



District of Columbia
Primary Care Association

Action And Innovation For Health Equity.

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Council of the District of Columbia

PUBLIC HEARING on

**Bill 19-0002, the "Department of Health Care Finance District
of Columbia Health Care Exchange Authorizing Act of 2011"**

February 9, 2011

Committee on

Public Services and Consumer Affairs

The Honorable Yvette M. Alexander, Chairperson

By

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Good afternoon, Chairperson Alexander and distinguished members of the committee. My name is Sharon Baskerville, chief executive officer for the DC Primary Care Association (DCPCA). DCPCA represents historic, safety net, community-based primary care providers and other key stakeholders who are committed to our mission of creating a health care system in the District of Columbia that allows for everyone to be covered and everyone to be cared for. I am here today to speak about Bill 19-0002, the “Department of Health Care Finance DC Health Care Exchange Authorizing Act of 2011.”

A HEALTHY WORKFORCE IS A PRODUCTIVE WORKFORCE

Models of insurance exchanges can vary widely. At minimum, an exchange can be an online portal that helps buyers compare plan options and enroll online. At the other extreme, an exchange can actively standardize benefit designs and negotiate with insurers in an attempt to manage premium increases, as is the case in Massachusetts. Small business and individual markets do vary in needs and process when it comes to purchasing insurance. But both require a competitive marketplace and options that our current system does not offer. Consider DCPCA’s insurance options as a small business employer over the last two years. Limited to only four insurance companies – Aetna, CareFirst BlueCross BlueShield, Kaiser Permanente, and UnitedHealthCare – our rates have been astronomical:

2009 - 34 employees [30 received benefits] – More than \$200,000 (close to \$6,700 per member)

2010 - 32 employees [29 received benefits] – More than \$230,000 (nearly \$8,000 per member)

Many of the community health centers DCPCA represents are small businesses as well¹, which require affordable insurance products for their employees, particularly as they provide care regardless of their patients’ ability to pay.

THE SAFETY NET

➤ *THE PATIENTS*

Insurance exchanges offer a centralized location for people to shop for health insurance. For a long time in DC we have been exploring options to better streamline eligibility and enrollment for public benefits, for everything from Temporary Assistance for Needy Families (TANF) to Medicaid and the DC HealthCare Alliance, to new insurance products like CO-OPS and exchanges. When combined with other coverage policies, exchanges can also act as a risk-pool, decrease administrative burden for purchasers, and

¹ An Economic Impact Analysis from 2007 shows that DC community health centers benefit the District at multiple levels – as public service providers, employers, and local businesses. Not only do they provide health care to all, regardless of patients’ ability to pay, they also generate a significant economic impact in their communities. In Fiscal Year 2005, health centers had an overall impact of more than \$185 million. This includes an injection of \$116 million in operating expenses into the local economy, which produced indirect and induced economic activity of more than \$69 million. Furthermore, the health centers generated a total of 1,830 jobs: 1,297 direct positions and an additional 533 jobs as a result of their total operating expenditures.

facilitate premium payments or subsidies to health plans. If DC creates its own exchange, rather than allowing the federal government to set one up for us, we have some authority over how to best design eligibility, enrollment, insurer participation, among other efficiencies. Additionally, the District often celebrates its rate of insurance coverage in DC, with nearly 94 percent of its residents having some type of coverage. However, we must remember that more than a third of the District residents are covered by the Alliance or Medicaid programs. We must make certain that no resident loses coverage as a result of health care reform, and that people do not choose plans that adversely affect their situation (i.e., choosing a low premium plan which carries with it high co-pays and large deductibles). One important issue to note is that while there are federal subsidies available to consumers for assistance with the premium, there are few requirements on premium and co-pays, which can render a plan completely useless for low-income families who are unaware of potential hidden costs. The District needs to also consider that there may be many working poor who are now on Medicaid, as the result of the recent economic downturn, but who we may think will shift to the exchanges. The likelihood that these people can afford the out-of-pocket costs associated with exchange plans is slim.

➤ *THE COMMUNITY HEALTH CENTERS*

Private insurers in the health insurance exchange will be required to contract with community health centers and other priority primary care providers. These new provisions will protect health center patients from being excluded from private insurance coverage under the health insurance exchange, and health centers should no longer be underpaid for their services. *The District should go beyond these requirements in support of DC’s historic safety net providers. While only a third of the District’s health centers are FQHCs, they are all Medical Homes DC projects and they are all on the path towards becoming certified “Patient Centered Medical Homes,” and as health homes, with a broad scope of services, they should be contracted with and reimbursed appropriately.*

Another important provision is the inclusion of preventive services in insurance plans. Starting this year, some individual insurance and group health plans must offer preventative services for no additional out-of-pocket charges to consumers, and grants are available to Medicaid to incentivize chronic disease prevention. Covered services include immunizations, cancer screenings and checkups. Prevention is important in lowering health care costs long term and improving health outcomes for patients. *It is essential that insurance products offered through the exchange should, at a minimum, include preventive services and parity with benefits offered through the Medicaid program. There is absolutely no reason why District residents should be willing to accept anything less.*

CLOSING

Chairperson Alexander, I would like to thank you for the opportunity to testify at this public hearing before the Committee on Public Services and Consumer Affairs. DCPCA remains firm in our commitment to advocate for all District residents. We have worked diligently to make sure that all low-income individuals receive the health care they are seeking at the right time, in the right place, and that their basic human rights are met with dignity and integrity. As we implement Federal health reform here in the District, developing our own Health Insurance Exchange is crucial, and we must move more quickly since we must notify HHS of our decision to implement our own exchange by January 1, 2013. We are running out of time, and we may miss out on additional planning money. As we plan the exchanges, we should also have a real clear understanding of how the exchange will interact with our broader health system, and the hundreds of thousands of District residents who seek care in that system. This bill gives the DC Department of Health Care Finance the authority to create a health insurance exchange, and we believe that they should move as quickly as possible towards developing an exchange that meets the needs of District residents, small business employers, and others.

I am happy to answer any questions that you may have.