Community Benefit Obligations

Earlier this year, CareFirst President and Chief Executive Officer Chet Burrell acknowledged the "important obligation we have to our community at large" in a May 30, 2008 letter to Council Chairman Gray (p. 3).

Mr. Burrell's statements are heartening, given that one year ago, CareFirst/GHMSI stated in a letter to Councilmember Cheh that it has no "legal obligation" to "improve the health of the residents of the Nation's Capital." (David D. Wolf, Interim President and CEO, letter to

Councilmember Cheh, October 10, 2007, p. 4). The company has consistently denied that GHMSI has any charitable obligation separate from its business of selling health insurance, despite the "charitable and benevolent" obligation stated in GHMSI's federal charter, its financial capability to improve community health, and the successful example of a community benefits programs in other jurisdictions such as Pennsylvania.

In 2005, GHMSI's then President and CEO Williams Jews testified before the DC Council at a hearing chaired by Councilmember Graham on an earlier proposal to hold the company accountable. Mr. Jews insisted that GHMSI was like every other health insurer and had no special obligation to address the unmet healthcare needs of the community. (See Testimony of William L. Jews, DC Council Committee on Consumer and Regulatory Affairs Hearing, Oct. 2, 2005, p. 8). Mr. Jews also protested the DC Council's exercise of its statutory oversight and regulatory responsibility over GHMSI, explicitly granted under the company's federal charter, claiming the Council's action "represents an unprecedented intrusion into the governance of a private company's operations." (p. 1).

Bill 17-0934 clarifies whatever confusion may be remaining over CareFirst/GHMSI's mission and obligations. The bill specifies that CareFirst has a public health obligation, enumerates the types of activities and investments that will satisfy that obligation, and creates a fair and transparent process to implement that public health mission in a manner consistent with financial soundness and efficiency.

10. The proposed bill provides a fair and even-handed process for holding GHMSI accountable to the public.

All of the described developments over the past five years raise serious questions about whether GHMSI is meeting its healthcare obligations to the public, or that it fully acknowledges those obligations. We therefore believe the time is ripe for this legislation, that effectively holds GHMSI accountable to the public, and that it does so in a way that is completely fair to the company. It does this in several ways.

First, the bill clarifies that GHMSI has a community-benefit obligation to its service area and codifies the legal standard for meeting that obligation. The bill appropriately declares that "the corporation has a public health mission, which it must fulfill by engaging in community health reinvestment in its service area to the maximum feasible extent consistent with financial soundness and efficiency." (Sec. 2(c)).

Second, the bill provides a definition of community investments that is consistent with examples provided in the Attorney General's opinion. This is an important premise, particularly in light of past uncertainty over what qualifies as community benefits.

Finally, the bill provides that the Mayor must annually examine whether GHMSI's surplus "exceeds the upper bound of its sufficient operating range" and should be applied instead to support community benefits. Significantly, this provision of the bill allows flexibility to respond to changes in the market and economic conditions. Equally significant is the requirement that

community health reinvestment be “to the maximum feasible extent consistent with financial soundness and efficiency.” (Sec. 2(c)). The bill also provides that the Mayor shall determine the appropriate gross premium percentage that the company must devote to community healthcare investments.

Conclusion

We applaud the action of Councilmember Cheh and her 10 co-sponsors in introducing this bill. It puts in place a fair process that will assure that GHMSI – a publicly owned asset—meets its important healthcare obligation to the public, and does so in a way that protects the competitiveness and financial strength of the company.

**Testimony of Deborah Chollet, Ph.D., Senior Fellow
Mathematica Policy Research, Inc.**

**Before the Council of the District of Columbia
Committee on Consumer and Regulatory Affairs**

October 10, 2008

Thank you for this opportunity to testify regarding the Medical Insurance Empowerment Act of 2008. This testimony reflects solely my own opinions, not those of Mathematica Policy Research, its directors, or employees. I am an economist, and have worked with many states on matters related to private health insurance coverage, markets, and regulation.

I would like to address three issues embodied in this legislation, updating information provided in my December 2004 report to D.C. Appleseed:

1. GHMSI's surplus continues to exceed that of other major insurers in the National Capital Area—including other CareFirst companies. The Medical Insurance Empowerment Act would establish a process to determine an efficient surplus range for GHMSI and a level of community benefit consistent with GHMSI remaining a strong and competitive company.
2. There is precedent for this legislation. Since 2005, Pennsylvania's Blue Cross and Blue Shield plans have contributed 1.6 percent of gross premiums to community benefit, under a Community Health Reinvestment Agreement with the state. These contributions support the Pennsylvania's AdultBasic program, which offers affordable health insurance to low-income adults. In addition, Pennsylvania identifies an efficient surplus range for the plans and approves premium increases for all Blues products consistent with efficient surplus.
3. GHMSI voluntarily operates an open enrollment product for District residents who are otherwise uninsurable. Absent some other provision to guarantee access, District residents with health problems could not buy individual health insurance. The Medical Insurance Empowerment Act would re-establish GHMSI's prior obligation to offer an open enrollment product as a component of its community benefit obligation.

Can GHMSI Afford to Spend More for Community Benefit?

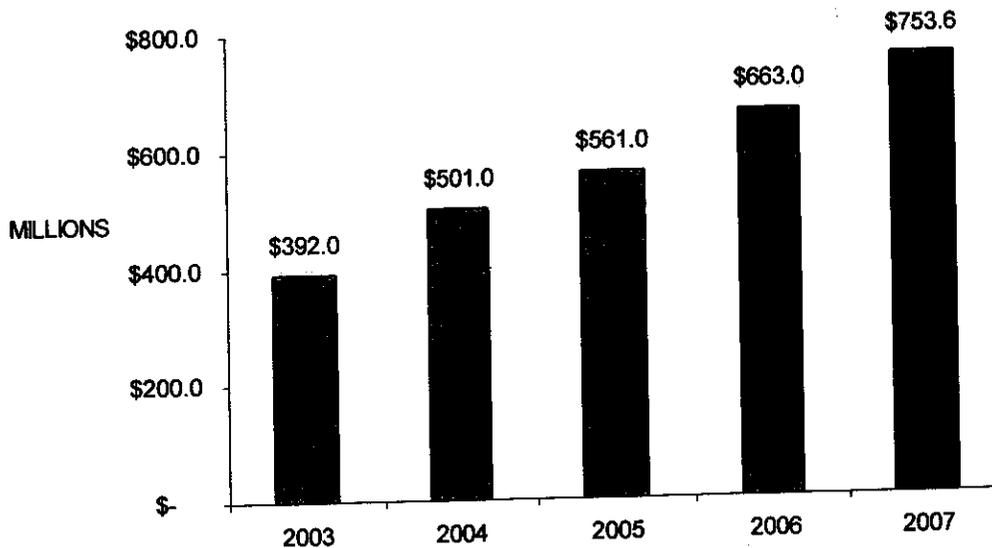
In my December 2004 report to D.C. Appleseed, I concluded that GHMSI could allocate at least 2 percent of gross premium to community benefit and remain financially strong. Three separate considerations all pointed to the same potential standard GHMSI's community benefit:

- GHMSI could spend 2 percent of gross premiums for community benefit simply by not adding to surplus that already was unusually high relative to regulatory standards, other CareFirst companies, and other competitors.

- GHMSI's market power allowed it to set premiums consistently 2 percent higher than its nearest competitor. As documented in our December report, GHMSI is a price leader, and its pricing reflects its market power.
- Other nonprofit insurers spend 1.5 to 2 percent of gross premiums for community benefit. Pennsylvania's Community Health Reinvestment Agreement with its Blues companies uses a similar standard: 1.6 percent of gross premiums.

Since my December 2004 report, none of these findings have changed. GHMSI has continued to accumulate surplus well above its competitors. In each of the past five years, GHMSI has increased surplus, accumulating more than \$361 million in additional surplus since 2003 (Figure 1).

FIGURE 1
GHMSI'S SURPLUS: TOTAL ADJUSTED CAPITAL 2003-2007



Source: Key Annual Statements 2003-2007. Reports for 2008 are not yet available.

Regulators consider insurance carriers' surplus levels relative to a risk-based measure of assets available to pay unanticipated claims. This measure—called Authorized Control Level risk-based capital (ACL)—considers various elements of risk to insurers.¹ Insurer surplus is measured as Total Adjusted Capital (TAC), which is also risk-based.

¹ The NAIC Risk-Based Capital system has two main components: 1) the risk-based capital formula, that establishes a hypothetical minimum capital level that is compared to a company's actual capital level, and 2) a risk-based capital model law that grants automatic authority to the state insurance regulator to take specific actions based on the level of impairment. Based on reviews performed as part of the NAIC Accreditation Program, 47 of the U.S. insurance jurisdictions have adopted laws, regulations or bulletins that are considered to be substantially similar to

The minimum surplus that any carrier may hold is 200 percent of ACL. At that level, regulators act to prevent insolvency. Most insurance carriers in the United States hold surpluses in the range of 350 to 400 percent of ACL, even at the low point in the underwriting cycle.² The Blue Cross Blue Shield Association requires its members to hold at least 375 percent ACL to use the Blues brand. Note that Companies' capital or surplus standards are never measured as dollars per member month. While CareFirst has used such a simple measure for public relations purposes, it is simplistic and fundamentally meaningless.

In 2007, GHMSI's surplus was more than 9 times its ACL—higher than other CareFirst companies and much higher than other major carriers in the National Capital Area (Figure 2). In Pennsylvania, the state's standard for similarly sized Blue companies is 5.5 to 7.5 times ACL.³

(continued)

the NAIC's risk-based capital for Insurers Model Act (http://www.naic.org/documents/committees_e_capad_RBCoverview.pdf, accessed 10/9/08).

Components of the risk-based capital formula include:

- Asset Risk – Affiliates (the risk of default of assets for downstream insurance subsidiaries)
- Asset Risk – Other (the risk of default for debt assets and loss in market value for equity assets)
- Insurance Risk (underwriting risk, including the surplus needed to provide for excess claims, both from random fluctuations and from inaccurate pricing for future level of claims)
- Interest Rate Risk (the risk of losses due to changes in interest rate levels, making it more difficult to synchronize asset and liability cash flows)
- Health Provider Credit Risk
- Business Risk (including the variability of operating expenses, collectibility of payments for administering third party programs, and excessive growth)
- Guaranty Fund Assessment Risk.

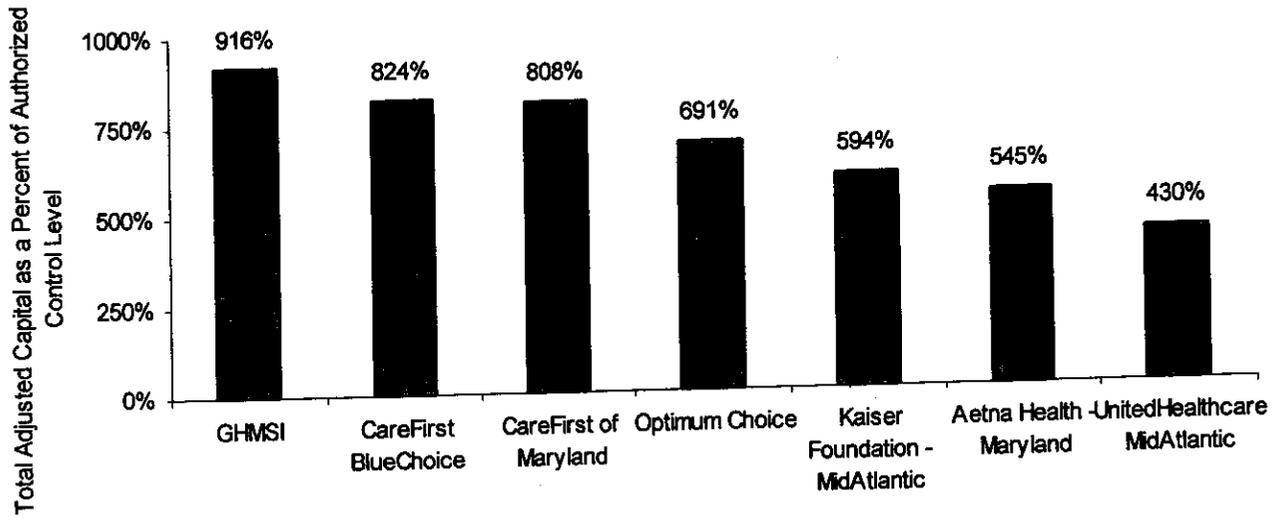
Each formula recognizes the correlation between various types of risk. The greater the number of slices that the total risk-based capital is carved into (asset risk, underwriting risk, etc.), the greater the effect of the covariance adjustment. Therefore, even if the formulas use the same risk factors for the same types of assets and liabilities, the results of the covariance adjustment can produce a difference in the final risk-based capital requirement for each insurance type (http://www.naic.org/documents/committees_e_capad_RBCoverview.pdf, accessed 10/9/08).

² Maryland Health Care Commission, Health Insurance Premiums, the Underwriting Cycle, and Carrier Surpluses, March 2005 (http://mhcc.maryland.gov/spotlight/health_ins_prem_spotlight_0305.pdf, accessed 10/9/08).

³ See: http://www.ins.state.pa.us/ins/lib/ins/whats_new/2004bc/Surplus_Statement_for_2007.pdf, accessed 10/10/08.

FIGURE 2

TOTAL ADJUSTED CAPITAL AS A PERCENT OF AUTHORIZED CONTROL LEVEL
RISK-BASED CAPITAL IN 2007, MAJOR COMPANIES IN THE NATIONAL CAPITAL AREA



Source: Key Annual Statements 2003-2007. Reports for 2008 are not yet available.

The Medical Insurance Empowerment Act would require the Mayor to determine an appropriate level of community benefit for GHMSI each year, as a percentage of gross revenues. To illustrate the potential impact of this type of provision, we calculated the level of surplus that GHMSI would have held if it had contributed 1.6 to 2.5 percent of gross revenues to community benefit each year, from 2003 to 2007, without further increasing premiums. These estimates are reported in Table 1. Table 1 displays GHMSI's actual surplus (TAC), its regulatory standard (ACL), and its gross premium revenue. The additional amount it would have contributed to community benefit and its remaining (net) surplus as a percent of ACL are reported in the "Illustration" columns.

Consider the "total" row at the bottom of the table, which aggregates values for all years from 2003 to 2007. Had GHMSI contributed 1.6 percent of gross revenues to community benefit—the community reinvestment standard in Pennsylvania's agreement—GHMSI would have contributed more than \$183 million to community benefit from 2003 to 2007. It would have maintained an average surplus equal to 744 percent of ACL, without further increasing premiums. In 2007 alone, GHMSI would have contributed \$45 million to community benefit. In contrast, CareFirst projected spending \$14.9 million for community benefit in the National Capital Area in 2007, the same level as in 2006. It has released no estimate for 2008.

TABLE 1
 ILLUSTRATION OF GHMSI'S NET SURPLUS WITH POTENTIAL
 ALTERNATIVE COMMUNITY BENEFIT STANDARDS, 2003-2007
 (All dollars in millions)

	Total Adjusted Capital (TAC)	Authorized Control Level Risk Based Capital (ACL)	TAC/ACL	Total Revenue	Illustration:					
					Community Benefit Spending			TAC/ACL, Net of Additional Community Benefit		
					<i>Community Benefit Standard as a Percent of Total Revenue:</i>					
				1.6%*	2%	2.5%	1.6%*	2%	2.5%	
2003	\$392.0	\$49.8	787%	\$1,891.2	\$30.3	\$37.8	\$47.3	726%	711%	692%
2004	\$501.0	\$52.7	951%	\$2,032.7	\$32.5	\$40.7	\$50.8	832%	802%	765%
2005	\$561.0	\$62.8	893%	\$2,257.4	\$36.1	\$45.1	\$56.4	736%	697%	647%
2006	\$663.0	\$69.4	955%	\$2,457.6	\$39.3	\$49.2	\$61.4	756%	706%	644%
2007	\$753.6	\$82.3	916%	\$2,828.5	\$45.3	\$56.6	\$70.7	693%	637%	567%
Total	\$2,870.6	\$317.0	906%	\$11,467.5	\$183.5	\$229.3	\$286.7	744%	703%	652%

Source: GHMSI Key Annual Statements.

* Equal to Pennsylvania's Community Reinvestment Agreement.

At 2.5 percent of gross revenues, GHMSI would have contributed nearly \$287 million to community benefit from 2003 to 2007, without further increasing premiums. Its surplus would have been much lower—but still within the range allowed in Pennsylvania for its Blues companies of a similar size (550 to 750 percent ACL).

Setting a Standard for Community Benefit and Efficient Surplus

GHMSI's surplus relative to the regulatory minimum has consistently and substantially exceeded that of other CareFirst companies as well as its other major competitors for at least the past 5 years. At a minimum, this pattern raises questions about whether GHMSI's surplus is efficient.

Simple inspection of GHMSI's situation suggests that it might have contributed more to community benefit without further increasing premiums, while still maintaining adequate surplus. But this determination needs to be made carefully by DC authorities who are charged with overseeing GHMSI's rates and financial practice in the interests of the community. The Medical Insurance Empowerment Act establishes a process for doing this.

The Medical Insurance Empowerment Act incorporates key elements of a model that has operated successfully in another state since 2005: Pennsylvania's Community Health Reinvestment Agreement with its Blue Cross and Blue Shield carriers. Pennsylvania's Agreement established the amount of the Blues' community benefit obligation as 1.6 percent of gross premiums. By agreement with the state, these funds are contributed to the AdultBasic

program for low-income adults who otherwise are ineligible for Medicaid or other affordable health insurance. Last month, more than 50,000 Pennsylvanians were enrolled in the AdultBasic program. In the 2007-2008 fiscal year, Pennsylvania's Community Health Reinvestment funds on hand totaled \$103.1 million.⁴

In addition, Pennsylvania's Insurance Department annually determines an efficient range surplus for each of the Blues. The Insurance Department approves rate increases that are consistent with the carriers maintaining efficient surplus.

The Medical Insurance Empowerment Act incorporates both of these key features:

- (1) Annual determination of a standard for GHMSI's community benefit obligation, and
- (2) Annual determination of an efficient range of surplus, with oversight of rate increases that are consistent with GHMSI maintaining efficient surplus.

This combination has worked well for Pennsylvanians.⁵ The Medical Insurance Empowerment Act would use the same combination. It would put in place a process for annual review of GHMSI's surplus, and it would establish GHMSI's community benefit obligation in light of the company maintaining a level of surplus that is efficient.

GHMSI's Open-Enrollment Product in the District of Columbia

The Medical Insurance Empowerment Act would require GHMSI to continue to offer an open enrollment product. Prior to 2007, the District required GHMSI to operate an open-enrollment program for individuals who otherwise would not qualify for coverage because of current or past health problems. GHMSI was required to contribute 1 percent of non-FEHBP premiums to a Rate Stabilization Fund to subsidize premiums in the open-enrollment product. But the amount that GHMSI actually spent from the Fund to subsidize premiums was remarkably low. In each year, GHMSI expended just 11 to 19 percent of its annual contribution to the Rate Stabilization Fund to subsidize open-enrollment premiums. As of June 2005, just 319 individuals were enrolled.

In 2006, the Budget Support Act changed GHMSI's open enrollment obligation. The District required GHMSI to pay the same premium taxes as other insurers (instead of allotting money to the rate stabilization fund), and to continue the open enrollment product only for current enrollees for another five years. GHMSI was not allowed to use money in the rate stabilization fund to subsidize premiums for new enrollees after March 2007.

⁴ [http://www.budget.state.pa.us/budget/lib/budget/\(2008-2009\)_executive_budget_documents/exec_budget/2008_09_executive_budget.pdf](http://www.budget.state.pa.us/budget/lib/budget/(2008-2009)_executive_budget_documents/exec_budget/2008_09_executive_budget.pdf), accessed 10/4/08.

⁵ See: Carol Pryor and Catherine Dunham, *The Pennsylvania Community Health Reinvestment Agreement: Establishing Non-Profit Insurers' Community Benefit Obligations*, August 2006 (<http://statecoverage.net/pdf/monograph0806.pdf>, accessed 10/9/08).

GHMSI has voluntarily continued to operate an open enrollment product for new applicants since March 2007, in the absence of any other arrangement to protect District residents who otherwise could not find individual health insurance. However, CareFirst has apparently continued to subsidize premiums in this product at very low levels, and the product continues to be difficult for consumers to find: CareFirst's web site continues to direct individual applicants to the company's underwritten products or to the very expensive HIPAA product. Overall, CareFirst claims to have spent about \$1.4 million on DC open enrollment in 2007, including new and renewing enrollees. Some of this amount was financed from GHMSI's old rate stabilization fund, not current effort for community benefit.

GHMSI offers the only open enrollment product available in the District. It is important that this product have a benefit design that is mainstream—not so meager that people with health care needs could not afford their out-of-pocket costs, but not so rich that the premium is unaffordable even with a significant subsidy. For this reason, I believe that the benefit design should be benchmarked to the most popular underwritten product that GHMSI offers in the District—one that individuals have found worthwhile to buy and generally affordable. It should be advertised widely—in the print media, on its web site, and through telephone sales representatives. And, of course, the open enrollment product should be affordable. By setting premiums as close as possible to standard premiums for underwritten coverage, GHMSI could make this product a meaningful vehicle for community benefit.

Conclusion

GHMSI's charter charges the District with oversight of a major public asset in the National Capital Area—one that affects the lives of many District residents, as well as our neighbors in Maryland and Virginia. The Medical Insurance Empowerment Act of 2008 would establish the Mayor's responsibility to review GHMSI's surplus, to ensure that it is efficient—neither inadequate or excessive. It would establish GHMSI's accountability to its community benefit mission, recognizing the importance of GHMSI remaining strong and efficient. In both respects, the legislation would follow a working precedent in Pennsylvania, that has the same elements of accountability and flexible oversight, and that has worked well.

Finally, the legislation would attend to a critical issue for District residents—access to individual insurance coverage. In the absence of this provision, residents must rely on GHMSI continuing its open enrollment product in the District voluntarily. This is this only open enrollment product available in the District. Should GHMSI discontinue this product, residents with past or ongoing health problems would have no options for finding coverage in the District.

**Testimony of Kurt G. Calia, Partner, Covington & Burling LLP
on behalf of DC APPLESEED CENTER FOR LAW AND JUSTICE**

**Before the Council of the District of Columbia,
Committee on Consumer and Regulatory Affairs**

October 10, 2008

First and foremost, thank you for this opportunity to testify in support of the Medical Insurance Empowerment Amendment Act of 2008. This important legislation would amend the Hospital and Medical Services Corporation Regulatory Act of 1996 to require the GHMSI board of trustees to cause the company to use its assets to the maximum extent feasible to assist and support public health initiatives, while ensuring that it does so while maintaining financial soundness and efficiency as a health care insurer. I would first like to provide a brief overview of the legal foundation for this important legislation, and then say a few words about the structure of the legislation itself and how it will create a framework for ensuring that GHMSI's commitment to community benefits is finally actualized.

I. Legal Foundation for the Act

Although virtually the entire DC City Council has co-sponsored this legislation and Council members have no doubt satisfied themselves of the sound basis for this legislation, it has been suggested by CareFirst at one point that this legislation is an unwarranted intrusion into the affairs of a private corporation and that the District has no authority to impose the legal requirements set forth in this Act. Respectfully, I disagree. This legislation finds ample basis in the Congressional charter that gave life to GHMSI in 1939 (including its legislative history and amendments), in the ability for the District to govern its own affairs, and in the relevant case law concerning charitable and benevolent entities.

A. GHMSI's Congressional Charter

GHMSI's charter and the legislative history of amendments to the charter make clear that the company has a special status as a charitable and benevolent institution. Specifically, Section 8 of the Congressional charter declares that GHMSI is a "charitable and benevolent" institution. This status goes beyond establishing a premise for tax exempt status -- Congress has plenary power over taxation and has frequently declared entities to be tax-exempt without declaring them to be charitable and benevolent. Rather, this status defines GHMSI's mission. Although Congress has amended the GHMSI charter on several occasions, it has never re-defined this mission, even when it altered the nature of GHMSI's tax exemption some years later. Importantly, in the margin notes of Section 8 of the charter, it states "Purposes declared." In other words, the very purpose of GHMSI is to achieve charitable and benevolent ends. This broad purpose was recognized by the then-Attorney General for the District of Columbia, when he wrote in a March 4, 2005 Opinion: "[GHMSI] cannot fulfill [its] mission simply by allocating a specified percentage of premium ... to 'charitable' activities ... GHMSI is to devote *its entire operation* to serving, directly or indirectly, the purposes for which it was chartered." March 4, 2005 Spagnoletti Opinion, at 2 (emphasis added).

Further support for the proposed legislation is found in a 1993 Amendment to the GHMSI charter that expressly and unambiguously gave the District the power to regulate GHMSI (to the extent that there was any doubt prior to that time).¹ The 1993 Amendment states, in relevant part: "the corporation [GHMSI] shall be licensed and regulated by the District of

¹ This amendment was added in the wake of numerous management missteps in the late 80s and early 90s that placed GHMSI in a precarious financial condition. The legislative history regarding this amendment makes clear that Congress wanted the District's Insurance Commissioner to be able to hold GHMSI accountable for its financial actions.

Columbia in accordance with the laws and regulations of the District of Columbia.” Pub. L. No. 103-107, § 138, 107 Stat. 1336, 1349 (Oct. 29. 1993).² It is thus beyond cavil that the DC Council has the authority to regulate GHMSI. Indeed, the Council has already done so in the past when, in 1997, it enacted the Healthcare Entity Conversion Act (which is set out in the D.C. Code beginning at section 44-601), it found and declared that the assets of a charitable healthcare entity *are held in trust for the benefit of the public* – not for the benefit of the company’s current subscribers only, and certainly not for the benefit of the company’s management or the benefit of any would-be acquiror company that succeeds to the ongoing business operations of GHMSI. District law (D.C. Code § 31-3514(i)) also requires GHMSI to provide health-related education for residents in the company’s service area.

Thus, it is *already the law*, as the Attorney General of the District of Columbia stated in his March 4, 2005 opinion (at p. 4), that “GHMSI’s assets belong to the public” and the company “exists to serve the public.” Indeed, in two separate opinions on the matter by the Attorney General for the District of Columbia, it was concluded that “GHMSI has a legal obligation to devote its entire operation to serving, directly or indirectly, the charitable, public

² It should be observed that the 1993 Amendment to the GHMSI Charter makes clear that it is the District -- and only the District -- that has authority to regulate GHMSI. This is important because in its September 16, 2008 Press Release announcing its opposition to this legislation, CareFirst (GHMSI’s parent company) argues that this legislation purports to make CareFirst’s reserves “a new revenue source for the District’s budget despite the fact that the overwhelming majority of CareFirst’s subscribers who have paid into our reserves are not residents of the District, but rather live [in Maryland and Virginia suburbs].” September 16, 2008 CareFirst Press Release. CareFirst misapprehends the import of this legislation, which in no way limits the revenues dedicated to community health reinvestment to the needs of residents of the District of Columbia only. But in addition, the GHMSI charter makes clear that it is the District -- and not Maryland and Virginia -- that has the authority to regulate GHMSI (on the issue of community health reinvestment or anything else, for that matter). Accordingly, if the District does not exercise its authority and hold GHMSI accountable to its chartered purpose, no one will.

health purposes for which it was chartered.” August 4, 2005 Spagnoletti Opinion, at 1. The Attorney General opinions made clear the District’s legal basis for ensuring that GHMSI stays true to its chartered purposes.

In its recent press release, CareFirst posits that two opinions of the Attorney General of the District support its position that “CareFirst meets its legal obligations by serving its policyholders.” September 16, 2008 CareFirst Press Release. The Attorney General opinions in fact warrant a contrary conclusion -- that GHMSI has a broader obligation to the public, the owner of GHMSI’s assets. Specifically, the March 9, 2005 Opinion states, in relevant part, that under its charter, “GHMSI must operate as a charitable and benevolent institution, consider with operating for the benefit of its present *and future* subscribers,” and it must “devote its entire operation, directly or indirectly, to serving the purposes for which it was chartered.” March 9, 2005 Spagnoletti Opinion, at 2 (emphasis added). In a second opinion, the Attorney General further stated that “[u]ntil GHMSI acknowledges its obligations as a ‘charitable and benevolent institution’ to operate for the benefit of the public, one cannot presume that its corporate decisions are based on ... how best to fulfill the corporation’s charitable purposes” August 5, 2005 Spagnoletti Opinion, at 2. As shown by the press release issued in response to this proposed legislation, GHMSI still refuses to acknowledge its obligations as a charitable and benevolent institution. This, of course, confirms the necessity of this legislation.

B. Authority Pursuant to the D.C. Code

The GHMSI charter is not, however, the only source of authority that supports the District’s ability to regulate GHMSI. The subchapter of the D.C. corporations code related to the creation and operation of a business corporation states, in relevant part:

- (a) The Mayor shall be charged with the administration and enforcement of this chapter. Said Mayor is authorized to employ such personnel as may be

necessary for the administration of this chapter, within appropriations made by Congress.

D.C. Code §29-101.120 (2001). Mayor; duties and functions.

Further, in the subchapter of the D.C. corporations code related to the creation and operation of a non-profit corporation, it says the following:

- (a) The Mayor shall have the power and authority reasonably necessary to enable him to administer this subchapter efficiently and to perform the duties therein imposed upon him.

Id. at § 29-301.93.

Thus, apart from the express authority granted pursuant to the GHMSI charter, as amended, the D.C. Code expressly grants the Mayor the power to regulate corporations, including non-profit corporations.

C. Relevant Case Law on Charitable and Benevolent Entities

Finally, the relevant case law further supports the ability of District to take steps to ensure that GHMSI lives up to its obligation to use its assets for the betterment of the public. Now, it is true that the environment in which GHMSI operates has changed a great deal since its inception in 1939. At that time, providing health insurance was a charitable endeavor, not a commercial one. That has obviously changed -- selling health insurance is essentially a commercial activity, not a charitable one, and one in which private insurers have access to capital markets. But that does not mean that GHMSI is excused from its charitable mission to meet unmet public health needs. That conclusion is contrary to some very basic legal principles (under the law of charitable trusts and the so-called *cy pres* doctrine). Under the law of charitable trusts, GHMSI is obligated to fulfill its commitment to substantially benefit the community -- and not just its current subscribers. The *cy pres* doctrine requires that when it

becomes impossible for an entity to achieve its charitable mission through one set of prescribed activities, it must pursue that charitable mission in another, closely related way.

This makes good sense. While GHMSI may not enjoy the same tax exemptions that it enjoyed when it was originally chartered in 1939, it did enjoy those benefits for a very long time. As we have heard, it is by far the largest health care insurer in the National Capital area, which owes a great deal to the benefits it received as a result of the charter. Those benefits have placed GHMSI -- even in today's competitive market -- and a distinct advantage vis-à-vis competitors; it has had the advantage of being a first market mover, and continues to enjoy the residual, continuing benefits from its historic tax-exempt status. Indeed, GHMSI has enjoyed these benefits for literally decades. Under the *cy pres* doctrine, the contemporary expression of this "charitable and benevolent" entity requires GHMSI to embrace its community benefit obligation even as it operates within a competitive environment. No longer a purely charitable institution given that it sells health insurance and competes with for-profit insurers, GHMSI nevertheless enjoys market power due to its unique history. And with that power comes responsibility -- the responsibility under its charter to make the promotion of public health *the bottom-line charitable purpose of its health insurance operations*. As recognized by the Attorney General, GHMSI must devote its entire operation to that bottom-line purpose, such that all of its excess surplus from its operations as a commercial health insurer is devoted to meeting unmet public health needs. And that is what the proposed legislation will require GHMSI to do.

To be clear, while GHMSI is correct that it has a responsibility to its current subscribers, GHMSI's responsibility does not end there. GHMSI's broader obligation extends to current and potential future subscribers, as is clear from the language of the charter itself and as is consistent with the *cy pres* doctrine and relevant case law. Under the GHMSI Charter, Section

3 states that the corporation shall be conducted for the benefit of “aforesaid certificate holders.” The phrase “aforesaid certificate holders” refers to the groups or persons identified in Section 2 of the GHMSI Charter, including those with whom GHMSI is empowered to enter into contracts or provide for care -- in other words, *prospective* certificate holders.³ In addition, relevant cases make clear that this obligation applies to both current *and* prospective policy/certificate holders - - i.e., the larger community.⁴

Despite its current refusal to acknowledge its legal obligations to anyone other than current subscribers, GHMSI has not always acted without regard to this obligation. During 2002 when CareFirst proposed to convert from non-profit to for profit-status, it acknowledged that its assets belonged to the public in that its conversion/acquisition proposal entailed a plan to pay the value of GHMSI’s assets into a charitable trust. Had GHMSI’s assets not belonged to the public, there would have been no reason to create such a trust. But they do, as further demonstrated by GHMSI’s statement that “it is undisputed that the public ‘owns’ the entire consideration paid by Wellpoint to acquire CareFirst.” Memorandum of Law in Support of The Compensation Arrangements Approved by the Board of Directors of CareFirst, Inc., November 13, 2002, at 15. In many jurisdictions in which conversions have been attempted or completed (e.g., Missouri, Kansas, Minnesota, Rhode Island, Colorado, and Maine), courts have concluded

³ Section 2(c) of the GHMSI Charter states that GHMSI is authorized “to cooperate, consolidate, or contract with individuals or groups or organizations interested in promoting or safeguarding the public health.”

⁴ To the extent that GHMSI may suggest that it is a company more akin to a mutual company that owes an obligation only to its subscriber-owners, rather than a charitable and benevolent institution that owes an obligation to the public, GHMSI is incorrect. As noted by the Attorney General, “[u]ntil GHMSI acknowledges its obligation as a ‘charitable and benevolent institution’ to operate for the benefit of the public, one cannot presume that its corporate decisions are based on ... how best to fulfill the corporation’s charitable purposes.” August 4, 2005 Spagnoletti Opinion, at 2.

that the Blues entities seeking conversion have a charitable obligation as public benefit organizations.⁵

D. The Pennsylvania Model

There is perhaps no better acknowledgement of GHMSI's obligation to the public that by looking to the example of the Blue Cross/Blue Shield health insurer in Pennsylvania. In Pennsylvania, the Blues also accumulated excessive surplus at the expense of meeting charitable obligations, and they also denied that any charitable obligation existed. See Carol Pryor & Catherine Dunham, The Access Project, *The Pennsylvania Community Health Reinvestment Agreement: Establishing Non-Profit Insurers' Community Benefit Obligations 2-6* (August 2006), available at <http://www.statecoverage.net/pdf/monograph0806.pdf>.

As the Council should here, the Pennsylvania legislature evaluated the Blues' obligation, disagreed with the Blues' self-assessment of their obligation, and crafted a solution. Specifically, the legislature pushed for and obtained an agreement with the Pennsylvania Blues to clarify that obligation and set a metric by which it could be achieved. The Pennsylvania agreement between the legislature and the Blues requires the Blues to dedicate a specified

⁵ In an opinion dated May 15, 2005, then Commissioner of the D.C. Department of Insurance, Securities, and Banking, Lawrence Mirel, concluded that the provision of health insurance by GHMSI constitutes a charitable activity under its charter. May 15, 2005 Mirel Opinion, at 9. However, the Mirel Opinion agreed that GHMSI has an obligation to continue to operate as a charitable and benevolent institution and that it "can and should do more to promote and safeguard the health of the residents of the District of Columbia." *Id.* at 2, 7. It is because GHMSI can and should do more that the framework set forth in the proposed legislation is so vital -- to ensure that GHMSI does do more.

Notably, the Mirel Opinion was temporally bracketed by the D.C. Attorney General Opinions that found that GHMSI has a mission to operate for the benefit of the public at large and not merely subscribers. Indeed, the August 4, 2005 Opinion provided perhaps the clearest pronouncement by stating: "OAG's conclusion is that GHMSI has a legal obligation to devote its entire operation to serving, directly or indirectly, the charitable, public health purposes for which it was chartered." August 4, 2005 Spagnoletti Opinion, at 1.

percentage of premium revenues to specific, enumerated community health reinvestment endeavors, and to examine on an annual basis the surplus. As we have heard, the Pennsylvania model appears to be working well. Thus, what this proposed legislation proposes to do is far from an unprecedented intrusion into the affairs of a private company, as GHMSI has at one point claimed. Rather, the proposed legislation finds ample precedent in the Pennsylvania model which has resulted in the acknowledgement of the Blues' legal obligation, a framework for ensuring that obligation is met, with the result that millions of dollars have been spent on community health reinvestment in that state.

II. The Proposed Legislation

A. The Framework for Accountability

So, how does the proposed legislation ensure that GHMSI meets its community benefit obligation? It does so in four ways. First, the proposed legislation defines "community health reinvestment" and thus specifies how GHMSI can use its assets to serve the public that owns them. Second, it makes a series of findings that, in effect, codify GHMSI's obligation to the community. Third, it establishes a framework for how the District will review GHMSI's activities -- and how GHMSI must cooperate in that process -- to ensure that GHMSI is meeting its legal obligation. And finally, it firmly establishes a commitment by GHMSI to the open enrollment program, which was discussed earlier.

I will only elaborate further on the framework that the legislation establishes to promote these goals. Let me preface the description of the structure by stating that it is critical that GHMSI remain a healthy and vibrant health insurance company. Any legislation that would function to impair GHMSI's ability to compete in the marketplace would be a disservice to the citizens of the National Capital area. Accordingly, this legislation has an important safety valve -- whenever there is a metric established for GHMSI's community benefit obligation, the

legislation makes clear that this obligation must be fulfilled "to the maximum feasible extent consistent with financial soundness and efficiency." That safety valve means that during years in which GHMSI can show that spending down its surplus or attaining a certain level of funding for community benefit programs will impair its financial position, regulation of this entity will accommodate the need of GHMSI to remain financially sound and competitively strong.

The proposed legislation requires GHMSI to meet its community benefit obligation through the establishment of two metrics. First, the Mayor will make a determination of a specified percentage of gross premium revenue from all sources that will be dedicated to community health reinvestment (again, to the maximum feasible extent consistent with financial soundness and efficiency). Spending less than the specified percentage creates a presumption that GHMSI has failed to meet its obligations -- a presumption that can be rebutted by clear and convincing evidence from GHMSI as to why the amount GHMSI has actually spent is appropriate under the circumstances. Second, in addition to the percentage of gross premium revenue, the Mayor will also determine the appropriate sufficient operating surplus range for GHMSI -- net the percentage of gross premium revenue for community health reinvestment. Operating above that range will create a presumption (again, rebuttable by clear and convincing evidence) that the surplus is excessive. And as with the gross percentage of premium revenue determination, the surplus evaluation also contains the safety valve that GHMSI must dedicate to community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency.

There is also an enforcement mechanism for this structure. If the Mayor determines that the community health reinvestment obligation is not met, then GHMSI has 90 days to explain why it has not met its obligation and to submit a plan for meeting the obligation.

If the Mayor determines that GHMSI's reasons are insufficient, the Mayor will deny all premium increases for a year and may issue other enforcement orders as necessary.

B. The Necessity of this Framework for Accountability

As shown by the recent CareFirst press release, GHMSI has no intention of voluntarily subjecting its community benefit investment to the scrutiny by the public which owns its assets. Worse, GHMSI has resorted to scare tactics by threatening that in response to a purported "tax" in the form additional revenues mandated to be spent on community health reinvestment, GHMSI would be forced to increase premiums and/or reduce coverage leading to more uninsured.

GHMSI's tactics should be seen for what they are. GHMSI is not at liberty to simply increase its premiums because that ability is constrained by the Commissioner of the Department of Insurance, Securities, and Banking (DISB), which has the authority to regulate premiums. Specifically, the Commissioner has the authority to review premium rates and to disapprove of those it deems excessive and to otherwise address what it perceives to be unjust, unfair, inequitable, misleading or deceptive practices associated with setting rates (among other things). D.C. Code § 31-5107 (2001).

Moreover, the proposed legislation itself reveals the impossibility of GHMSI raising premiums in response to a requirement that it meet its community health reinvestment obligation. First, the framework of the legislation contemplates an examination by the Mayor of community health reinvestment at then-existing premium levels. If the Mayor determines that GHMSI can dedicate more to community health reinvestment at the then-existing premium levels (which it must do to the maximum feasible extent consistent with financial soundness and efficiency), GHMSI cannot simply raise premiums in response -- the determination of its ability to do more was made with full consideration of existing premiums. In other words, at the time of

such a determination, the Mayor will have determined that an additional expenditure is appropriate at the *then-existing* premium levels. Any effort by GHMSI to increase premiums at that point simply represents an attempt to override the Mayor's determination. Second, the legislation makes clear that upon a determination that GHMSI's community health reinvestment obligation has not been met and GHMSI fails to present clear and convincing evidence that it has been, the Mayor will deny all premium increases for a year and may issue other enforcement orders as necessary. Thus, should GHMSI fall short of meeting its legal obligation and thus be required to do more, it will not be able to simply increase its premiums. Its claim to the contrary is illusory and clearly designed to instill fear that rate increases are the inevitable consequence of this legislation. That simply is not the case.

GHMSI's rhetoric underscores the importance of this legislation because there is no assurance from GHMSI, and no history that could provide any assurance, that this company seeks on its own to meet the maximum feasible extent standard. Indeed, to date, GHMSI's public position (reflected in the recent press release) is that it owes no duty to and has no responsibility for anyone other than its paying subscribers -- as though it were a for-profit, private health insurer. No one has asserted that the GHMSI portion of the CareFirst commitment that has been described represents all that GHMSI is capable of doing to meet unmet public health needs in its service area. GHMSI can and should do more to promote and safeguard the health of the residents of the National Capital area.

* * *

Again, thank you for this opportunity to testify in support of this important legislation.



601 E Street, NW
Washington, DC 20049

T 202-434-2277
1-888-OUR-AARP
1-888-687-2277
TTY 1-877-434-7598
www.aarp.org

**Testimony of JoAnn Lamphere, DrPH, Director
State Government Relations, Health & Long-term Care
AARP**

**Before the Council of the District of Columbia
Committee on Public Services and Consumer Affairs**

October 10, 2008

Madam Chair, Council Members and staff, good morning. My name is Dr. JoAnn Lamphere, and I serve as Director of AARP's State Government Relations Health & Long-term Care team. On behalf of AARP's 90,000 members in the District of Columbia, I am honored to testify in support of Bill 17-934, the Medical Insurance Empowerment Amendment Act of 2008.

Securing affordable medical coverage and care is a growing worry for many adults in the District of Columbia and elsewhere in the United States, particularly in today's economy. For those without job-based health benefits or public coverage, and for those who face unexpected or chronic medical expenses, there is little peace of mind. Access to both health and financial security are basic needs we all share. That is why AARP has been advocating at the national and state levels for many years to expand the availability of affordable health coverage. Our organization applauds Councilwoman Cheh for her efforts to bring about improved access to quality health care for all District residents.

Questions have been raised for many years about whether CareFirst (GHMSI) is or is not complying with its not-for-profit mission as a charitable institution and whether it is adequately meeting public health needs of our community – particularly for at-risk populations. It's been estimated that GHMSI has accumulated more than \$745 million in surplus funds.

The Medical Insurance Empowerment Amendment Act would allow the Mayor to set an "appropriate surplus range" and establish a specified percentage of surplus revenues to be invested back in to the DC community for community health purposes, such as health coverage for low-income, uninsured, and underinsured individuals; subsidies for public health provider programs; and other approved health care programs. Reinvested funds would also be utilized for health coverage programs, including Health DC and Medicaid, along with other programs that provide affordable and accessible insurance for individuals. We strongly support this community health reinvestment.

Of even greater importance to our members is assuring that the Open Enrollment program will continue without interruption. Hard working individuals in our community are struggling to make ends meet and often cannot afford medically underwritten coverage in the open health insurance market if they have chronic medical conditions. The high cost of insurance is one of the reasons the District of Columbia has so many residents who forgo necessary coverage and health care. That is why it is so important to extend the District's requirement that CareFirst (GHMSI) maintain indefinitely its Open Enrollment program, rather than allow it to expire in December 2010. The bill also establishes critical affordability and adequacy criteria for the program to assure that annual premiums don't exceed 125 percent of standard market rates. Both of these measures, open enrollment and affordability protections, will go far in helping DC residents achieve improved and more secure health and financial protections.

The legal obligation of CareFirst (GHMSI) to provide charitable benefits to Washington, DC residents may mean little without clear standards or enforcement by the District government. AARP believes that it's important for the District of Columbia to ensure that CareFirst 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 in a financially viable way.

In summary, this bill will give the Mayor the ability to set targets for community health reinvestment by CareFirst (GHMSI) and provide improved assurances of health coverage and care to members of our community that so desperately need it.

Thank you for the opportunity to convey AARP's support for Bill 17-934, the Medical Insurance Empowerment Amendment Act of 2008.

**Testimony of Cheryl Fish-Parcham, Deputy Director of Health Policy, Families USA
On Bill 17-934, the "Medical Insurance Empowerment Amendment Act of 2008"
October 10, 2008**

Thanks for holding this hearing today. Families USA is a national consumer health advocacy organization. I applaud the city for working to ensure that individuals will be able to buy coverage, regardless of their health conditions. This bill takes the necessary steps to continue and improve the open enrollment program provided by CareFirst.

In my work, I take calls from consumers around the country who face health insurance problems. If the District does not take the steps to protect individuals that are set forth in this bill, its residents will face similar crises. Particularly heartrending are calls from people in Georgia and Florida who have absolutely no place to go to obtain coverage. I have spoken to people who were turned down by insurers for seemingly minor conditions – a woman who took antidepressants five years ago; a child who was below-average height that insurers feared would require growth hormones. I also talked to people with major problems, such as cancer or heart disease, as well as hemophiliacs who can lead relatively healthy, long lives if they receive very expensive blood factor to help their blood clot, but who will die without it. Because conditions like hemophilia are rare, the drugs to treat them are affordable only if costs are spread among the whole population, but the costs are totally impossible for an individual to bear alone.

This bill does several important things for the high-risk population in the District of Columbia:

- It continues CareFirst's "open enrollment" program indefinitely, guaranteeing people access to health insurance. If this bill is not enacted, current law allows CareFirst to stop selling open enrollment policies to new people, to raise rates, and to end the open enrollment program for current enrollees in 2010, leaving high-risk individuals with no place to buy health insurance.
- It requires advertisement of the open enrollment product. This is extremely important. Subscribers in this plan grew from about 200 people a few years ago when open enrollment was not advertised to 1,000 people when it was advertised. This August, CareFirst finally began posting information about open enrollment on the internet, which will help people find it.

★ } It prohibits annual benefit maximums and lifetime service limits. Right now, the open enrollment policy has a \$1,500 annual drug cap, which is insufficient to meet the needs of individuals with high health care risks.

- It bases both benefits and premiums on standard policies, with premiums capped at no more than 125 percent of standard individual market rates. As we have looked at insurance programs for this population around the country, we have found that states like Maryland and Minnesota that keep premiums within these caps do a much better job of enrolling high-risk people who would otherwise be uninsured than do states with higher premiums.

There are two more improvements that we suggest for the high-risk population.

- 1) Prohibit or curb pre-existing condition exclusions. Such exclusions should be barred or, at a minimum, outside time limits, as short as possible, should be placed on them. Currently, CareFirst's open enrollment policy does not medically underwrite and does not exclude coverage of pre-existing conditions for any period of time. However, in past years, CareFirst did sell people policies that excluded coverage of pre-existing conditions for 10 months, and this discouraged enrollment. Why, after all, would you pay monthly premiums for 10 months for a policy that did not cover the things you most need? Current DC law is silent on whether or not Carefirst can impose pre-existing condition exclusions in its open enrollment product. There are debates in policy circles about whether exclusions are needed to deter people from gaming the system and waiting until they are sick to buy coverage. However, no data show that this is a problem in the District nor do any studies discuss whether the expense of medical underwriting is worth the pain it causes to consumers. At the moment, CareFirst's open enrollment policy seems to be working fine without any pre-existing condition exclusion, so it should be kept that way; the Council should have oversight and the public should have an opportunity to comment if a change is ever contemplated.
- 2) Ensure reasonable pricing of HIPAA policies. Currently, the bill encourages CareFirst to consider subsidizing HIPAA policies as a possible community health reinvestment, but does not require CareFirst to do so. We understand that CareFirst now prices the HIPAA policies by looking at the risks of the individuals insured in the HIPAA products alone, and they are thus two or three times the standard rates. For people aged 55, the HIPAA low-option PPO plan costs \$1,171 per month and the high option plan costs \$1,715 per month – clearly not a price that many people can afford. We suggest using the same premium cap for these policies – 125 percent of standard rates – that the bill requires for open enrollment plans.

This bill also takes important steps to oversee GHMSI/CareFirst's obligations to the community. In other jurisdictions, state insurance departments have taken surplus into account when

reviewing insurers' rates and market conduct. In September, Rhode Island reduced a Blue Cross plan's proposed rate increase by considering, among other factors, the amount of surplus it held and the amount that proposed premiums would contribute to the surplus. The Colorado insurance commissioner and Kaiser Permanente reached an agreement this summer that Kaiser would issue premium credits to subscribers, build new medical facilities in Colorado, and expand a "Medical Financial Assistance Program" that assists low-income subscribers with copayments and cost-sharing. That agreement was the outcome of the Colorado insurance commissioners' financial examination of the company, which showed that Kaiser's net worth was steadily increasing and the company had much more than it needed in reserves. In Pennsylvania, the Blue Cross plans help to fund coverage for low-income adults. In DC, GHMSI is chartered as a charitable and benevolent institution, and it should be using its excess surplus to serve the community.

We have many unmet health care needs in the District. I hear from consumers about gaps in mental health care and coverage, disparities in the quality of care and health outcomes in various parts of the city, and the expense of caring for children with special needs who may have coverage but whose families still pay a great deal out-of-pocket for uncovered services. Our excellent public coverage programs need diverse funding so that those serving adults who do not qualify for Medicaid are not entirely reliant on the District's general revenues. GHMSI can and should use its resources to assist with these community needs.

**TESTIMONY OF ROBERT F. VAN DYKE
BEFORE THE DC COUNCIL
ON THE MEDICAL INSURANCE EMPOWERMENT ACT OF 2008
BILL 17-0934**

My name is Robert Van Dyke. I have been resident of the District of Columbia for over 20 years. During that period, I have worked in the health care industry for three largest health insurance companies in the United States -- Aetna, CIGNA, and United Healthcare. But I have also been on the other side of the table. I worked for health care providers, such as MedStar Health, owner of the Washington Hospital Center and represented them in negotiations with insurance companies. A few years ago in 2003, I served as a consultant for Maryland Health Insurance Plan. My assignment there was to recruit providers to participate with MHIP, a program designed to help Maryland residents obtain, affordable health care coverage. I currently work for RealMed, a health care technology company that offers a service to physicians and hospital which accelerates cash flow and increases efficiency and productivity in insurance billing and collections. I am here today because I thought it was important to share my perspective on the proposed legislation with you.

CareFirst is a not-for-profit company. They provide affordable access to health care coverage to people in the District and throughout the region. CareFirst has deep roots in this area and has demonstrated their commitment to our community and its subscribers. Let me provide some examples.

In 2007, CareFirst contributed more than \$32 million to benefit communities in D.C., Northern Virginia and Maryland. This included direct support to over 300 charitable organizations and health care causes. Over the past three years, CareFirst has contributed over \$100 million to programs and initiatives that expand access, affordability, quality and safety in health care. This included support of a unique program here in the District with YMCA to fight childhood obesity.

Here is my favorite example of CareFirst's contributions to our community: Some of you may be familiar with an organization called Community Council for the Homeless at Friendship Place. I have been involved with CCH thorough family, friends and fellow church members. CCH customers are often referred to Unity Healthcare. I was very pleased to hear this past summer that CareFirst provided Unity Healthcare with support for new dental services for District's homeless residents.

Without a doubt, no other health insurer approaches this level of commitment to our community. In fact, based on my experience, the for-profit health insurance companies that I worked for in this area are more focused on shareholder value (i.e. their stock price and earnings) and keeping provider reimbursement as low as possible versus making donations to health care causes in our community.

*Are there any other
NFP insurers w/ a \$760m
sup*

In conclusion, while I support the need to increase access to health care, I believe this legislation will end up causing premiums to increase for those people who can least afford it. Ultimately, some people will be forced to drop their coverage. And we don't need more uninsured people in DC -- or anywhere for that matter.

CareFirst has demonstrated significant history of contributions to the District, its residents, and our community. Thus, I strongly believe the proposed legislation is not a good direction for the District of Columbia. Thank you for your time.

Respectfully Submitted By:

Robert F. Van Dyke
4453 Faraday Pl, NW
Washington, DC 20016
Email: rvandyke@aol.com
Phone: (202) 365-8170



Testimony

Bill 17-934, the "Medical Insurance Empowerment Amendment Act of 2008"

October 10, 2008

Committee on Public Services and Consumer Affairs

The Honorable Mary Cheh

By

**Sharon Baskerville
CEO, DCPCA**

Good afternoon Chairman Cheh and distinguished members of the committee. My name is Sharon Baskerville, CEO for the DC Primary Care Association (DCPCA). DCPCA represents safety net providers and other key stakeholders who are committed to our mission of creating a community based, primary care focused health care system that guarantees DC residents the right care, in the right place, at the right time. I am here today to talk about the Medical Insurance Empowerment Amendment Act of 2008.

Introduction and History

CareFirst is a not-for-profit health care company which administers a comprehensive portfolio of health insurance products through the Group Hospitalization and Medical Services, Incorporated. The Group Hospitalization and Medical Services, Incorporated better known as GHMSI, is an independent licensee of the Blue Cross and Blue Shield Association and has a strictly defined region (known as a service area) in which it can operate. GHMSI's service area includes: 1) Maryland; 2) the District of Columbia; 3) the cities of Alexandria and Fairfax; 4) the town of Vienna; 5) Arlington County; and 6) the areas of Fairfax and Prince William Counties in Virginia lying east of Route 123. GHMSI was chartered by Congress in 1939 as a "charitable and benevolent institution". It was the intent of Congress that the provision of health insurance is charitable for the purposes of the charter. Simply put, GHMSI's charitable obligation is to the public at large. Through much debate and scholarly research, this issue has reached a level of community consensus about GHMSI's obligation and willingness as a non-profit

organization to provide charitable benefits for community health reinvestment. That level of community consensus is what brings us here today.

CareFirst not only operates as a health plan in the District of Columbia, but it also provides coverage to the residents of Maryland, Delaware and Virginia. Over the last several years, protecting the rights of patients has been the interest of all four of these regions. However, there is ample room for aggressive efforts in maximizing community benefit for all. What is evident is GHMSI's excessive \$745 million surplus. To put this in perspective, this figure is larger than CareFirst's other area affiliates in both Virginia and Maryland. Moreover, CareFirst GHMSI's reserves are larger than any of the other BlueCross BlueShield organizations in the nation.

In an attempt to balance the scales, Bill 17-934, "the Medical Insurance Empowerment Amendment Act of 2008" is being offered for public dialogue and discussion. While DCPCA believes this is a strong bill in the right direction towards Community Health Reinvestment, we have questions regarding the implementation plan of how this goal will be achieved. The Mayor will have executive authority to administer funding towards community health reinvestment however, what remains unclear is how this law will be implemented. Some analysts believe that the District Government does not have the strongest track record in managing investments for DC residents effectively. DCPCA is asking for appropriate and responsible planning and oversight for administering

health care funding for our constituency. We therefore would like to offer the following questions that should be of concern:

- What specific role would the Mayor and City Council play in the strategic planning of community health reinvestment?
- Is there a more well defined model of the process for determining the allocation and for the subsequent targeted investment?
- How would we eliminate biases and create transparency in the allocation of funds once this plan is in place?
- How would we provide for accountability and oversight that reflects strong community consensus?
- What are the concerns, if any, from the surrounding areas to include Maryland and Northern Virginia that the Mayor may be overstepping jurisdictional boundaries? If so, how will we address these?

OPEN ENROLLMENT

This legislation reinforces GHMSI's mission to reinvest in the community's health "to the maximum feasible extent" as well as strikes an important balance to ensure that they remain financially viable so that it will continue to provide and expand coverage to the residents of the District. Most importantly, it also holds GHMSI, the largest insurance provider in the District with a \$745 million surplus, accountable to its nonprofit mission.

The provision of the bill requires GHMSI to promote and provide substantial community reinvestment in health coverage for low-income, uninsured, or underinsured persons. It is critical that the health care product is affordable and that the subscriber contracts do not contain service limitations. It is important that GHSMI make available affordable premiums and to adequately market their health products as an enhanced benefit to low-income subscribers.

The bill has several broad areas that would focus community reinvestment. We would hope to participate in the process of advising the District government on where investment will have the greatest impact to effectively assist stakeholders and subscribers in the Washington-Metropolitan area.

CLOSING

Through on-going mutual efforts, I have been working with CareFirst over the past several years to improve their community investment. They have provided \$1.5 million over three years to fund the Medical Homes DC Quality Transformation project. They have been participating in the DC RHIO efforts as part of what we view as a potential critical role they can play in the future of Health Information Exchange in the region as a sustainability partner. I look forward to working with Chairwoman Cheh and the members of the Committee on Public Services and Consumer Affairs to ensure that the bill's goals of transparency, public accountability, and equity are achieved. In addition, I look forward to helping to determine the appropriate mechanism and participating in

the strategic planning for community health reinvestment. A long-term transformational investment is needed to address DC's health care needs. In order to achieve systemic change, a steady stream of funding is needed to increase access to care and improve health outcomes in the District. This is one strategy by which we may move forward productively to improve the overall health of a community who needs a guarantee to access to quality health care and the elimination of disparity in their health outcomes. We also must guard the financial viability of this major insurer in troubled economic times. I know there is a commitment on behalf of this government to do both

Thank you for the opportunity to testify on this important issue. I am happy to answer any questions you may have.

Testimony
Public Services and Consumer Affairs Committee
Council of the District of Columbia
October 10, 2008
DC Coalition on Long Term Care/IONA Senior Services

My name is Vera Waltman Mayer. I appear today as the Senior Advocate for IONA Senior Services and as the Coordinator for the DC Coalition on Long Term Care and as the Senior Advocate for IONA Senior Services. I am accompanied by Theodore A. Burkett who will present information on his problem with CareFirst due to his high cost health needs. IONA's health insurance expert was unable to find any affordable insurance for him.

We welcome this opportunity to address the Committee on the unmet health needs in the District and how CareFirst could be of great assistance. IONA Senior Services is the lead agency for the DC Office on Aging west of Rock Creek Park but providing a variety of services throughout the city to enable seniors to live in the community with independence and dignity. The Coalition consists of consumers, advocates and DC health care providers whose common mission is to assist the DC government in the development of long term care options for low-income DC residents with chronic health care needs. Fundamental to the missions of both IONA and the Coalition is the development and expansion of a home care workforce with living wages and health benefits who can assist seniors and persons with disabilities with their basic activities of daily living to remain in their own homes.

Despite successful advocacy to increase their hourly wages, home care workers are still unable to afford health benefits and are forced to rely primarily on hospital emergency room care. Home care workers whose income are between 200% to 400% of

the Federal Poverty Level cannot qualify for either the DC Alliance or Medicaid. One non-profit home care agency which pays 60% of the premium for its employees, has found that only 30% of its employees can afford to participate.

Therefore, most of these workers in the health field either go without health care or seek emergency room care when sick. The lack of health benefits for these vital workers has multiple consequences for themselves, their families, their clients and the District: (1) loss of wages and primary health care for the home care workers often resulting in chronic diseases; (2) discontinuity of care for their clients; ^{workers not easily replaceable} and (3) costly emergency services and avoidable hospital admissions for both the workers and their clients, mostly financed by the District and Federal governments.

CareFirst could make an important contribution to resolving these problems by applying its surplus ^{reserve} funds to: (1) enable the DC Alliance, currently entirely dependent on local DC funding, to increase its benefits and its coverage; and (2) contribute to the proposed DC program to subsidize uninsured DC residents with incomes between 200%-400% of the Federal Poverty Level. Another great health-related need is funding for transportation to medical appointments and treatments..

Thank you very much for your important efforts to extend and improve health benefits to DC residents.

Testimony
Public Services and Consumer Affairs Committee
Council of the District of Columbia
October 10, 2008 Hearing
Theodore A. Burkett

My name is Theodore A. Burkett and I live in Ward 3 in Tenleytown of Washington, D.C. My employment at Sterling Optical on Pennsylvania Avenue, NW was terminated on March 31, 2008 when the store where I had worked for many years was closed for extensive building renovations.

I had CareFirst health insurance which was fully paid for by the store's franchise owner. The benefits were good and co-payments for doctor visits and medications were reasonable.

Because it is mandatory for me to have good coverage, I requested a policy identical to my current one but it was denied to me and was replaced with one with high co-payments and a limit on benefits received.

I am seeking a policy which would return me to the original one I had when I was working at a reasonable cost.

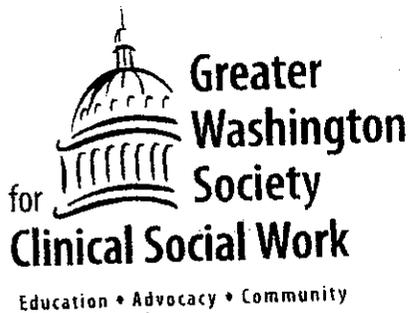
Under their plan I currently pay the first \$100 of medication then CareFirst starts paying until the cost reaches \$1,500. When I reach \$1,500 deductible, I have to pay the rest, which amounts to approximately \$18,800 for the year. So basically, CareFirst pays only about \$1,400 for my medicine annually which is less than I pay for one month's worth of medication. The total cost for the year out of my pocket is \$20,200.

For my doctor bills, I pay the first \$750 after that CareFirst pays 80% up to \$3,500 per year and I pay 20%. After the \$3,500 is reached I have to cover all doctors' expenses.

Total out of my pocket cost for the year as of October 9, 2008 has been \$14,392.35. At the same time, I paid CareFirst \$ 5,800 in premium, and they have only covered \$1,400 in medicine cost. For the Doctor's cost, my share has been \$750, while CareFirst only paid \$133.47.

The question I ask is the \$5,800 I pay in premiums for the first 10 months of the year, Carefirst has only paid out \$1,533 in benefits for me. I have given them \$5,800 in premiums and they have only paid \$1,533. The absolute maximum that CareFirst will ever be required to pay is \$1,500 for medicine and \$3,500 for Doctors expenses, a total of \$5,000, while my premium for 12 months would be \$ 7,056. That figures to be about \$2,056 profit out of my total premium and their cost of only \$5,000.

I would appreciate help in paying for my health care. Thank you very much.



PO Box 3235, Oakton Virginia 22124 ♦ 202-537-0007 ♦ www.gwscsw.org

Testimony

before the
Council of the District of Columbia
Committee on Public Services and Consumer Affairs

Bill 17-934, the "Medical Insurance Empowerment Amendment Act of 2008"

Friday, October 10, 2008

The Greater Washington Society for Clinical Social Work is pleased to be here today to testify in support of Bill 17-934, the proposed Medical Insurance Empowerment Amendment Act of 2008. The Society has a membership of over six hundred licensed clinical social workers at the masters and doctoral level in the DC metropolitan area, in hospitals, social service agencies, non-profit centers, mental health clinics, schools, and in private practice.

We clinical social workers see at first hand the impact of lack of access to affordable, quality health and mental health care on such troublesome District concerns as HIV/AIDS, domestic violence, gangs, teen pregnancy, child abuse and neglect. Bill 17-934 requires CareFirst to apply its huge excess surplus to community health reinvestment, providing health coverage for low-income, uninsured, or under-insured persons; through subsidies for public health provider programs, and with other community healthcare-related expenditures approved by the Mayor. The Bill provides clear direction for this non-profit insurer, which has for so long taken all the benefits of its federal charter as a "charitable and benevolent institution," to at last take responsibility fulfilling the charter's mandate.

The Bill will require CareFirst to maintain an Open Enrollment program for those who cannot qualify for a group or public healthcare plan, and sets standards for affordability and adequacy; it protects against annual and lifetime caps. In our experience, such controls are appropriate and very necessary: we have clients

(over)

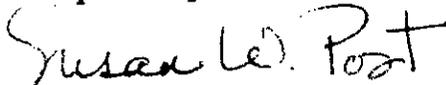
whose only possibility of continuing coverage after COBRA is exhausted is priced at \$1000 and up per month; we have others whose premiums are affordable but, given deductibles of over \$2000, permit coverage only in case of catastrophic illness.

Two concerns remain.

- First, we urge that the standards for adequate care set by the legislation address expressly prevent refusal or delay of care for so-called "pre-existing conditions." } Pre ex
- Second, we ask the Council to be aware that maintaining an adequate provider network will require, at the very minimum, reimbursement rates comparable to Medicare rates, and urge the Council to address this issue. At present, CareFirst is well known among providers both for the extraordinarily generous remuneration packages it offers its executives and board members, and, at the same time, for the nickle-and-diming approach it takes to provider reimbursements. Increasingly, experienced providers are leaving the CareFirst panels with the complaint that they cannot afford to practice at the contractual rates. \ mental health reimbursement rates

In closing, we applaud the Council for taking this step to hold CareFirst to its moral and ethical responsibilities as well as its legally mandated obligation to promote community health, we urge you to take the additional steps, and we thank you for the opportunity to comment on this bill.

Respectfully submitted,



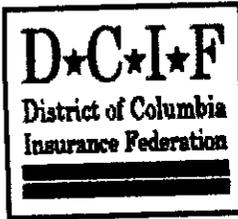
Susan Post, LICSW
President



Margot Aronson, LICSW
Vice President for Legislation and Advocacy



Mary Lee Stein, LICSW
DC Legislative Committee



DISTRICT OF COLUMBIA INSURANCE FEDERATION

P.O. Box 34757 Washington DC 20043

e-mail: wmcowen@dcif.org

Tel: 202.797.0757; Fax: 202.797.0758

Testimony of

District of Columbia Insurance Federation

before

The DC Council Committee on Public Services and Consumer Affairs

10 October 2008

Bill 17- 934 "Medical Insurance Empowerment Act of 2008"

Good morning Chairperson Cheh, members of the Committee on Public Services and Consumer Affairs and staff. My name is Wayne E. McOwen. I represent the District of Columbia Insurance Federation (DCIF), a state insurance trade association whose members provide property, casualty, life and health insurance products and services to residents and businesses in the District of Columbia. On behalf of DCIF, I am pleased to offer remarks with regard to Bill 17- 934, the "Medical Insurance Empowerment Act of 2008."

DCIF member companies work together to create progressive and balanced business and regulatory climates that enable insurers, agents and brokers to provide quality, affordable insurance coverage to District consumers. A component of that objective is the avoidance and/or elimination of onerous and unnecessary laws and regulations that make it more difficult for insurers to operate, thus potentially increasing costs to consumers. It is in this context that I offer comments before this Committee today on 17-934.

As an organization representing diverse segments of the insurance industry in the District of Columbia, DCIF believes this bill is both onerous and unnecessary owing to mechanisms currently in place and which follow universally recognized processes for the protection of consumers:

- The chief regulator in all jurisdictions – in this instance the DC Insurance Commissioner – is required to review, and has inherent authority to approve or disallow, insurer-proposed rate levels by a process which ensures the adequacy of capital reserves held for the protection of policyholders. That rates are approved by the chief regulator speaks to the adequacy of reserves.**
- Regulators follow a process which includes a Risk Based Capital analysis, a tool essentially enabling the evaluation of the potential for financial risk via mathematical calculation. Industry accepted formulas operate as an "early warning system" to identify potential financial pitfalls and benchmark levels for regulatory intervention. In extreme cases the regulator is empowered to take over a troubled company and may initiate rehabilitative processes. But, it is important to note that every company risk profile is different. Thus, "meeting the numbers" is not the same for all carriers. Similarly, every dollar above RBC limits may not necessarily be "excessive."**
- Like other corporate entities insurers are governed by a Board of Directors with the fiduciary responsibility for ensuring the financial soundness of their company. They are charged with making decisions regarding rates and reserves, as well as how much the company can afford to contribute in good works to the community. Most importantly, the fiduciary responsibility of directors comes with legal accountability for ensuring the reasonableness of cost**

projections and claims trends, and for setting rates sufficient to cover these costs.

- Annual Yellow Book filings, documenting the financial condition of insurers, require sign-off by independent actuaries attesting to the validity of management recommendations and, most critically, that reserves are adequate – neither understated nor excessive.
- Public hearings enable multiple stakeholders to weigh-in on prospective rate changes, ensuring that consumers have a voice in the process.

Of course there are other factors to consider. Profit versus not-for-profit status influences the above mechanism. But, like all companies selling a product or service, a loading is built into the price. For insurers, this loading enables the accumulation of reserves over time. For non-profits this loading may be their only avenue by which to secure future operations to the extent such companies may not have access to the traditional financial resources available to for-profit entities. In the case of health insurers, this may mean that the accumulation of reserves through policyholder premiums is the only way to attempt to keep pace with medical inflation (reportedly growing at an estimated rate of 12 – 15%) as claims spike up; and it may be the only way to protect itself from the catastrophic exposure of a pandemic. *(New to year?)*

said 10% out food...

As we have seen in recent weeks, the financial fortunes of even very large companies can change quickly. At a time when the financial markets are in total chaos because of a lack of capital, does it make sense for the District to abandon traditional solvency analyses to set arbitrary limits on insurer reserves? Does it make sense to potentially risk policyholder protections? Does it make sense to risk reduced availability, the unintended consequence of the perception of DC as a seemingly less competitive, less business-friendly environment? This is not a message worth sending.

In summary, we believe this bill is unnecessary and inappropriate to the extent it appears to require a new process as if a process does not now exist. Through the functions of the Chief Regulator, the company Board of Directors, and the consultative oversight of the actuarial community, reliable mechanisms are in place to provide appropriate and critical protections for consumers.

Thank you for this opportunity to provide comments. I would be pleased to answer questions regarding any aspect of my testimony.

Date: October 10, 2008

Event: Committee on Public Services and Consumer Affairs – Hearing

Agenda Item: Medical Insurance Empowerment Amendment Act of 2008, Bill 17-0934

Statement by:

James F. Brown, Director of Health Services, The Actors Fund, 729 Seventh Avenue, 10th Floor,
New York, New York 10019 212-221-7300 x166 jbrown@actorsfund.org

My name is Jim Brown. I'm the Director of Health Services at The Actors Fund, a 126 year old national human services organization that works with people in entertainment and the performing arts. My own background is in health insurance – I was a contract negotiator and regional manager for several health insurance companies, including Aetna and Empire Blue Cross, and a regulator of managed care plans at the New Jersey Department of Banking and Insurance – and in arts education – I was a professor at New York University's Tisch School of the Arts for 14 years.

In 1998, The Actors Fund created the Artists Health Insurance Resource Center with grants from the National Endowment for the Arts and The Commonwealth Fund in response to the high rate of uninsured among visual and performing artists – 30% in most surveys, i.e., twice the national rate and equal (according to the 2000 census) to the rate of self-employed people. The Center consists of a heavily-visited website of resources (ahirc.org) for getting health insurance and affordable health care, phone and in-person counseling, outreach seminars at arts organizations throughout the country, and a full-time free health clinic in New York City.

I'm testifying today in strong support of the Medical Insurance Empowerment Amendment Act of 2008 because it speaks directly to the needs of the population of artists we work with in the District of Columbia, among them dancers, musicians, writers, and painters. Both in its requirement for a continuation of an affordable and accessible open-enrollment program and its promotion of community reinvestment funds that can be used, among other options, to support primary care clinics, or "medical homes," and for premium subsidies (Healthy DC), the bill addresses the key problems our constituents face in obtaining health care – access and cost.

In New York, reinsurance (essentially a subsidy) has been successfully used to lower premiums by two-thirds in the Healthy NY program and thereby reducing the number of the working uninsured. For those still unable to afford insurance, The Actors Fund opened a full time free clinic in 2005 for the uninsured in entertainment and the performing arts which has become part of the essential network of community clinics in the city. Every patient who uses the free clinic also receives counseling on obtaining health insurance.

As we see it, there are two critical advantages to maintaining an open enrollment program with affordable premiums. First of all, the options for purchasing guaranteed-issue health insurance have shrunk radically over the past ten years for artists who, again like the self-employed, are outside the employer-based system through which 67% of Americans are covered. There are almost no professional organizations – sculptor societies, graphic artist guilds, etc. – left in the arts that offer association plans, as many once did, either because the premiums in these plans rose to a level much higher than in the individual market because of adverse selection (i.e., they were attracting the otherwise uninsurable) or because insurers would no longer sell to them. The few organizations that do offer health insurance either have PPO plans that are wildly unaffordable, particularly for any artist over 40 years old (\$800 or more a month for an individual policy), or bare-bones high-deductible policies that are useful only to the young and very healthy.

Secondly, for those performing artists, such as actors, writers and musicians, who have access to union membership, the income eligibility for benefits has risen along with the steep rise in health care costs and health insurance premiums, to the point where less than 20% of those in actors' unions are eligible for insurance at any given time. It is essential, therefore, that those who are otherwise denied access to the individual market have the right to purchase a quality, affordable plan whose availability is widely and repeatedly announced in the DC community.

I would like to note here that the District of Columbia should be commended for the very existence of an open-access program, as well as for health care coverage programs that set the income eligibility levels as high as 300% of the federal poverty level, which is far more realistic than the levels set by some other jurisdictions we deal with every day. [In California, for example, where The Actors Fund has a separate Los Angeles office and a very large community of clients, our social workers are confronted every day with individuals who are simply unable to obtain health insurance and are forced into the state's high-risk pool where they are charged as much as \$1200 to \$1500 a month for an individual plan, and where eligibility limits for government subsidized programs are set at 100, 135, and 150 percent of the FPL – 100% of the FPL is currently \$10,400 annual gross income for an individual and \$21,200 for a family of four.]

Among our constituents in the District there are some who remain uninsured or under-insured despite the current open-access program. There are artists who have household incomes above the threshold of government-subsidized plans but below a level that will allow them to purchase any kind of comprehensive plan for themselves and their families without real hardship. There are also those who are insured but unable to afford primary care visits to a private physician because their high-deductible policy will require them to pay the full freight, which can be as much as \$225 for a family physician visit or \$650 for an initial consultation with a specialist.

For these two groups, it is essential for the District to use the community reinvestment included in the bill to both expand coverage and maintain a well-financed and widespread community health system. Professionally staffed clinics can provide quality health care on a sliding scale based on income, as well as participate in public coverage programs, to prevent the ruinous debt our social workers at The Actors Fund see every day among those who, because of an illness or accident, move through emergency rooms (\$2500), surgeries (including anesthesia, between \$10 and \$100 thousand), hospital stays (\$3700 a day), and rehabilitation (\$300 a session) while uninsured.

Throughout the United States, cities are being renewed by attracting artists into crumbling districts and establishing vibrant new neighborhoods that bring in young, educated workers and small shops and businesses. By passing this bill, the District of Columbia will take a significant step toward creating an even more artist friendly, culturally vibrant and socially responsible environment than the one that already exists.

**TESTIMONY OF JANICE WILLIAMS, EXECUTIVE VICE PRESIDENT OF
PROGRAMMING, YMCA OF METROPOLITAN WASHINGTON**

TODAY'S CHILDREN ARE SICK. THEY HAVE A MAJOR PLAY DEFICIENCY. AND THIS DEFICIENCY IS LEADING TO EXCESS WEIGHT, WHICH ULTIMATELY LEADS TO AN UNHEALTHY AND UNHAPPY LIFESTYLE. SICK CHILDREN GROW UP TO BE SICK ADULTS, AND SICK ADULTS FORM SICK COMMUNITIES. AND WE ALL KNOW THAT NOTHING GOOD COMES FROM A SICK COMMUNITY.

THE PROBLEM OF CHILDHOOD OBESITY HAS ALREADY REACHED EPIC PROPORTIONS. HERE IN THE NATION'S CAPITAL ALONE, ONE IN EVERY FOUR CHILDREN IS EITHER OBESE OR OVERWEIGHT. BUT THE YMCA WITH THE GENEROUS SUPPORT OF CAREFIRST IS DETERMINED TO HEAL OUR COMMUNITIES AND TO STOP THIS MODERN-DAY PLAGUE.

~~Over~~ ^{Over 5 yrs} YEARS AGO, THE YMCA OF METROPOLITAN WASHINGTON CREATED A PROGRAM TO BRING ^{PHYSICAL ACTIVITY and} PLAY BACK INTO CHILDREN'S LIVES. WE NAMED IT PHD (THAT'S PHYSICAL, HEALTHY AND DRIVEN). IT WAS A SIMPLE PREMISE— BRING ^{EXERCISE, Games and} PLAYTIME BACK INTO FAMILIES LIVES. GET KIDS AND THEIR PARENTS EXCITED ABOUT HEALTH AND WELLNESS BY ENCOURAGING THEM TO EARN THEIR PHDS IN ACTIVE ^{Engagement} ~~PHD~~, NUTRITION, AND HEALTHY LIFESTYLES. A SIMPLE PREMISE TRUE, BUT THE RESULTS HAVE BEEN LIFE CHANGING AND IN MANY CASES LIFE SAVING.

DURING OUR FIRST CLASS, WE FOUND MANY CHILDREN UNDER THE AGE OF 12 HAD HIGH BLOOD PRESSURE. MOST OF THE KIDS COULD NOT RUN THE LENGTH OF THE GYM, AND MANY COMPLAINED THAT OUR GAMES MADE THEM TIRED. WE RAN THIS PROGRAM IN OUR AFTER SCHOOL CARE, AND WITHIN A FEW WEEKS, THE KIDS COULD NOT WAIT FOR ^{PHD} ~~PHD~~, WE TAUGHT PARENTS HOW TO PREPARE HEALTHY MEALS AND WE SAW AMAZING RESULTS IN OUR CHILDREN'S HEALTH. THE YMCA HAS BUILT A PROGRAM THAT HAS TRULY SAVED THOUSANDS OF LIVES. COUNTLESS LOCAL CHILDREN NOW HAVE THEIR PHDS.

TODAY, LOCAL FAMILIES ARE VYING TO BECOME A PART OF THIS LIFE-CHANGING PROGRAM. PARENTS REALIZE THAT WE ARE DELIVERING RESULTS AND CHILDREN ARE INTRIGUED BY OUR UNIQUE AND FUN APPROACH TO PHYSICAL FITNESS.

BUT STILL, THOSE WIDELY CITED CHILDHOOD OBESITY STATISTICS HAUNT US, AND WE KNOW WE MUST DO MORE. WE MUST REACH THE CHILDREN WHO DO NOT HAVE A PLAYGROUND NEARBY. THE CHILDREN WHO HAVE NEVER KNOWN THE TASTE OF FRESH FRUIT. THE CHILDREN WHO WANT NOTHING MORE THAN TO SINK DEEPER INTO THEIR COUCHES AND PLAY ANOTHER ROUND OF VIDEO GAMES. BUT THEY NEED SO MUCH MORE.

THANKS TO THE GENEROUS SUPPORT OF CAREFIRST, WE CAN EXTEND OUR OUTREACH AND OUR IMPACT.

AS A CHARITABLE ORGANIZATION SERVING GREATER WASHINGTON, THE Y RELIES HEAVILY ON FINANCIAL CONTRIBUTIONS FROM AREA BUSINESSES AND FOUNDATIONS TO ENABLE US TO DELIVER SERVICES FOR THOSE WHO OTHERWISE COULD NOT AFFORD TO PAY AND CAREFIRST IS ONE OF THE YMCA'S MOST GENEROUS SUPPORTERS. THIS YEAR, CAREFIRST GAVE \$1 MILLION TO SUPPORT THE PHD PROGRAMS, ALLOWING US TO BRING THIS PROGRAM TO AREA SCHOOLS WITH NO PHYSICAL EDUCATION CURRICULUM AND TO EXTEND OUR REACH INTO CENTRAL MARYLAND. CAREFIRST HAS FUNDED THE YMCA'S PHD MOBILE, A TRAVELING ^{Fitness} PLAYGROUND THAT ALLOWS US TO BRING THE PHD PROGRAM TO AREAS WHERE KIDS DO NOT HAVE A SAFE PLACE TO PLAY. AND CAREFIRST'S SUPPORT GOES BEYOND MONETARY CONTRIBUTIONS. CAREFIRST EMPLOYEE'S HAVE VOLUNTEERED THEIR TIME TOWARDS YMCA EVENTS DEDICATED TO EXERCISING KIDS SPIRIT, MIND AND BODY SUCH AS OUR ANNUAL THINGAMAJIG INVENTION CONVENTION, WHERE MORE THAN

3,000 CHILDREN COME TOGETHER TO LEARN ABOUT PROTECTING THE ENVIRONMENT,
CREATE ECO-FRIENDLY INVENTIONS AND OF COURSE....PLAY!

CAREFIRST HAS LONG BEEN DEDICATED TO ERADICATING THE CHILDHOOD OBESITY
CRISIS. WE CANNOT BATTLE THIS INSIDIOUS PLAGUE THAT HAS INFECTED OUR CHILDREN
WITHOUT THE SUPPORT OF CAREFIRST AND I ENCOURAGE THIS COUNCIL TO NOT DO
ANYTHING THAT WILL HAMPER THIS LIFESAVING MISSION OF CAREFIRST AND THE YMCA.
WITH STRONG COMMUNITY SUPPORT LIKE WE HAVE RECEIVED FROM CAREFIRST, THE
METROPOLITAN WASHITON REGION CAN AGAIN ENJOY A DAY WHEN CHILDREN ARE WELL,
WHEN THEY RUN AND PLAY AND LAUGH AND SMILE, WHEN THEY GROW UP TO BE STRONG
AND HEALTHY ADULTS AND ULTIMATELY BECOME THE STRONG COMMUNITY LEADERS WHO
WILL CARRY ON THE LEGACY WE ARE CREATING FOR THEM.

###

TESTIMONY OF DOREEN D.HODGES

Friday, October 10, 2008

Committee Chair, Mary Cheh
Re: Bill 17-934

Good Morning Councilmember Cheh:

Thank you for the opportunity to testify before you regarding **Bill 17-934 Medical Insurance Empowerment Act of 2008**.

I am Doreen Hodges, proud mother of two children diagnosed with special healthcare needs and/or disabilities. I am a native New Yorker and since moving from NYC to the District of Columbia, I have been a Ward 8 resident, community healthcare/education advocate for the past 9 years. My oldest son, known to many, named King Titus Hodges (**HAPPY BIRTHDAY TITUS**) is dually diagnosed with Down Syndrome and Pervasive Developmental Disorder (PDD) which is on the Autism Spectrum Disorder.

My youngest child, Brother Jacob Hodges is 1 years old and was born 3 months premature and has some Developmental Delays. Both diagnoses are defined as Developmental and Mental Health according to definition of the MCHB/HRSA (Maternal Child Health Bureau and HRSA).

I am also the Executive Director of Family Voices of the District of Columbia Inc, and home of the DC Family to Family Healthcare Information Center. Family Voices of the District of Columbia Inc., is a local chapter of a national grassroots network of families and friends, advocating for health care services for children and youth with special health care needs and/or disabilities and believes **all** children and youth with special health care needs and/or disabilities, both public and private deserve quality, primary and specialty health care that is affordable and within geographic reach.

The F2FHIC actively began assisting families of children, youth and adults with special health care needs and/or disabilities and the professionals who served them in January 2008.

The federally funded project, F2FHIC, offers information, training, support, resources and options for informed decision-making by/to families of children and youth with special health care needs and to the professionals who serve them.

As the District's demographics are changing, it is noted that more middle class families of children, youth and adults with special healthcare needs and/or disabilities are moving into the District of Columbia, which adds to the numbers already here to whom are able to become participating members of Blue Cross and Blue Shield/Carefirst.¹

In 2006, Councilmember Graham introduced Bill 16-493, the "Habilitative Services for Children Act of 2006". This bill was passed and became Law effective as of June 2007. This new law states that health insurance plans in the District of Columbia must cover "habilitative services"² for children up to the age of 21 to the same extent that they cover other services.

Most HMOs, and PPOs such as Blue Cross Blue Shield/Carefirst regarding these services limits are 60 visits per calendar year. This would total out for families to choose one (1) therapeutic service a week, which means you schedule out could/would be one (1) OT visit for **week 1** and a PT visit for **week 2** and a speech and language visit for **week 3** and then a critical decision per the recommendation from the professional(s) you should use for **week 4**.

Unfortunately, this is not enough to for our children, youth and adults with special healthcare needs and/or disabilities.

Most times, families incur excessive out-of-pocket expenses due to the "medical necessity" of more therapy visits needed for the children, youth and adults with special healthcare needs and/or disabilities.

The impact of therapeutic services/interventions, whether implemented early or current would allow our children, youth and adults with special health care needs and/or disabilities to overcome some of the barriers that would allow them to live full productive lives in today's society.

It would also serve to be cost effective in the long term. Such therapeutic services as: physical, occupational, and speech services.

The words "**ACCOUNTABILITY**" and "**CHANGE**" are those that really express definitive, strong, upholding meaning and this Bill 17-934 puts some accountability of "giving back" to the community and the special health care needs and/or disability community is one that is truly forgotten many times.

¹ If the insurance is used as the Primary, the co-pays and premiums are very costly for families of children, youth and adults with special healthcare needs and/or disabilities.

² Habilitative services are services designed to treat children with congenital or genetic birth defects in order to enhance their ability to function. For example, the new law will help children diagnose with Autism, Down Syndrome, Cerebral Palsy receive services such as speech therapy, occupational therapy, physical therapy and other related services that are deemed as a medical necessity.

The Bill 17-934 could/would assist many families of children, youth and adults with special healthcare needs and/or disabilities here in the District of Columbia. There are several ways but one way on how would it assist our families could be one such as establishment of a **Catastrophic Relief Fund**.

Many families of children, youth and adults with special healthcare needs and/or disabilities and the providers whom serve them, may be unable to attend today, but they are members of the network of Family Voices of District of Columbia Inc., which is expanding and again are participating members of the Blue Cross Blue Shield/Carefirst network are in support of Bill 17-934, with respect that it proposes an opportunity to assist families of children, youth and adults with special health care needs and/or disabilities. An extensive SIGN ON letter will be forwarded to you and the other supporting Councilmembers within the next week.

I am available to answer any questions and concerns now or in the near future with regards to the special health care needs and/or disabilities community.

Again, thank you for the opportunity.

Sincerely,


Doreen D. Hodges
Executive Director
Family Voices of the District of Columbia, Inc.
4363 Barnaby Road, SE
#204
Washington, DC 20032
Telephone: 202-373-5564
Direct Dial: 202-230-8201

STATEMENT OF STEPHEN J. ACKERMAN
NATIONAL WRITERS UNION—DC CHAPTER
ON
BILL 17-934, THE MEDICAL INSURANCE EMPOWERMENT AMENDMENT ACT
OF 2008
Council of the District of Columbia
Committee on Public Services and Consumer Affairs.
10 October 2008

Good morning. My name is Stephen J. Ackerman. I am a self-employed writer living in Washington, DC. I am testifying on behalf of the DC Chapter of the National Writers Union, Local 1981 of the United Auto Workers.

Thank you for giving me the opportunity to share my all-too-typical experiences as a self-employed person who lost access to affordable health coverage long ago. Applying for insurance in the individual market, I met rejection repeatedly for trivial, incorrect, seemingly trumped-up reasons. "It's no accident," a man who had just left a job at Kaiser Permanente told me. "They tell us to find ways to reject anybody aged 45 to 65."

One firm rejected me solely because, in an effort to be completely honest, I indicated that I might need inexpensive laser eye surgery to correct narrow angles some time in the future. So I inquired whether I could be covered if I had the procedure done now, at my own expense. The clerk checked, then told me no, that there was "other stuff" disqualifying me.

Another insurance company said I could not get coverage because of seasonal allergies—which would disqualify most of DC.

Then I asked an insurance broker what to do. "Move to Maryland," he said. "They have a good program in Montgomery County."

I don't want to move. I like it here.

Finally, I applied to CareFirst. They rejected me for current treatment for cataract, for "pernicious and anemia." K. Peterson, R.N., who signed the rejection, further noted that I am obese, claiming that my "physician listed my height and weight as 5'7" 196 pounds" with Body Mass Index of 30.7. Nurse Peterson was wrong on every particular, as you can see.

She must have ransacked my medical records to retrieve some report with typos contradicting all others. She thus shortened and fattened me. When I had my body fat checked, it was 16.7 percent. I am taller than 5'7."

I was not being treated for cataracts then, nor am I now or soon.

Finally, anyone signing a document "R.N." should know that the term is "pernicious anemia"—a serious condition, surely, but once diagnosed and brought under control, negated by one monthly self-injection of vitamin B-12 that might cost an insurer perhaps \$7.00 a year.

This incompetent rejection offers no provision for appeal or correction, just referral to a high-cost, low-benefit Open Enrollment Program.

Councilmembers, I am not alone. The system is rigged, against older people and against the self-employed.

Bill 17-934 begins to address the open enrollment concerns by making that option less of a bad deal. It could be strengthened by addressing actuarial corruption, making the process more transparent and subject to challenge. I have just learned that Washington State has standardized underwriting criteria. Perhaps the insurers' blatant age discrimination might be curbed if they had to clarify all obstacles to acceptance up front, rather than trumping up new ones as they go along. There should be a way of responding to factually flawed decisions like CareFirst's.

Politicians pay much lip service to entrepreneurialism, yet the present health system is driving many self-employed workers from their careers with its "gotcha" underwriting practices.

With our parent, United Auto Workers, NWU-DC believes that health care is a basic right that can best be served through a comprehensive, national single-payer health care reform plan. This reform plan should guarantee universal coverage to all Americans, without regard to age, income, health status or employment status. The Insurance Empowerment Amendment Act is a step in that direction for self-employed Washingtonians.

Thank you.

D.C. COMMITTEE ON PUBLIC SERVICE AND COMMUNITY AFFAIRS
Medical Insurance Empowerment Act of 2008 (Bill 17-0934)
Hearing: 9:00 a.m. Friday, October 10, 2008

Testimony by
Solomon Irwin Royster, Director for Community Outreach
Ophelia Egypt Health & Program Centers

Good morning. I am Irwin Royster, Director for Community Outreach at Planned Parenthood of Metropolitan Washington DC, Inc .

Since 1937, Planned Parenthood of Metropolitan Washington DC, Inc. (PPMW) has supported and protected the right and responsibility of every person to make free, informed reproductive choices, by providing safe, affordable and confidential reproductive health care, family planning, birth control and education services to teens, women, and men at its five community health centers in the metropolitan D.C. area. Over half of PPMW's family planning patients at all five health centers are low and/or moderate-income, and over two-thirds are women of color. Additionally, over 44% of PPMW's patients are under the age of 25.

Since 2003, PPMW's Teen Medical/Educational (MedEd) Clinic, formally called the Ophelia Egypt Health Center, has provided a growing number of D.C. teens with **free, community-based, comprehensive reproductive health care services, including testing for Sexually Transmitted Infections (STI), HIV, and pregnancy and preventive health education.** These services are targeted to D.C.'s most impoverished and highest risk teens in Wards 7 and 8, East of the Anacostia River. In just four years, the number of teens served (ages 11 to 25) has grown from 508 in its first year to 1,886, a **growth rate of over 350%.**

PPMW also operates a Program Center which is located in a retail space adjacent to the Health Center, where PPMW offers structured prevention education workshops, after-school enrichment activities for teens and other reproductive health resources for community members. The Teen MedEd Clinic also incorporates a Youth health messenger program with a Peer Leadership component, based at the Program Center, which provides youth with training and education on reproductive health issues so that they are able to conduct peer outreach in the community. This project directly fulfills PPMW's mission of providing, protecting, and promoting reproductive health care and education by increasing at-risk teen and young adult awareness and by improving access to free Teen Clinic health services, including STI testing and treatment and HIV prevention education, testing, counseling and referral services.

D.C. suffers the fourth highest rate of full-blown AIDS cases among the nation's 40 largest cities, with 1 **in every 50 D.C. residents having AIDS.**¹ **The share of recent AIDS cases**

¹ D.C. HIV/AIDS Administration Report on Cumulative AIDS Cases, 1980-2002 (Washington Post: July 17, 2003)

OPHELIA EGYPT PROGRAM CENTER

3933 Minnesota Avenue, NE - Washington DC 20019
(202) 398-5025 Fax: (202) 398-5040 <http://www.pp.org>

among minority teens has grown most dramatically in three wards—12.7% in Ward 5, 10.4% in Ward 7, and 11.6% in Ward 8.²

CareFirst BlueCross BlueShield (CareFirst) is one of the many organizations that has helped PPMW, to fulfill and expand its efforts of providing free health services for at-risk teens at the Ophelia Egypt Health and Program Centers. This support has allowed PPMW to demonstrate its commitment to teens in the District of Columbia by providing prevention and intervention programs.

In addition by providing contributions to our many collaborative partners CareFirst BlueCross BlueShield has helped to pave a future for our youth in the way of college scholarship.

In closing, it takes a village of funders to support a village of youth, and we thank all of our supporters who have helped PPMW fulfill its mission of providing safe, affordable and confidential reproductive health care, family planning, birth control and education services to uninsured and underinsured teens, women, and men of the Washington DC, Metropolitan Area.

² Table 3, Summary of AIDS Trends by Ward, D.C. *HIV Prevention Two-Year Plan (2003-2004)* Volume 1

**Revised Testimony of Katherine Nordal, Ph.D.,
of the American Psychological Association
Relating to the October 10, 2008 DC Council
Hearing on the Proposed Medical Insurance Empowerment Act of 2008**

I am Alan Nessman, Special Counsel with the Practice Directorate of the American Psychological Association (APA). The APA, located in Washington, DC, is the largest scientific and professional organization representing psychology in the United States, and is the world's largest association of psychologists. APA's membership includes more than 148,000 researchers, educators, clinicians, consultants, and students. APA works to advance psychology as a science and profession, and as a means of promoting health and human welfare. APA has almost a thousand members and affiliates in the District of Columbia. I am presenting the testimony of Katherine Nordal, Ph.D., our Executive Director for Professional Practice.

We support this legislation based on our extensive experience with the impact of managed care on mental health care generally, and our experience with CareFirst Blue Cross Blue Shield in particular. We also base our support on our understanding of the mental health needs of the District.

We understand that CareFirst's charter requires it to conduct itself as a "charitable and benevolent" institution. Based on this mission, we agree with intent of this proposed legislation that instead of maintaining large reserves inappropriate for a non-profit entity, CareFirst should reinvest in community health. We urge that a portion of that reinvestment be directed toward the District's mental health needs.

For over a decade, APA has been concerned about profit-driven managed care practices undermining quality mental health care. As I will describe later, there are allegations that in the past CareFirst strayed from its charitable and benevolent purpose with respect to mental health, prioritizing company profits over quality mental health care for its subscribers. This legislation would help keep the company focused on its non-profit mission.

From talking with experts on mental health in the District, such as psychologist Dr. Ann Doucette, a research professor at George Washington University, we understand that the District has serious mental health needs, although they are not yet well quantified. A 2003 Study by the Mayor's Interagency Task Force on Substance Abuse estimated that District had 60,000 residents with addiction problems but only 14% of that population was receiving treatment. That study also estimated that 26,000 to 42,000 of that population had co-occurring mental illness.

Reinvestment by CareFirst in the District's mental health needs could help with efforts such as:

- Providing mental health coverage in the Alliance program (which makes coverage available to those who could not obtain in the private market).
- Coordinating data about those needs and services, which is held by different parts of the District's public health system, in order to better target services
- Coordinating services more effectively between the different players serving mental health needs in the District

We also support the Open Enrollment provisions of the proposed bill. Mental illness creates its own barriers to seeking care, such as the debilitating effects of depression and other conditions, and the stigma associated with mental illness. Nevertheless, often the largest barrier to care is the inability to afford care due to the lack of insurance. For those citizens who fall into the gap between those who can afford most private insurance and those who qualify for public programs, CareFirst should continue its critical role as the District's insurer of last resort. This will reduce the number of District residents with unmet mental health needs. We also agree with those who testified in favor of adding a provision to the bill that limits CareFirst's ability to deny care based on pre-existing conditions. Removing arguments about whether current treatment relates to some prior mental illness will remove a major barrier to necessary care.

I want to close by talking briefly about our experiences with the company that we believe demonstrate the need to focus CareFirst on its non-profit mission.

We learned much from a lawsuit in the DC courts brought against CareFirst by our affiliate, the Virginia Academy of Clinical Psychologists (VACP) that led to a settlement several years ago. That suit alleged that the company slashed reimbursement rates for psychologists in order to boost its profits at the time of the merger that created CareFirst. Documents from the case revealed that the rate cut drove a large number of psychologists to leave the panel and left about 250 patients in the DC Metro area needing to switch to other providers. At the same time, CareFirst boasted in a press release that the merger would give subscribers "a larger, seamless network." VACP alleged that the company responded to the shortage of psychologists by pressuring subscribers to access far less mental health care than they were entitled to. The Maryland Insurance Commissioner cited some of this evidence in his 2003 decision to reject the company's bid to shed its non-profit status.

Since then, we have continued to hear complaints from our psychologist members about the company's low pay and bureaucratic hassles, and patients having difficulty getting the correct information they need to access their mental health benefits. Our members echo the testimony of Ms. Aronsen of the social workers' group: psychologists feel that they are being "nickel & dimed" in their reimbursement, while the top company executives receive astronomical compensation packages. In fact, the most recent

complaint we had about CareFirst was from a psychologist serving DC residents who plans on resigning from the company's network due to low pay combined with administrative hassles. We were pleased to hear on Friday that Councilperson Cheh intends to look into this issue in another context, and we would be pleased to work closely with her on this issue.

We have offered to work with Councilperson Cheh's office to address some of the other issues through other channels, but they remind us that the proposed bill is an important step toward keeping CareFirst on track with its public interest role. We hope that CareFirst's reinvestment will help the District address its serious mental health needs, including those that may have resulted from the company's limits on care.



71 "O" Street, NW
Washington, DC 20001
Tel: (202) 797-8806
Fax: (202) 797-1867
Web: www.some.org

Nina Swanson, Director of Advocacy & Social Justice
SOME, Inc. (So Others Might Eat)
Committee on Public Services & Community Affairs
Bill 17-934, Medical Insurance Empowerment Amendment Act of 2008
October 10, 2008

Thank you for the opportunity to submit written testimony in support of Bill 17-934, the Medical Insurance Empowerment Amendment Act of 2008. SOME is particularly supportive of this bill because it values community investments in health care services for the poor and underserved.

SOME is an interfaith, community-based organization that has served the homeless of the District of Columbia for 38 years. By meeting our clients' immediate daily needs and then offering services such as affordable housing, job training and addiction treatment, SOME works to break the cycle of poverty. Providing health care services is a vital piece of our continuum. In 2007, we provided over 10,000 medical and dental care visits to homeless people who could not afford a doctor or dentist. In addition, we provided crisis psychiatric services, served homeless adults with chronic mental illness through a therapeutic day socialization program, and offered a comprehensive addiction treatment program. Our Behavioral Health Services program served over 1500 clients with individual and group counseling, case management and supportive services.

SOME has a strong tradition of relying on private donors to support its programs, but with ever-increasing health care costs and growing demand, there is an increasing need for community and public investment in community health care for the underserved. A recent report issued by the RAND Corporation identified serious health care needs in the District, and also areas where the community can make targeted investments that will have high impact.¹ The options for "community reinvestment" by CareFirst as outlined in Bill 17-934 are apt: with one out of three DC residents participating in public insurance programs,² DC Medicaid and the DC HealthCare Alliance need continuous funding in order to maintain a strong health care safety net.

Thank you for the opportunity to offer our support of Bill 17-934.

¹ Nicole Lurie, et.al. *Assessing health and health care in the District of Columbia*. RAND Corporation, June 2008.

² District of Columbia Department of Health. <http://doh.dc.gov>

Restoring Hope & Dignity One Person at a Time

SOME is an interfaith, community-based organization established to help the poor and homeless of our nation's capital.
SOME is a 501(c)(3) organization and contributions are tax-deductible. Federal ID #23-7098123.

Designate
UW # 8189



Designate
CFC # 7440:



October 7, 2008

The Honorable Vincent C. Gray
Chairman
Council of the District of Columbia
1350 Pennsylvania Avenue, N.W.
Washington, D.C. 20004

Dear Chairman Gray:

I am writing to express my concern about any action that might well affect the control of premiums paid by companies covered by CareFirst.

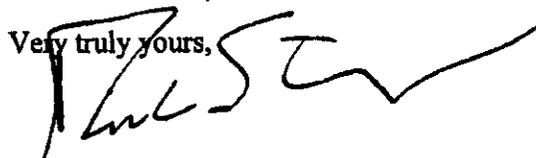
Our nine-year old company, headquartered in the District of Columbia, currently has 71 employees. We anticipate growth of 30% annually in the number of people we employ in the District.

I am concerned that the District government might take a portion of CareFirst's reserves for a purpose other than that for which they were intended, and could increase costs to small businesses through higher future premiums. Given that benefits are the second largest expense after salaries for my company, this is no minor issue for us. An additional tax on us is not acceptable.

I trust that the hearing on October 10th regarding the "Medical Insurance Empowerment Act of 2008" will establish that any such taking would be inappropriate and against the interests of job creation and access to health insurance for small businesses located in the District of Columbia.

Please reject B17-0934.

Very truly yours,



Richard D. Stamberger
President and CEO

cc: **The Honorable Mary Cheh**
The Honorable Adrian Fenty



NATIONAL GAY & LESBIAN CHAMBER OF COMMERCE
 WASHINGTON, DC
 2008 OCT -9 AM 10:07
 1010 MONTGOMERY AVENUE, N.W.
 SUITE 308
 WASHINGTON, DC 20005
 TEL: 202.234.9185
 FAX: 202.234.9185
 WWW: WWW.NGLCC.ORG

October 8, 2008

The Honorable Vincent Gray
 Chairman
 Council of the District of Columbia
 1360 Pennsylvania Avenue, N.W.
 Washington, D.C. 20004

Dear Chairman Gray:

I have deep concerns regarding B17-0934, legislation which would divert and use for other purposes a portion of the reserves paid in by Care First subscribers - some of them struggling small businesses. I have no doubt these small business owners and employees intended these premiums to pay for their own health insurance coverage.

As I have traveled across the country, access to affordable healthcare is one of the top issues for LGBT small businesses, as it is a concern for all small businesses. This year it is especially relevant given the attention it has received during the presidential election. Taking a portion of the premiums paid by the subscribers of CareFirst - the largest insurer of small businesses in the District - would likely adversely affect premiums and inadvertently result in some small businesses being unable to pay higher premiums and possibly increasing the number of uninsured.

CareFirst has been a leader in the District of Columbia on healthcare issues facing LGBT small business. It was among the first insurers to offer domestic partner health insurance coverage to companies with fewer than 100 employees. CareFirst did so without any additional profit motive in mind and likewise, through its philanthropy, has been a supporter of lesbian and gay health needs in the District.

Representing the organization advocating the interests of the more than 800,000 lesbian, gay, bisexual, and transgender owned businesses and our networks in 46 states including Washington DC, the National Gay and Lesbian Chamber of Commerce is the largest LGBT business development and economic advocacy organization in the world. We are proudly based here in Washington, DC, and proudly call CareFirst our insurance provider.

I urge you to please reject B17-0934.

Sincerely,

Justin Nelson
 President, National Gay and Lesbian Chamber of Commerce

cc: The Honorable Mary Cheh
 The Honorable Adrian Fenty

America's LGBT Chamber of Commerce

**Testimony of Samuel Jordan, Executive Director, Health Care Now! (HCN)
Hearing on Medical Insurance Empowerment Amendment Act of 2008
DC Council Member Mary Cheh, Chair October 10, 2008**

Good morning and thank you. I am Samuel Jordan, Executive Director of Health Care Now! (HCN) and am testifying today in support of the passage of the Medical Insurance Empowerment Amendment Act of 2008. The support of Health Care Now! its members, Board of Directors and affiliates is grounded in a long experience seeking recognition of the principle that has been our slogan since our founding in 1997, "health care is a human right." We are encouraged to hear that slogan gain impressive currency in the presidential campaign that has captured the attention of the nation like no other.

In 2002, CareFirst Blue Cross Blue Shield formally applied for conversion from non-profit to for-profit status in the three jurisdictions in its service area simultaneously. Health Care Now! joined CareFirst Watch, a coalition formed under the auspices of the DC Appleseed Foundation to monitor the conversion process. After review of the conversion application, including the proposal for acquisition of CareFirst by Wellpoint Health Network of California and studies commissioned by various public interest groups including the Abell Foundation of Baltimore and reports from the attempts by Blues Plans to convert in several states around the country, Health Care Now! concluded that the conversion itself would be detrimental to the affordability, access and quality of health care services available to health care consumers in Washington, DC. It appeared that perhaps CareFirst which stated in its conversion application that it needed capital to make acquisitions had in fact accumulated excess cash reserves, more than \$700 million, in order become an attractive target for takeover that would reward its executives beyond ethical limits.

Achievement of our mission, to make quality health care affordable to all without regard to ability to pay, was threatened by the prospect of the conversion of CareFirst and its planned acquisition by Wellpoint. We moved into action and formed the "Cross-Border Coalition to Keep CareFirst Non-Profit." An appearance on the Diane Rehm Show on National Public Radio with Bill Salganik of the Baltimore Sun, meetings in northern Virginia with Representative Jim Moran and families of children requiring in some cases extraordinary assistance at Children's Hospital, testifying at each hearing conducted by the DC Department of Insurance, Securities and Banking, and a series of action rallies and forums marked our local efforts and public informational campaign. Health Care Now! conducted a Conversion 101 weekly seminar at First Congregational Church downtown and sponsored a catered luncheon attended by the Speaker of the Maryland General Assembly, the Honorable Michael Busch to discuss Maryland's opposition to the conversion.

The denial of the conversion and acquisition by Maryland's Insurance Commissioner Larsen was a victory of sorts, but there was a continuing concern that emerged in the course of our review of the financial condition of CareFirst. That concern is the subject of today's hearing, the possibility that CareFirst had accumulated excess surplus in its cash reserves that had no legitimate or chartered purpose in keeping with its status as a

“charitable and benevolent” institution.

Concerns about excess surplus have arisen in Pennsylvania, Rhode Island, Maryland, New Jersey, Hawaii, Montana and Delaware. States with maximum surplus limits for non-profit insurance carriers include Hawaii, Michigan, New Hampshire and Pennsylvania.

Pennsylvania set upper limits on surplus on all four of its Blue plans (950% RBC for Blue Cross of NEPA and Capital Blue Cross; 750% for Highmark and Independence Blue Cross). Currently none of the Pennsylvania Blue plans holds excess surplus given these upper limits. If a plan did exceed the surplus upper limit, the plan would have to file a report with the Pennsylvania Insurance Commissioner justifying its current surplus level or file a plan explaining how it will divest its surplus in a manner that will benefit its policyholders.

Michigan has capped Blue Cross Blue Shield of Michigan’s surplus at an RBC ratio of 1000%. If the cap is reached, BCBSM must file a plan for approval by the Commissioner to adjust its surplus to a level below the allowable maximum surplus. The Commissioner can formulate an alternate plan if it disapproves of the plan filed.

Hawaii law requires that if a non-profit health plan’s net worth exceeds 50% of the prior year’s total health care expenditures plus operating costs, the plan must refund the money to policyholders

New Hampshire caps a non-profit health insurer’s contingency reserve funds at 20% of annual premium incomes. However, the law is moot since the New Hampshire BCBS plan, which was the state’s only non-profit plan, is now a for-profit. Prior to the conversion, the state chose not to enforce the limit.

On February 7, 2005, Pennsylvania concluded what was then unprecedented among the states addressing the determination of excessive surplus in its cash accounts, by signing the Community Health Reinvestment Agreement. Two days, Pennsylvania Insurance Commissioner Koken issued a determination that the Blues plans in the state did not have excessive surpluses, but did establish an analytical methodology for setting the range of efficient, sufficient and inefficient cash holdings. The inefficient range was that range in which the monies held were deemed surplus and subject to an order of distribution by the Governor for use in charitable and public health programs including providing health insurance coverage to thousands of Pennsylvania residents who could not obtain health insurance due to cost and/or existing health conditions.

Health Care Now! supports the Medical Insurance Empowerment Act of 2008 (MIEA), because it addresses the issue of surplus reserves fairly and is an improvement over the Pennsylvania model, providing greater interventional scope by the District’s elected Chief Executive. In the first instance, Pennsylvania’s Community Health Reinvestment Agreement does not recognize the non-profit carriers’ statutory obligation to engage in community benefit activities. Secondly, and perhaps most importantly, the MIEA

establishes the threshold requirement that CareFirst owes a duty of investment of a percentage of its surplus for charitable and benevolent purposes without the finding of an excessive surplus. That is, we applaud the scheme of the legislation in that it requires a community health and well-being contribution as a staple of CareFirst's operation in the District.

We would caution that the legislation and its regulatory oversight determine to what extent CareFirst may include the expected charitable contribution in the loads to be calculated in setting its rates and risk profile. Will the company simply adjust its rate structure to compensate for its statutorily mandated community health investment? In other words, will the policy holders pay and/or how much for the community health investment obligation? We ask that the assessment of the company's risk backed capital and consolidated risk assessment analyses separate any funds and steps taken by the company to include the public benefit in its premium rates as part of a separate section in its periodic Risk Backed Capital report as may be required under the Risk Backed Capital Act of 1996 and other regulatory and risk assessment measures undertaken by the Department. ¶ In the normal designation of sufficient capital reserves, where sufficient is distinguished from efficient and inefficient, risk and contingency loading is not permitted. We ask that this standard apply in the periodic review of CareFirst's risk status as well. Janet

We note that the legislation does not specify which methods will be employed to determine the sufficiency of CareFirst capital reserves, a process to be developed by the Department and the Mayor, but we would advise that the ranges developed by the Pennsylvania Insurance Commissioner Koken, be studied for their applicability and compliance with the letter and spirit of this legislation, a process that might require a periodic review of the actions taken by the Mayor and the Department.

Health Care Now! supports without qualification the protection and extension of the Open Enrollment Program well past its projected expiration in 2010. We conclude with an appeal to all Members of DC Council to concur with the Chair and co-sponsors of this bill and speed its enactment. Thank you.