**Testimony of Cheryl Fish-Parcham, Families USA**

**June 25, 2014**

**Surplus and Community Health Reinvestment Review and Determination for Group Hospital and Medical Services, Inc., a Subsidiary of CareFirst, Inc.**

Good afternoon. I am Cheryl Fish-Parcham, Private Insurance Program Director at Families USA. I would like to offer brief comments on the surplus held by GHMSI, protections that insurers receive against unforeseen costs under the ACA, and some emerging community benefits needs. Families USA is a national nonprofit, nonpartisan organization dedicated to the achievement of high-quality, affordable health care for all Americans. We concur with DC Appleseed that GHMSI has far more in uncommitted assets than it needs, and should be required to spend more on community health reinvestments.

**Surplus**

GHMSI states that Rector’s analysis concludes that it should aim to hold surplus of 958% RBC-ACL. We question why the targeted surplus level is so much higher this year than in 2009. GHMSI’s surplus level is higher than the RBC levels held by many health insurers around the country. For example, the Colorado insurance commissioner’s 2013 Annual Report to the General Assembly showed that from 2007 to 2011, most insurers in that state had a 5-year average RBC lower than 800%; the RBC for Anthem Blue Cross averaged 445%.[[1]](#endnote-1) In Vermont, Vermont Legal Aid serves as the state’s Health Care Advocate and represents the public in rate hearings. Vermont Legal Aid informs us that Blue Cross Blue Shield of Vermont strives for an RBC between 500-700%; at the end of 2012 it was 587%; at the end of 2013 it was 575%.[[2]](#endnote-2)

**ACA costs**

GHMSI states that “the ACA has dramatically altered the markets in which GHMSI must operate and imposes significant new risks on the Company.” While it is true that ACA has dramatically altered the market, we want to point out that ACA has done a lot to protect companies from any increased risk. These mechanisms include:

* Risk adjustment: If GHMSI’s enrollees have higher health risks than enrollees in other health plans, the other plans will help pay the cost of the increased risk;
* Reinsurance: If GHMSI’s enrollees’ costs exceed a threshold, GHMSI will receive additional compensation;
* Risk corridor: If claims paid by GHMSI are much higher than it predicts, GHMSI will receive funds that help defray unexpected expenses.

Moreover, ACA has increased plan enrollment and assisted plans in attracting new members.

With these mechanisms in place, it is not appropriate for GHMSI to increase its surplus levels due to ACA risks.

**Contribution to reserve**

District small businesses and residents need help continuing to afford health insurance. In its recent filing for small group rates for 2015, GHMSI proposes to increase rates by 8% in 2015, with some products increasing 9.5%. GHMSI proposes to contribute an additional 1.6% of premium dollars to reserves. Given its already high reserve levels, this should be disallowed.

GHMSI also proposes to raise rates for individual coverage by 12.1%, with price increases for some products ranging as high as 15.3%. Though the insurer does not plan to contribute to reserves through the price increases in individual products, we request that if reserve levels are found to be too high, that these price increases also be disallowed.

**Community health reinvestment needs**

As GHMSI and District officials plan how they can best meet community health needs in the future, we would like to call several needs to your attention:

* We appreciate the support that CareFirst provides to community clinics. These clinics play a critical role in serving the District’s population, and will continue to do so.
* In the past, GHMSI/CareFirst has maintained an open enrollment program that served people with pre-existing conditions who would have been excluded from other coverage. That product was subsidized through other GHMSI resources. Since ACA now allows individuals to enroll in any plan regardless of their pre-existing conditions, community needs for such a product have changed. But other needs have emerged.
* An emerging need that some of the newly insured will face is for help with cost-sharing. The District protects people with incomes up to about 210 percent of the poverty level from all but nominal costs through Medicaid, and the Affordable Care Act provides some cost-sharing help to privately insured households with income up to 250 percent of the poverty level ($39,325 for a family of two). But adults with incomes near or over this level may have difficulty affording care until they reach their plans’ deductibles. CareFirst silver plans for an individual have deductibles ranging from $1300 to $2500; bronze plans have deductibles ranging from $3500 to $6000. While consumers could avoid these deductibles by buying a higher level of coverage (such as a 0-deductible gold plan), we know that many consumers in the District have tight budgets and will not do that. (For example, a recent report by the DC Fiscal Policy Institute, *Bursting the Bubble* (http://www.dcfpi.org/wp-content/uploads/2014/06/6-20-14-bursting\_the\_bubble\_2014\_FINAL\_web.pdf) noted the high housing costs in the area: median rents in the District are $1424, and with 50 percent of renters in the District paying more than a third of their incomes for housing costs, it is not a surprise that many residents have little to allocate towards health care.) Nonprofits such as GHMSI may want to consider establishing a foundation to provide further help to consumers who cannot afford their cost-sharing, similar to the patient assistance funds that drug manufacturers have established, or working with the District to establish some other sort of wrap-around assistance to lower silver plan deductibles for those with financial need.
* The newly insured will need more help in understanding their coverage. Ten years ago, peer programs in the District helped new Medicaid managed care enrollees learn to use managed care plans. A number of residents newly enrolled in Medicaid and in the individual market again need both expert and peer education.
* Some people are not eligible for federal premium assistance because their spouse’s employer pays for the spouse’s plan and offers (but may not contribute to) family coverage. We are not sure how many people in the District are affected by this problem. However, GHMSI could use community benefit dollars to provide a subsidized insurance product for people that fall into gaps in federal protections such as this “family glitch.”

There are many unmet health needs of District residents. A recent public health report showed that DC still has a high rate of infant mortality, and high rates of heart disease, cancer, diabetes, and HIV.[[3]](#endnote-3) We hope that DISB will find that GHMSI has a responsibility to reinvest more in the community’s health, and will consult the public and relevant city agencies about how best to do that.

1. Department of Regulatory Agencies, Annual Report of the Commissioner of Insurance to

   The Colorado General Assembly on 2012 Health Insurance Costs, page 37. [↑](#endnote-ref-1)
2. Correspondence with Lila Richardson, Vermont Legal Aid, June 25, 2014. Below are RBCs for the last five years from both of Vermont’s insurers, as calculated from year-end financial statements:

   MVP – RBC: 2012: 629; 2011: 551; 2010: 616; 2009: 469; 2008: 459

   BCBSVT –RBC:2012: 587; 2011: 681; 2010: 673; 2009: 553; 2008: 506. [↑](#endnote-ref-2)
3. DC Department of Health, District of Columbia Community Health Needs Assessment, February 28, 2014. [↑](#endnote-ref-3)