Council of the District of Columbia

OVERSIGHT HEARING on

Office of Risk Management

February 22, 2011

Committee on
Government Operations and the Environment
The Honorable Mary Cheh, Chairperson

By

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Good afternoon, Chairperson Cheh and distinguished members of the committee. My name is Howard Liebers, director of policy 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. As we set out to achieve health equity in the District through action and innovation, I am here today to focus my testimony oversight of the Office of Risk Management.

The Office of Risk Management has worked ambitiously towards managing the Captive Insurance program, and we appreciate the efforts of Phillip Lattimore, Mareco Edwards, Amy Mauro and other ORM staff to continue to provide the critical malpractice protection community health centers need. The coverage provided to health centers across DC through the Medical Liability Captive Insurance Agency (MLCIA) has been instrumental to health centers' growth and success. The result of MLCIA on health centers has been the allocation of funds for direct patient care services rather than purchasing commercial malpractice coverage—which would have been cost prohibitive, and in fact some health centers could not even get an insurance quote in the private market. As stated in previous testimony, our health centers are committed to providing services to the uninsured and underinsured regardless of their ability to pay. Since the mission of community health centers is to see the most vulnerable, there is little margin because of relatively low reimbursement for primary care, as well as extensive unreimbursable services such as translation services, case management, and other wrap-around services that support patients' ability to access quality care. Some health centers, through their savings on malpractice insurance through the Captive subsidy, have in fact been able to hire more staff, allowing them to provide more comprehensive care and see more patients. The availability of Captive has resulted in increased resources, providing a direct benefit for our indigent client population, because of the savings from not having to purchase expensive commercial malpractice insurance.

The DC Primary Care Association has several questions and concerns with regards to the Captive's continued sustainability, such as:

- The Office of Risk Management was never intended to be the manager in the issuance of policies. We had an advisory council, which has not met in a couple of years now, which had indicated that AON would manage the program and issue policies (in a more fiscally sound manner through the support of a larger risk pool), while ORM would serve as supervision and oversight.
- The Office of Risk Management has never purchased re-insurance to protect the pool of money in the Captive Trust, and so if there is ever a claim, the District would be at risk of having to support the issued policies.
- There has not been clarity about the amount of money that exists in the Captive Trust, though both this Committee and the Committee on Health expressed re-allocating funds during the previous budget oversight hearings.
- There is no clear process or methodology for assessing subsidies for the health center premiums. For example, Family and Medical Counseling Service, Inc. was issued a premium of $121,981 with an 85% subsidy, and therefore only had to pay $18,297.15 whereas the Family Health and Birth Center was issued a premium of $114,686 with absolutely no subsidy at all.

The previous leadership at ORM had no understanding or experience with Captive insurance programs, as demonstrated by their attempt to instead issue grants to health centers to purchase their insurance products on the private market. DCPCA again requests that there be an audit, in an effort to secure remaining funds and locate where and how the previous $8.4 million dollars allocated to the program were spent. On the issue of subsidies, DCPCA proposes that perhaps there be some flat assessment or percentage across the board for Medical Homes DC projects, consistent with an arrangement struck for Certificate of Need (CON) where all health centers pay $5,000 for their CON.

DCPCA hopes the government of the District of Columbia will continue our partnership by providing the resources that health centers require to continue serving as the primary care and safety net provider for the more than 230,000 District residents on Medicaid and the Alliance, as well as many others who are without any insurance. This is an essential program for the District's safety-net and it is critically important that we find solutions which ensure the program is sustainable. Thank you for the opportunity to testify on this important issue. I am happy to answer any questions you may have.