FamiliesUSA
The Voice for Health Care Consumers

August 31, 2009

Mrs. Leslie Johnson, Hearing Officer
DC Department of Insurance, Securities and Banking
810 First St, NE Suite 701
Washington, DC 20002

cc: Mr. Stephen Taylor, General Counsel

Dear Mrs. Johnson:

I am writing concerning the upcoming surplus review for CareFirst/GHMSI. I would like to testify on September 10 and enter this statement in the record. Families USA is a national consumer advocacy devoted to quality, affordable health care for all Americans. In the District, we work closely with consumers and community organizations to improve coverage both for people with low incomes and people who are in poor health. We request that you look carefully at any excessive surplus that may be held by GHMSI and direct GHMSI to invest in meeting unmet health needs for CareFirst subscribers, potential subscribers, and other city residents.

Specifically, CareFirst should use its excess surplus to lower premium rates for current subscribers; make a larger contribution to assist high-risk or "uninsurable" residents; eliminate the cap on drug coverage for individual subscribers without substantially increasing their premium rates; and contribute to District programs to subsidize coverage for people above public coverage guidelines who cannot afford the full cost of private insurance.

Individual subscribers have contacted us about the large premium increases they faced this summer. We heard from consumers whose premiums had increased by 25 percent or more. This was particularly hard for many District residents who saw their incomes and assets decrease in this year's bad economy.

We see in the filings that there were substantial premium increases for both the underwritten and the open enrollment products. (See attached chart based on the filings on the Web. We cannot tell if some of these filings were in lieu of others, or if all of these increases took place.) Consumers who had been enrolled in the open enrollment product for several years faced an additional problem because CareFirst had closed the pharmacy block of business under which many of them initially purchased coverage, and premiums for that rose 30 percent. Could these consumers have switched to the open block of pharmacy business at a lower cost, and if so, were they informed of this? Could CareFirst have priced the two blocks together to moderate the increase? The consumers who called us were not notified of any alternatives to paying these increases.

The Medical Insurance Empowerment Act as initially passed by Council last year would have required CareFirst to accept more people who are denied coverage due to their health conditions and eliminate annual benefit caps, such as the $1500/year maximum that CareFirst now pays for its members' prescription drugs. CareFirst has argued that this would impose too great a financial burden on them and that other insurers

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should share the cost of the high-risk or "uninsurable" population. Though we agree that the city should ultimately determine a fair way to spread the cost of coverage, coverage for people who would otherwise be uninsurable should also be among the highest priorities for CareFirst's community reinvestment. CareFirst says that it now invests $5 million to offset losses in open enrollment. However, if its surpluses beyond required reserves are in the hundreds of millions of dollars, it should be able to devote much more money to open enrollment or whatever other mechanism the city creates to cover the high-risk population.

The $1,500 drug cap that is currently in place does not meet the needs of residents who are in poor health. For example, one CareFirst subscriber testified in Council hearings last fall that when he lost his job in a small business, the replacement plan CareFirst provided him only covered $1,500 of drugs when his annual drug costs were about $20,000. People who have diseases such as Crohn's disease, multiple sclerosis, hemophilia, and AIDS often must take very costly medications for which there are no generic substitutes. For some drugs, there are no programs available through pharmaceutical manufacturers or private foundations to help with payment. CareFirst should do more to cover its subscribers' drug needs.

As you know, the Council also passed legislation to create Healthy DC, a program to subsidize premiums for people above income guidelines for Medicaid, CHIP, and the Alliance who still cannot afford private coverage on their own. Healthy DC would, for example, allow home care workers to maintain coverage when their wages increase to a more decent pay rate. Council and CareFirst have discussed a possible community investment in that program. This would be a great use of surplus, but it should be in addition to CareFirst's investment to help uninsurable residents. People of all income levels can be denied coverage due to their health status. People with low- and moderate-incomes *and* other people who are in poor health need help affording meaningful, comprehensive coverage.

The following are a few questions and concerns about CareFirst's and Milliman's reports and filings:

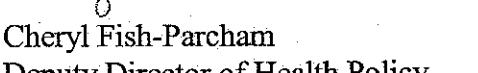
1) Milliman suggests an "optimal" RBC range of 750-1050 percent. Shouldn't CareFirst reinvest any money beyond the *lowest* point in this range (or below whatever other range the insurance department determines is optimal) in the community? It seems that CareFirst should not retain more than the minimum amount that is optimal since statute specifically requires the company to commit the "maximum feasible" amount to community benefits, consistent with remaining financially sound.

2) It is not appropriate for CareFirst to build higher reserves at this juncture in anticipation of national health reform. On page 5 of its report, CareFirst says that the national proposal for insurers to take everyone without regard to health status or pre-existing conditions "could produce losses that would cut into the reserves of GHMSI and other insurers nationwide." However, in the bills currently before Congress, this is not a large risk that GHMSI would face in the near future. Under the House bill, requirements for guaranteed issue and the prohibition on pre-existing condition exclusions in the individual market go into effect in 2013. In the same year, other reforms will guard against risk for individual insurers: individuals will be required to maintain coverage and will receive significant federal subsidies for premiums and risk adjustment mechanisms between insurers will prevent any one insurer from baring an unfair cost burden. Under the Senate HELP bill, states would have six years to put market reforms in place, and again, an individual mandate and federal subsidies for coverage would increase insurance pools, and risk-adjustment mechanisms would help protect insurers against losses. We do not know what health reform bill will ultimately pass, but national lawmakers will be working to make sure that reform is viable for both consumers and insurers.

3) CareFirst's 2008 statements show that its assets have continued to grow and that it continues to collect more in premiums for both its individual and small group products than it incurs to provide health services.

In other states, insurance commissioners have denied premium rate increases, reduced them, or required other community investments when insurers were increasing their surplus and/or when consumers faced unaffordable costs. For example, insurers all withdrew rate increase filings in Rhode Island this summer at the Commissioner's request (see http://www.ohic.ri.gov/2009%20RateFactorReview.php). In response to a market conduct exam in 2008, the Colorado Insurance Department and Kaiser Permanente agreed that Kaiser would invest $155 million in lowering premium rates, providing financial assistance with copayments, and building medical facilities in Colorado in 2008 and 2009 (http://www.dora.state.co.us/dora_pages/newsreleases/Kaiser62308.pdf). We urge you to take similar action.

Sincerely,



Cheryl Fish-Parcham
Deputy Director of Health Policy

Market	4/1/2008	7/1/2008	10/1/2008	1/1/2009	4/1/2009	7/1/2009	10/1/2009	1/1/2010
Small Group Non-CDH Plans	4.90%	0.80%	4.6%	6.50%	7.20%	0.50%	2.80%	2.80%
Small Group HSA	0	0.80%	7%	7.50%	16.70%	6.5%	6%	3%
Small Group HRA	0	0.80%	7%	7.50%	16.70%	15.40%	6%	3%
Small Group Drug Products	7%	2.40%	0%	4%	2%	3%	1%	
Open Enrollment (Medical)	9.20%	0.00%	0%	0	15.10%	0.00%	0%	0
Open Enrollment Closed Rx	9%	0	0	0	30%	0	0	
HIPAA	0	3.60%	0	12.3	0	2.80%	0	
Individual Group Conversion PPO	21.10%	0	0	0	24.80%	0	0	
Individual Group Conversion Rx	13%	0	0	0	0	0	0	0
Individual Indemnity (Comprehensive Major Medical) Underwritten and Group Conversion	0	0	0	14.50%	0	0	0	
Individual BluePreferred Standard Underwritten	0	3.60%	0	12.30%	5.70%	2.80%	0.00%	
Individual BluePreferred Underwriten Saver	0	0	0	0	5.70%	8.80%	0	
Individual HSA	0	0	0	0	29%	0	0	
Small Group Dental PPO	0	0	0	3.40%	0	4.60%	0	0.00%
Small Group Dental PPO Rider	0	0	0	3.40%	0	4.60%	0	0.00%
Small Group Dental Indemnity	0	0	0	6.70%	0	4.60%	0	0.00%
Small Group Dental Indemnity Rider	0	0	0	6.70%	0	4.60%	0	0.00%
Large Group BlueChoice non-CDH Medical and Drug (51-199 and 200+ contracts)		2%						
Large Group BlueChoice CDH Medical and Drug (51-199 and 200+ contracts)		4%						
Medigap Underwritten	0	0	0	14.50%	0	0	0	
Medigap Standardized Non-Underwritten				9.50%				
Medigap Plan C and F, Ages 65-69	0	-7.50%	0	0	0	0	0	
Medigap Plan C and F, Ages 70-74	0	-2.50%	0	0	0	0	0	