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HEALTHCARE IN THE DISTRICT OF COLUMBIA: ACCESS TO PRIMARY CARE AND AFFORDABLE HEALTH INSURANCE

HEARING

BEFORE A

SUBCOMMITTEE OF THE

COMMITTEE ON APPROPRIATIONS

UNITED STATES SENATE

ONE HUNDRED NINTH CONGRESS

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HEALTHCARE IN THE DISTRICT OF COLUMBIA: ACCESS TO PRIMARY CARE AND AFFORDABLE HEALTH INSURANCE

THURSDAY, APRIL 6, 2006

U.S. SENATE,
SUBCOMMITTEE ON THE DISTRICT OF COLUMBIA,
COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 1:32 p.m., in room SD–138, Dirksen Senate Office Building, Hon. Sam Brownback (chairman) presiding.

Present: Senator Brownback.

OPENING STATEMENT OF SENATOR SAM BROWNBACK

Senator BROWNBACK. The hearing will come to order. Thank you all for joining us this afternoon.

Today we've convened a hearing of expert witnesses to better understand the health status and insurance status of District of Columbia residents, the access to preventative and primary care in the District of Columbia and ways to increase the availability and affordability of health insurance for those who live and work in this city.

About 17 percent of District adults have no health insurance at all, some 50,000 people at any one time, and 75,000 at some time during the year. One in ten African-Americans are uninsured, and one in three Latinos are uninsured. This compares to about 1 in 20 Caucasians uninsured. We have a chart up, showing that, on the side. I'm concerned, however, that this rate of uninsurance may actually be higher than what even the charts say.

I believe that it is an important goal to help people gain access to affordable health insurance, because, as Mr. Bovbjerg, of The Urban Institute, will soon testify, people with health coverage have better access to medical care, and are measurably healthier, than those who are not insured. I believe that access to preventative and primary care is crucial for helping individuals live longer, healthier lives, and more productive lives.

Aside from poor overall health outcomes, individuals who are not insured usually do not seek routine and preventative care, and often use hospital emergency rooms to access treatment for non-emergency ailments. The cost of so-called "free" emergency room treatment is not free at all, because it is passed on to insured patients, via higher premiums, and to other payers.

We look forward to hearing from our witnesses today about the healthcare needs of those they serve, available services for the pa-

tients they care for, and their perception of the barriers to expanding health insurance coverage. We also look forward to hearing ways that we can reach and enroll uninsured persons who live and work in the District.

Senator Landrieu may join us a little later, but if she can't make it her statement will be inserted in the record. They're having a caucus right now on a topic, immigration, which has certainly grabbed all of us lately, so I don't know if she'll be here or not, but if she is, I'll recognize her for any statement that she might have.

We've combined our panels, and I'm appreciative of all of you being here. We'll run the clock at 5 minutes and each of you can put your written statements in the record, if you'd be willing to do that, and then testify on the topics that you're interested in and what you think we need to be considering. And I then want to ask some questions of you.

We'll have testifying Ms. Brenda Donald Walker, Deputy Mayor of the District of Columbia for Children, Youth, Families, and Elders; Mr. Randall Bovbjerg, principal research associate of The Urban Institute; Ms. Sharon Baskerville, executive director of the D.C. Primary Care Association; Ms. Maria Gomez, president and CEO, Mary's Center for Maternal and Child Care; Ms. Christine Reesor, medical clinic coordinator, D.C. Spanish Catholic Center; Mr. Lawrence Mirel, former commissioner of insurance securities and banking for the District of Columbia; and Mr. Edmund Haislmaier, research fellow, Center for the Health Policy Studies at The Heritage Foundation.

I appreciate all of you joining us today. Your full written statement will be put into the record.

And let's start with Ms. Walker, and your testimony. Thanks for joining us.

STATEMENT OF BRENDA DONALD WALKER, DEPUTY MAYOR, CHILDREN, YOUTH, FAMILIES, AND ELDERS, DISTRICT OF COLUMBIA

ACCOMPANIED BY DR. GREGG PANE, DIRECTOR, DEPARTMENT OF HEALTH, DISTRICT OF COLUMBIA

Ms. WALKER. Thank you so much.

Good afternoon, Senator Brownback and members of the staff and the subcommittee.

I am Brenda Donald Walker, District of Columbia Deputy Mayor for Children, Youth, Families, and Elders. I am accompanied here today with—by Dr. Gregg Pane, who is director of the District's Department of Health. We are very pleased to be here to discuss the status of healthcare in the District.

Over the past 7 years of the Williams administration, there has been significant progress on several fronts, but there is still much work to be done.

The most significant accomplishment of this administration is in the area of health coverage. Five years ago, the Mayor created the D.C. Healthcare Alliance, a program that offers comprehensive health coverage to all District residents under 200 percent of poverty who don't qualify for Medicaid. The Alliance provides care to roughly 30,000 District residents, and it has led to decreases in emergency room visits and an increased use of primary care. The District is now the only jurisdiction in the United States that offers

health coverage to all residents under 200 percent of poverty. The Mayor has proposed to expand coverage even further in fiscal year 2007 by expanding Medicaid for children up to 300 percent and adding an adult dental benefit.

Despite high rates of insurance, though, not every District resident has ready access to medical services. To address this, the Mayor has strongly supported the medical homes initiative, which you will hear more about, to improve the quality and availability of primary care in underserved neighborhoods. In addition, he has proposed to build a new private hospital, in partnership with Howard University, to provide access to medical care and emergency care for residents on the eastern side of our city.

Yet, the District continues to face some very dire health statistics. Our rates of chronic and communicable illness are much higher than the national average, especially in some parts of the city. In particular, we are concerned about diabetes, hypertension, asthma, infant mortality, HIV/AIDS, and substance abuse.

In the past year, we have developed several new initiatives to address the root causes of illness. We have just launched an innovative model of healthcare in our jail facilities to improve inmate care and provide continuity of care when inmates are released back into the community. We are also focusing on HIV/AIDS, and the Mayor has announced a high-level task force to develop a full plan. In the meantime, we are partnering with George Washington University to improve surveillance and also to encourage widespread HIV testing.

We know, of course, that there is much more to be done, and we welcome opportunities to work with the Federal Government, especially on projects that could serve as demonstrations for the rest of the country. One such initiative is a comprehensive prevention and disease management program that has three different components—a major media campaign to communicate health behaviors and to—to communicate health behaviors necessary to stay healthy, a health outreach program that we think will address some of the people who are eligible for coverage, but who are not yet insured, and also to provide peer-to-peer health education and a chronic disease collaborative to improve care management among District health providers.

Another area for potential partnership is the creation of a National Capital Area Regional Health Information Exchange, to develop a model of data sharing among healthcare providers across the region.

Another potential Federal/local initiative would be a partnership to further expand health coverage in the District. While we lead the Nation in offering health coverage to low-income individuals, there is still a gap for people who earn too much to qualify for public programs, but can't afford private insurance.

Thank you for this opportunity to testify. Dr. Pane or I will be happy to answer questions that you have. Thank you.

Senator BROWNBACK. Thank you very much.

[The statement follows:]

PREPARED STATEMENT OF BRENDA DONALD WALKER

Good afternoon Senator Brownback and distinguished Members of the committee. I am Brenda Donald Walker, District of Columbia Deputy Mayor for Children, Youth, Families and Elders. I am here today with Dr. Gregg Pane, director of the District's Department of Health. I am very pleased to be here to discuss the status of healthcare in the District and opportunities for the District and the Federal government to work together to improve health outcomes in our Nation's capital. Over the past 7 years of the Williams Administration, we have made significant progress on several fronts, but there is still much work to be done.

The most significant accomplishment of this administration is in the area of health coverage. Five years ago, the Mayor made the difficult decision, supported by Congress and the former Financial Control Board, to close the financially and medically troubled District of Columbia General Hospital. This closure was met with significant opposition from the District of Columbia hospital industry, employees of the hospital, and healthcare advocates, who made doomsday predictions about the impact of the closure. However, by closing the hospital, the Mayor freed up significant local funds which were used to start the DC Healthcare Alliance (the Alliance), a program that offers comprehensive health coverage to all District residents under 200 percent of the Federal Poverty Level (FPL) who don't qualify for Medicaid. The Alliance, now 5 years old, is routinely lauded as one of Mayor Williams' most important accomplishments. Through the Alliance, we now offer primary and preventive care, as well as choice of healthcare provider, to roughly 30,000 District residents who used to receive most of their care in the District of Columbia General emergency room. Since the early days of the Alliance, ER visits among the Alliance population have decreased, inpatient admissions have declined and primary care visits have increased. We have also begun to see a decline in "avoidable hospitalizations", which are preventable through adequate primary and preventive care. This trend is particularly evident for District children. This means that we are keeping District residents healthier and spending taxpayer dollars more wisely. Over the next several months, we will be significantly improving the ability of the Alliance to monitor health outcomes by transitioning it to a managed care model, similar to our District of Columbia Healthy Families Medicaid program.

In addition to the creation of the Alliance program, Mayor Williams implemented SCHIP (State Children's Health Insurance Program) in 1997, expanding Medicaid coverage to children and parents from 100 percent to 200 percent of poverty. With the expansion of Medicaid and the creation of the Alliance, the District of Columbia is now the only jurisdiction in the United States that offers health coverage to all residents under 200 percent of poverty. This expansive health coverage policy is reflected in District statistics on the uninsured. In 2003, the Kaiser Family Foundation found that the District's rate of uninsurance was just 9 percent compared to a national rate of 21 percent. In a more recent study, the Urban Institute found that just 5 percent of the District population is both uninsured and over 200 percent of poverty, without access to a public insurance program. The Mayor has proposed to expand coverage even further in his recent fiscal year 2007 budget submission. The budget offers Medicaid coverage for children up to 300 percent of poverty, and it closes a major gap in the Medicaid benefit package by adding an adult dental benefit.

Despite these high rates of insurance in the District, not every District resident has ready access to physician and hospital services. A 2004 report by the Rand Corporation and Brookings Institution, sponsored by the District of Columbia Primary Care Association, showed that in some neighborhoods, particularly on the east side of the city, as many as 25 percent of the population has no regular source of primary care. In addition, there is little access to specialty, diagnostic, inpatient and emergency care on the east side of the District. Many patients travel long distances to reach doctors, health centers and hospitals, which are primarily located in the Northwest quadrant of the District of Columbia, even though the highest concentrations of chronically ill residents and emergency transports come from the east side of the city.

To address this issue of lack of access to care, the Mayor has supported two major initiatives. The Medical Homes initiative, in partnership with the District of Columbia Primary Care Association and the Brookings Institution, is designed to increase the availability of primary care health centers in underserved neighborhoods and to improve the quality of care in health centers across the District. The National Capital Medical Center proposal, in partnership with Howard University, to build a new private hospital is designed to ensure access to specialty, diagnostic, inpatient, emergency, and trauma care to residents on the eastern side of the city. Through these two initiatives, the city will provide capital funding to spur the development

of new private nonprofit healthcare facilities in underserved neighborhoods. As a result, residents with either public or commercial health insurance will have somewhere to use their insurance cards.

Health coverage programs for low-income individuals are largely in place in the District, and initiatives to expand the private healthcare delivery system are moving forward. However, the District continues to face some very dire health statistics. Our rate of chronic illness is much higher than the national average, especially in some parts of the city. For example, 20 percent of Ward 8 residents and 13.5 percent of Ward 7 residents reported being diagnosed with diabetes in 2004. Nationally the figure is 7.0 percent.[1] The District has one of the Nation's highest asthma rates. In 2002, 13 percent of Ward 1 residents and 12.3 percent of Ward 7 residents reported having been diagnosed with asthma, while the national was just 8.2 percent.[2] In 2003, the District experienced an alarming rate of death from hypertension of 64.2 per 100,000, which is significantly higher than the national average of 7.5.[3]

In addition, infant death rates, primarily attributable to poor prenatal care and risky behavior during pregnancy, are very high in certain parts of the city. For example, in Wards 8, 7, and 5, the infant death rates are 18.4, 12.9, and 12.6 per 100,000 respectively, compared to a national rate of 6.9.[3] Our rates of communicable disease, most notably HIV/Aids, are deplorable. In 2004, the rate of HIV/Aids infection in the District was 179.2 per 100,000 residents compared with 15.0 nationally.[4] And our rate of substance abuse is 9.6 percent, 52 percent higher than the nationwide rate of 6.3 percent. Approximately 60,000 residents—nearly 1 in 10—are addicted to illegal drugs or alcohol.

I will note a few silver linings in our health outcomes data. Some of our health statistics are better or equal to national averages. For example, the District's rate of school age immunization is now 96 percent, one of the highest in the Nation.[5] The District death rate from strokes is significantly lower than national average, with a rate of 37.4 per 100,000 compared with 54.3 nationally in 2003.[6] The prevalence of smoking in the District has gone down to 20.8 percent and is now equal to the United States average.[7] I will also point out that the District frequently compares very unfavorably to States and to the national average, where a more apples-to-apples comparison to other urban areas would show more comparable data.

Despite these silver linings, the District's health status in general is in need of substantial improvement. We believe that over time, health coverage and access to medical facilities will improve these outcomes. But in order to significantly move our health indicators, we must attempt to address the root causes of illness, many of which are linked to individual behaviors and lifestyles, and we must target hard-to-reach populations. We have recently started a number of initiatives designed to address health outcomes.

We have taken very seriously a report on the HIV/AIDS epidemic in the District of Columbia, authored last year by the District of Columbia Appleseed Foundation. We are beginning to implement many of the recommendations from that report. First, just this week, we are announcing a high-level HIV/AIDS Task Force to develop a full plan to address the epidemic. Second, we are also pleased to announce an academic public health partnership with George Washington University School of Public Health—a partnership that will help us improve the surveillance activities and monitoring of our local epidemic. Third, consistent with President Bush's State of the Union message about the importance of HIV testing and outreach to communities with high rates of HIV infection and the CDC's initiative to make HIV testing routine in all medical settings, the District of Columbia will soon undertake an initiative to encourage widespread testing, so that everyone in the District of Columbia knows their HIV status. Finally, also consistent with President Bush's concerns

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[1] Behavioral Risk Factor Surveillance System, 2004; analysis by the National Center for Chronic Disease Prevention and Health Promotion, Division of Nutrition and Physical Activity, Centers for Disease Control and Prevention, available at *http://apps.nccd.cdc.gov/brfss/list.asp?cat=DB&yr=2004&qkey=1363&state=All.*

[2] Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2004. Available at *http://apps.nccd.cdc.gov/brfss/list.asp?cat=AS&yr=2004&qkey=4416&state=All.*

[3] DC Department of Health Vital Statistics, 2003.

[4] Table 14, HIV/AIDS Surveillance Report: Cases of HIV Infection and AIDS in the United States, 2004, Volume 16, National Center for HIV, STD and TB Prevention, Centers for Disease Control and Prevention, Department of Health and Human Services, 2005. Available at *http://www.cdc.gov/hiv/stats/2004SurveillanceReport.pdf.*

[5] Immunization rates data, District of Columbia Public Schools.

[6] DC Department of Health Vital Statistics, 2003.

[7] America's Health Ranking, United Health Foundation, 2005.

about services to incarcerated populations, the District of Columbia will expand HIV testing in the District of Columbia correctional facilities.

Another area of focus in the past year has been generally improving corrections healthcare. Just yesterday, the Mayor announced an innovative new partnership between the District's largest Federally Qualified Health Center, Unity Health Care, and the Department of Corrections to provide care to inmates in District jail facilities. The goal of the partnership is to create continuity of care from community health facilities to jail health facilities, since much of the population overlaps. Incarceration is an opportunity to identify and begin treatment for chronic and communicable diseases. By partnering with Unity, the District will ensure that treatment continues after inmates are released into the community. The District is fortunate to have received significant support through the Robert Wood Johnson Foundation to implement this new model in October.

To address quality of care for chronic illnesses, both of the District of Columbia's public health coverage programs, Medicaid and the Alliance, have selected quality performance metrics and are now implementing a plan to hold contracted managed care organizations accountable for improvement on their scores. Ultimately, we plan to create pay-for-performance incentives to catalyze improvements in disease management, and ultimately, District-wide health outcomes.

The District's new smoke-free legislation, banning tobacco use in most restaurants and bars, begins to take effect this week. In addition, in the past year, the Department of Health sponsored town hall meetings on healthcare disparities in every Ward of the District. These forums allowed us to gather information from District residents and begin to promote healthier lifestyles.

But we know there is more to be done. In our latest strategic planning cycle, we identified several major initiatives to address health outcomes that would benefit from a Federal partnership, and also potentially serve as demonstration projects that, if successful, could be replicated in other parts of the country.

One such initiative currently in development is a comprehensive, District-wide prevention and disease management program. This program would include three different components targeting both healthcare providers and patients. The first aspect of the initiative would be a major media campaign targeted at the general District population to communicate the key behaviors necessary to stay healthy. Supporting the media blitz, the second component would be a community health outreach worker program. This program would rely on peer-to-peer education about how to get screened for and manage chronic illnesses, as well as how to lead a healthy lifestyle. We would target this program to specific neighborhoods and populations with negative health indicators. For example, we could develop a group of Spanish-speaking outreach workers for the Latino immigrant community or a group of young adult outreach workers to target teens. Outreach would be conducted in places that already cater to key target populations, such as churches and barber shops. The outreach worker model has the added benefit of being a workforce development program, providing jobs and a career ladder for members of lower-income communities. The third component of the disease management initiative would be a District-wide chronic disease collaborative. Under this model, physicians and community health centers across the city would work together to simultaneously implement disease management methods to better track care and outcomes of populations with chronic illnesses. We believe that this type of multi-pronged effort to prevent and treat chronic illness is a key step toward progress on the District's negative health indicators. It would surely benefit from Federal start-up funds.

As an aside, one challenge in developing such a program is that currently, Federal funds supporting disease management are narrowly focused on specific diseases, making it difficult to create programs that target whole neighborhoods and sub-populations. We have begun a very positive relationship with the Centers for Disease Control to try to increase our flexibility, but Federal funds ideally would allow more broad-based expenditures.

Another area for a potential partnership is the creation of a National Capital Area Regional Health Information Exchange. Healthcare data sharing, with appropriate privacy and security protections, enables better coordination among emergency rooms, primary care physicians, specialists, and hospitals. This improved coordination allows primary care physicians to better manage chronic illnesses. It also decreases the incidence of medical errors and minimizes duplicative health services, ultimately slowing the growth of public and private healthcare costs. In addition, the data collected can be used to improve disease surveillance and healthcare policymaking. The District and surrounding jurisdictions in Maryland and Virginia are now in the early stages of developing a Regional Health Information Organization for the National Capital Region to develop a technical model and governance structure for health information exchange among hospitals, physicians, and payors. In

the Mayor's Fiscal 2007 budget, we funded the implementation of electronic medical records for all medical homes community health centers in the District. This is a major building block for health information exchange. In addition, we have begun an exciting pilot program called QuickConnect, which electronically provides key health records from hospital emergency rooms to community health centers, enabling them to follow up with patients who have visited the ER.

As a multi-state region, the National Capital Area is an ideal location to demonstrate data-sharing, because the ultimate goal is to foster a national, interstate model for data sharing. In addition, the region continues to be a target for terrorist attacks, and health data sharing will be crucial in responding to any major disaster. Finally, health coverage in this region is largely funded by the Federal Government, through the Federal Employees Health Benefits Plan, Medicare, and Medicaid. That means that the expected cost savings of health information exchange will accrue to taxpayers. We are currently seeking funding to fully launch the National Capital Area Regional Health Information Organization. We envision that this organization will ultimately adopt a self-sustaining business model.

Another potential Federal/local initiative would be a partnership to further expand health coverage in the District. While we lead the Nation in offering health coverage to low-income individuals, there is still a gap for low to moderate income individuals, especially between 200 and 400 percent of poverty. These people earn too much to qualify for public programs, but they have difficultly affording private insurance. In the last year, through a Department of Health and Human Services funded State Planning Grant for Health Coverage, we have explored numerous options for expanding coverage to this population. One such model would subsidize private commercial insurance through a State-run stop-loss pool. Another model would allow moderate income individuals to buy into District Medicaid and Alliance managed care plans, with sliding-scale premiums according to income level. We have also evaluated the Equal Access model, which would open the District of Columbia Government employee health purchasing pool to private employers. All of these models would require some level of sliding-scale subsidy in order to attract members.

Finally, additional Federal funding for our existing District health coverage programs, Medicaid and the Alliance, would allow us to continue to expand the District's market-based model for coverage to the low-income uninsured. With the Alliance, the District moved from a government-run, safety-net public health system to a market-based system for covering difficult populations, such as the homeless. As mentioned earlier, this new model appears to be making significant improvements to care. Until now, we have been able to budget enough local dollars to cover all eligible Alliance applicants. The District currently invests nearly $100 million in local dollars for the Alliance. However, we have been quite successful in expanding the Alliance program, and membership has increased steadily, up 25 percent in the past year alone to over 30,000 members. Soon, it is likely that demand for the program will outstrip the dollars budgeted for the program. In order to continue enrolling all eligible District residents, funding will have to increase in the next several years. The Federal Government could offer some flexibility that would allow the Alliance to transition to a Medicaid waiver program, thus qualifying for Federal funding. Another alternative would be to increase the District's FMAP rate for Medicaid, which would free up additional local funds for the Alliance program. Despite that fact that one in four District residents is covered by Medicaid, the District still only has a 70 percent FMAP rate, compared to States such as Mississippi, which have rates as high as 77 percent.

Thank you for this opportunity to testify today. Dr. Pane or I would be happy to answer your questions.

Senator BROWNBACK. Mr. Bovbjerg.

STATEMENT OF RANDALL BOVBJERG, PRINCIPAL RESEARCH ASSOCIATE, THE URBAN INSTITUTE

ACCOMPANIED BY BARBARA ORMOND, THE URBAN INSTITUTE

Mr. BOVBJERG. Yes. Good afternoon. I am Randall Bovbjerg. With me is Barbara Ormond. We're delighted to join you in an effort to improve health insurance coverage and make the District a better place to live, work, and do business.

We do work at The Urban Institute, and it is here in the District. We've also lived here for decades, although I grew up in Iowa, and Barbara grew up in Georgia.

Our testimony draws on work done for the State planning grant of the D.C. Department of Health. We thank Dr. Pane. But I am only speaking for me and Barbara today.

I also would like to pause and thank staff here for producing these colorful charts on very short order. You can barely see that, but they are quite colorful.

And I need to acknowledge that I have another colorful visual aid, sent to me by the Scots-Canadian branch of the family in honor of National Tartan Day, which was proclaimed by the Senate in 1998. So, Happy Tartan Day. I find it a useful reminder.

Senator BROWNBACK. Why didn't you have that on?

Mr. BOVBJERG. Because I am wearing my D.C. flag, which shows the District Building and the Capitol Building, both.

Senator BROWNBACK. So, it would kind of clash, those two?

Mr. BOVBJERG. It would be difficult. I had a plaid coat, and my wife made me give it away. I can use it here to highlight—that we already submitted, but we already submitted it to the record.

And that will serve to bring us back to the topic of health insurance, which is, indeed, as you said, Mr. Chairman, a very important topic, and for precisely the reasons you named. In short, people get better access to care. They're healthier, they live longer, they're likely more productive. They do better, even in communities that have invested heavily in safety-net facilities to provide care for the uninsured.

There is a lot more detail under the tartan, and I refer you to that. Let me mention four things very quickly.

The District has a slightly lower rate than the Nation as a whole, as we just heard. Most of the uninsured work, which is often unappreciated, they are disproportionately male African-American, and especially Latino, as the chart just showed. And they live all over, which I think isn't appreciated. Indeed, something more than a quarter live in the southeast quadrant of the District, which is a little bit higher than that share of the population. But about twice that many live in the northwest quadrant, which is only slightly less than its share of the population.

Now let's look at four charts that aren't in the report. We've got number one up there right away. They're from different sources, and they look at who has coverage and who doesn't. This is just a graphic illustration of what we've just heard, that the District has done a lot for poor people. And between SCHIP and Medicaid, in the dark color, and this quasi-insurance program, which is becoming more like insurance over time, called the Alliance, the District, in theory, offers coverage to everyone, up to 200 percent of poverty. Not everyone applies. And if everyone did, the current resources would not cover them.

Exhibit 2 takes a look at the people who are insured. It does it by income. And it does it by program eligibility category and by work status. About 50,000—you mentioned 50,000, Senator—are in this category that is targeted by either Medicaid or the Alliance. Some of those people, perhaps half, might be in the Alliance. We don't really know, because this survey doesn't really ask the ques-

tion to find out. It might be half of them have this quasi-insurance coverage already. On the other side are the same people, but broken out by work status. And here are the people, that were just referred to, who have incomes above the public assistance level, and yet don't have coverage. And there are somewhat over 13,000 of those, on a 3-year average early in the 2000s. This was a group that the State Planning Grant Advisory Panel identified as a likely target of subsidy to try to see if they wouldn't purchase insurance on their own.

Then exhibit 3 compares this group of the uninsured—and here they are again; this is the uninsured—with the similar people of the same incomes who have insurance, and how they got it.

So, what this shows is that if one targets this income group, the 200 to 400 percent income group, indeed, you capture the 13,000 people who don't have coverage, but you're also aiming more or less at the 83,000 of the same income who already have coverage. And that raises the possibility that there could be some displacement of those private dollars with public dollars unless steps are taken to avoid that.

Then exhibit 4 shows the wide variation that would occur if, indeed, uninsured people were made insured. And this assumes that the people would get insurance of the type that people of this income level buy for themselves. And the variation is enormous. So, you get—would get almost $12,000 in spending between the insurance coverage and the out-of-pocket amount for the elderly in fair or poor health, and, at the other end, you've got under $800 for the kids in excellent health. So, the average price, the average spending, the premium could be set targeted at $1,700, but that would not be enough if disproportionately above-average people were the ones who signed up. So, that's a significant problem. The insurers call it "adverse selection," and it's something you'll be hearing more about.

Thank you very much.

Senator BROWNBACK. Thank you.

[The statement follows:]

PREPARED STATEMENT OF RANDALL R. BOVBJERG

Expanding health insurance is a major District government priority. One manifestation of this priority has been funding analyses under the State Planning Grant (SPG) won by DC's Department of Health in conjunction with The Urban Institute. We are the co-Principal Investigators on this HRSA-funded project. The PI is Brenda Kelly of DC–DOH.

The reason for promoting insurance is that people with health coverage have better access to medical care, are demonstrably healthier, and likely more productive as well. Provision of coverage improves access more than does subsidizing institutions to provide safety-net care to the uninsured.[1] Today's testimony comes from SPG work, much of it done for DOH's Health Care Coverage Advisory Panel; a current and a past panel member are also testifying today.

[1] See, e.g., Hadley, Jack and Peter Cunningham. 2004. "Availability of Safety-Net Providers and Access to Care of Uninsured Persons," Health Services Research, 39(5):1527–1546; see also the DOH/SPG Advisory Panel's "Statement of Principles on Expanding Health Coverage and Safety Net Protection," accessible at *<http://www.dcpca.org/index.php?option=com_content&task=view&id=81&Itemid=79>*.

One major source of information on the uninsured in the District is our report of October 2005.[2] The report assesses the rate of uninsurance (which differs somewhat by survey), who lacks health insurance, which populations are most at risk of uninsurance, and the costs of being uninsured. It focused on working-age adults, 19–64, who are most at risk of uninsurance. Younger Americans are better covered—through families' private insurance, Medicaid, and the State Children's Health Insurance program (SCHIP), the last known as Healthy Families in DC. From age 65 of course, almost everyone is eligible for Medicare.

The report sought to improve understanding of the city's uninsured at a time when District policymakers have been considering various options to help. In June 2005, legislation was proposed to require universal health care coverage in the District. In October, the city made the first $1 million in grants to expand clinic capacity under its 10-year Medical Homes initiative. And $200 million in city funding for a new hospital is also on the table. This hearing is further evidence that DOH was prescient in launching the project.

Some of the report's key statistics include:

—About 17 percent of District adults have no health insurance—some 50,000 people at any one time and 75,000 at some time during the year. (Estimates vary among different surveys, and some of the uninsured have a form of coverage through the Alliance, discussed below.)

—Men are three times more likely than women to be uninsured.

—African Americans, 58 percent of District residents, are two-and-a-half times more likely to be uninsured than whites; Latinos, 9 percent of the population, are eight times more likely.

—The annual cost of health care for the uninsured is estimated at just over $120 million, about one third each from the uninsured themselves, from non-insurance funding, and from medical providers' uncompensated care (some of which is offset by Disproportionate Share Hospital, or DSH, allowances or other public funds). If health care coverage were universal, the cost would increase by about half, but the out-of-pocket cost to the formerly uninsured would be halved, and uncompensated care would decrease dramatically.

—Fifty-four percent of uninsured adults are employed, and 22 percent are temporarily unemployed; only 23 percent are non-workers.

—Twenty-eight percent of uninsured adults have family incomes below the federal poverty level; 6 percent have incomes at least four times the poverty level.

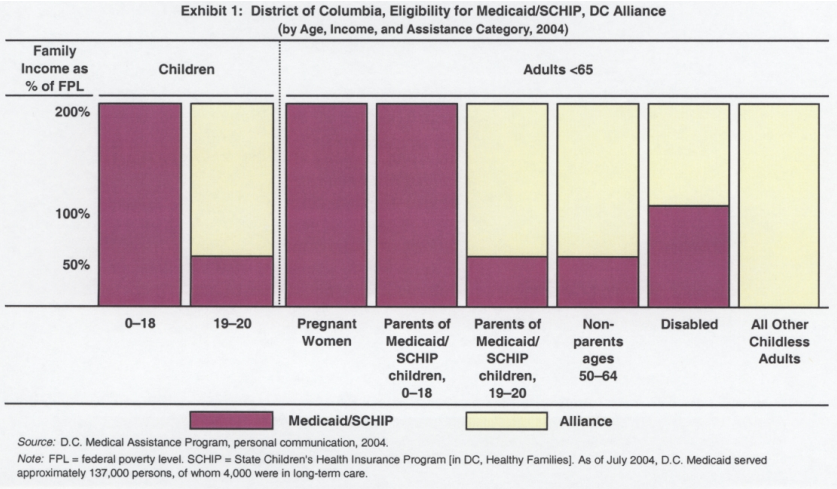
—Residents of Southeast Washington make up 23 percent of uninsured adults but only 19 percent of the population; 47 percent of the uninsured live in Northwest D.C. versus 54 percent of population.

Additional insight is available from SPG analyses not presented in that report. Four key charts are discussed here.

The first chart shows how the District's expansions of public program makes every resident with family income below 200 percent of the federal poverty level (FPL) eligible for some form of medical assistance (Exhibit 1). Medicaid covers the traditional categories to the FPLs indicated, in recent years augmented by SCHIP, which is operated as a Medicaid expansion. Since it closed its public hospital in 2001, the District has also run an innovative, insurance-like program known as the Alliance. It fills in gaps for people up to 200 percent of FPL for those with incomes above the applicable Medicaid ceiling and those who are categorically ineligible for Medicaid, such as childless adults.

Not everyone eligible actually applies, however, and the Alliance has to date had a budget limit that would not permit it to cover everyone if they did apply.

[2] See *Insurance and Uninsurance in the District of Columbia: Starting with the Numbers*, prepared by Jennifer King and the State Planning Grant Team, accessible at <*http://www.urban.org/url.cfm?id=311234*>; the full team is listed at the end of this testimony.



The next chart shows how the District's health insurance glass is part full and part empty (exhibit 2). It illustrates coverage gaps for all residents below age 65 by family income and by eligibility category (left two columns) and by work status (next three columns).

Exhibit 2: Target Populations for Expansion of Health Coverage

Number of Uninsured District Residents Aged 0-64 by Family Income, Eligibility Category and Work Status

Family Income (% FPL)	Program Eligibility Category		Work Status			Total uninsured
	Children & parents	non-Parents	full time, full year	part time	no worker	
0-99	10,694	20,882	3,396	9,854	18,326	31,576
100-199	5,089	13,361	10,953	6,464	1,032	18,450
200-299	(not applicable)		10,251	3,145	--*	9,711
300-399						4,735
400+			8,585	658	--*	9,243
					TOTAL UNINSURED	73,714

Source: Projected from 3 yrs of CPS data, 2001-03. Note: -- indicates insufficient data.

Medicaid target	Alliance target	Subsidy target	Total target of uninsured
15,783	34,243	13,396	63,422

About 50,000 people lacked health insurance in the early 2000s, according to the federal Current Population Survey (CPS), a standard source of data. About 16,000 were children and parents under 200 percent of FPL, who are targeted by Medicaid (left column). More than twice this number were non-parents under 200 percent of FPL—those targeted by the Alliance—about 34,000 people (next column). It is not reliably known just what share of these are actually in the Alliance, which is believed not to be captured as "insurance" coverage in the CPS, but up to half of the 50,000 may be. The good news here is that the number of uninsured is not large. The less-than-good news is that these data also show that the biggest gap in the District of Columbia insurance coverage is in the safety net of public programs meant to cover those with incomes below 200 percent of FPL.

The same uninsured people are shown in the next columns of exhibit 2 (past the first double bar). Here, they are re-categorized by their work status. Most of the uninsured are in families with a full time or part time worker. Those between 200 and 400 percent of FPL were considered by the SPG as potential candidates to receive some form of new subsidy to encourage purchase of coverage—about 13,000 people. (The data lack sufficient sample size to estimate the number of no-worker families above 200 percent of FPL; the numbers are likely small.)

The third chart compares those without insurance coverage to those with coverage, again by income level and work status (exhibit 3). Again, it shows some good news. Among all District of Columbia residents below age 65, those with insurance outnumber those without coverage by over 5 to 1. Among those with incomes of 200 to 400 percent of FPL and not already receiving public help—potential candidates for subsidy—the ratio is 6 to 1. On the other hand, any new subsidy targeted only by income levels (200–400 percent of FPL) will apply to some 82,000 people already covering themselves through private insurance as well as the uninsured group of only 13,000.

Exhibit 3: Populations Targeted for Expansion and Potential Crowd-Out of Private Dollars by New Public Subsidy

Number of UNinsured (residents 0-64 by income and work status)					Number of INsured (residents 0-64 by income and insurance)		
Family Income (% FPL)	Work Status			Total uninsured	Source of Insurance		Total insured
	full time, full year	part time	no worker		Medicaid, other public	Private	
0-99	3,396	9,854	18,326	31,576	63,690	24,376	88,066
100-199	10,953	6,464	1,032	18,450	26,267	29,503	55,770
200-299	10,251	3,145	--*	9,711	6,632	41,932	48,564
300-399				4,735	3,202	40,864	44,066
400+	8,585	658	--*	9,243	5,838	166,836	172,675
TOTAL UNINSURED				73,714	TOTAL INSURED		409,141

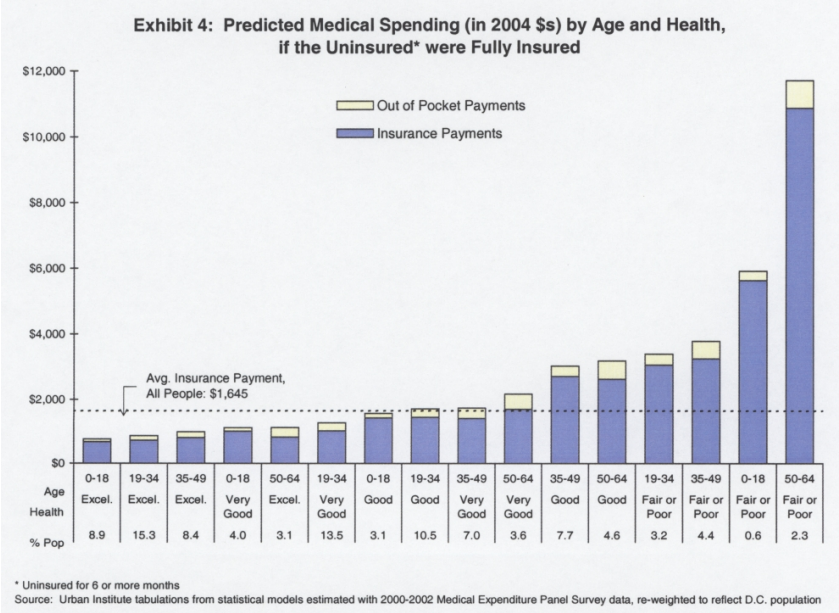
Source: same as Exhibit 2

13,396 Subsidy target

82,796 Potential crowd-out (some displacement of private dollars)

Such new aid can be expected to displace some amount of current self-help, so that not all of the new public resources go to increase access to health care—a phenomenon often called "crowd out"—unless specific steps are taken to reduce such displacement.

Fourth, the uninsured also differ in age, health status and other characteristics related to health spending (exhibit 4). The average level of medical spending per person would be some $1,700 a year if the entire population of today's uninsured were given coverage similar to that now obtained by those of comparable incomes. However, the range in spending by type of enrollee would be substantial, as the exhibit shows.



Those under age 19 who describe themselves as in excellent health would account for less than half that amount, while those aged 50–64 in fair or poor health would be at seven times the average. The policy implication is that how much a new insurance subsidy will cost depends upon which people sign up for it.

Thank you for the opportunity to testify today.

Senator BROWNBACK. Ms. Baskerville.

STATEMENT OF SHARON BASKERVILLE, EXECUTIVE DIRECTOR, D.C. PRIMARY CARE ASSOCIATION

Ms. BASKERVILLE. Good afternoon, Chairman Brownback, distinguished members of the subcommittee.

My name is Sharon Baskerville, executive director of the D.C. Primary Care Association (DCPCA). I just have to plug our mission. We are a group of stakeholders committed to creating a community-based primary-care-focused healthcare system that guarantees D.C. residents the right care in the right place at the right time.

We work with all of these people to try to create solutions. And I can say that since DCPCA was founded, in 1996, healthcare coverage has been expanded to over 50,000 D.C. residents, and we've had our fingers in all of those expansions, the result of a combination of progressive policies in a city whose pockets of concentrated poverty have increased like no other city in the country over the last decade. We have more than doubled, in the last decade, our areas of concentrated poverty. To battle the growing concentration of poverty, the District has been in the forefront of targeting new insurance expansions to medically vulnerable communities while also maximizing its local investment in healthcare dollars.

Just a sample of these targeted Medicaid coverage initiatives—and I think you see, on this map, currently, in 2002—and I think we have a small improvement—but adults without health insur-

ance, by zip code, so you can see that there is still a significant number of people who remain uncovered.

We have targeted, however, very low-income, childless adults between 50 and 64, after we realized that they were the highest spenders and the highest numbers of self—people who are in the hospital listed as self-pay, without insurance. So, we targeted this population.

Low-income residents who are HIV-positive, but we covered them at the point of diagnosis, rather than waiting until they're disabled by AIDS. And so, they have the opportunity to have heart therapy and sort of cutting-edge therapy to keep them healthier longer.

And kids and parents up to twice the poverty level, our CHIP expansion includes adults, as well as children. We've done a great job, and have evidence that we've covered just about all the kids in the District of Columbia who are eligible in our CHIPs expansion. And, as you hear in the upcoming budget, we're looking to expand to children up to 300 percent.

All of these expansions make sense on a variety of levels, in their wise use of District dollars. They dramatically improve healthcare for our vulnerable residents.

But expanding coverage alone will not work to improve health. Even if we were able to create universal coverage, not everyone would have a place to go to get care. The District must continue to improve the entire system of healthcare delivery. I think you've heard mentioned what is an initiative started by the D.C. Primary Care Association. Over half of the District's residents live in neighborhoods where they don't have adequate access to a primary care provider. The dark red areas on this map are federally designated health professional shortage in primary care shortage areas.

Now, this—the striped—the sort of striped red are currently under consideration by HRSA, because they—we have been able to prove that they are medically underserved, as well.

So, you see, these zip codes encompass about 300,000 residents in a city with just over 500,000 residents. So, it's a fairly shocking lack of access to primary care in a city with such chronic diseases.

These, of course, are predominantly on the eastern half of the city, which, you know, also parallels, if you look at every chart, poverty, unemployment, chronic disease, and uninsurance. So, clearly the disparities are shocking for a large number of people who live in the District of Columbia.

As a result of the coverage expansions, the District's rate of uninsurance is around about 9 percent, pretty low compared nationally to the States. But, despite such a low rate, a number of people depend—a high number of people depend on a primary care safety-net system. We define a "safety-net system" as providers who see people, regardless of their ability to pay. We certainly want them to maximize the ability to collect revenue from insurances, but they guarantee people, who walk in the door, care, and those are the people that I represent.

We did start Medical Homes DC, which is an initiative to strengthen community health centers, to rebuild the primary care system for the uninsured in the District, and to continue providing high quality care throughout the healthcare system, regardless of the ability to pay. To date, DCPCA, with an investment from the

city, of $15 million, which is soon, I believe, to become $21 million in capital money, we've awarded, since the fall, $1 million to seven community health centers for nine planning and capital projects. In addition to providing technical assistance, we've created something called the Institute for Primary Care Enhancement to build the infrastructure of health centers who have been providing free care, so building their billing systems, their financial systems, their clinical excellence systems.

These projects have already yielded a new demo suite in one health center, and other capital expansions are underway. But, as with all investments, we want to know and measure how we're succeeding.

We are able to show—and I think this is the most important part—the impact of the coverage initiatives in creating greater access to primary care is already making a quantifiable difference. As part of Medical Homes DC, we conducted one of the District's first in-depth studies of residents' healthcare and access.

While wide healthcare disparities continue to exist among District residents, two key findings are showing that the recent efforts by city and healthcare leaders are beginning to reverse troubling trends.

First, transfer ambulatory care-sensitive emergency room admissions, those hospital admissions that could have been avoided with proper treatment in a primary care setting, are decreasing for both children and adults. I've attached some slides to my testimony to highlight these findings. Six years ago, before most of Medicaid and the Alliance expansions took place, children and adults living in high-poverty areas were being admitted at twice the pace of their counterparts living in what we call low-poverty areas—I call them wealthy areas, but, you know—for avoidable causes. Now, when Medicaid expansions have covered almost every child in the District, avoidable hospital admission rates for children in high poverty have dramatically decreased, and rates are nearly the same for all children, regardless of income.

Looking at adults, we can see that the creation of the Alliance, avoidable hospitalizations are going down, as well, among high-poverty areas. Those are not quite as dramatic as children, but we expect to see that continue.

And I'll talk later, when—I know my time is up, but the disparity in rates of key chronic illnesses, such as asthma in children, is beginning to be eliminated, with greater coverage and access. And we can discuss that more with questions.

But we've brought you lots of maps. We have a lot of work to do. But we are leveling the playing field, and the D.C. Primary Care Association remains an innovator in these and other healthcare reforms. So, we hope to talk about a few of them later on.

Senator BROWNBACK. Very good. Thank you very much. I'm glad to hear some of those numbers are improving. I was wondering if that was the case.

[The statement follows:]

PREPARED STATEMENT OF SHARON A. BASKERVILLE

Good afternoon Chairman Brownback and distinguished Members of the committee. My name is Sharon Baskerville, Executive Director of the District of Columbia Primary Care Association. 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 the District of Columbia residents the right care, in the right place, at the right time.

DCPCA works very closely with the District government, council and safety net providers to expand health care coverage to as many residents as possible, and ensure greater access to primary care providers.

Covering New Populations in the District of Columbia

Since DCPCA was founded in 1996, health care coverage has been expanded to over 50,000 District of Columbia residents—the result of a combination of progressive policies and a city whose pockets of concentrated poverty have increased like no other over the last decade. To battle the growing concentration of poverty, the District has been in the forefront of targeting new insurance expansions to medically vulnerable communities, while also maximizing its local investment in health care dollars. Just a sample of these targeted coverage initiatives include: very low income childless adults between ages 50 and 64; low income residents at the point of HIV diagnosis, rather than waiting until they become disable by AIDS; and kids and parents up to twice the poverty level.

The District continues to work toward increasing coverage with the latest initiative from Mayor Williams to expand Medicaid for children up to three times the poverty limit—making the District of Columbia one of the most progressive Medicaid programs in the country.

All of these expansions make sense on a variety of levels—they are a wise use of District dollars and they dramatically improve health care for our vulnerable residents.

Health Care Access Not a Coverage Issue Alone: Medical Homes DC

But expanding coverage alone will not work. Even if we were able to create universal coverage, not everyone would have a place to go to get care. The District must continue to improve the entire system of health care delivery.

Over half of the District's residents live in neighborhoods where they don't have adequate access to a primary care provider. I've attached a map of the District that highlights where these areas are located—predominantly on the eastern half of the city, paralleling higher rates of poverty, unemployment, chronic disease, and uninsurance. As a result of the coverage expansions, the District's rate of uninsurance is around 9 percent—pretty low compared nationally and to the States. But, despite such a low rate, a high number of people depend on the primary care safety net system—nearly 160,000 individuals, or more than one fourth of our total population.

A key component of making this safety net system work is an innovative initiative led by the District of Columbia Primary Care Association called Medical Homes DC. Medical Homes DC is a 10-year strategic project to strengthen community health centers to improve and continue providing high quality care throughout the health care system and regardless of an individual's ability to pay.

To date, DCPCA has awarded $1 million to 8 community health centers for planning and capital projects, in addition to providing priceless technical and development assistance. These projects have already yielded a new dental suite in one health center, and other capital expansions are under way. But as with all investments, we want to know and measure how we're succeeding.

Coverage Expansions and Better Access Are Improving Health

In fact, we are able to show that the impact of coverage initiatives and creating greater access to primary care is already making a quantifiable difference. As a part of Medical Homes DC, we conducted one of the District's first in depth studies of residents' health care and access. While wide health care disparities continue to exist among District residents, two key findings are showing that the recent efforts by city and health care leaders are beginning to reverse troubling trends.

First, trends for ambulatory care sensitive ER admissions—those hospital admissions that could have been avoided with proper treatment in a primary care setting—are decreasing, for both children and adults. I've attached some slides to my testimony to highlight these findings. Six years ago, before most of the Medicaid and Alliance expansions took place, children and adults living in high poverty were being admitted twice as often as their counterparts living in low poverty for avoidable causes. Now, when Medicaid expansions have covered almost every child in the District, avoidable hospital admission rates for children in high poverty have dramatically decreased and rates are nearly the same for all children, regardless of income. Looking at adults, we can see since the creation of the Alliance, avoidable hospitalizations are going down as well among those in high poverty, though not quite

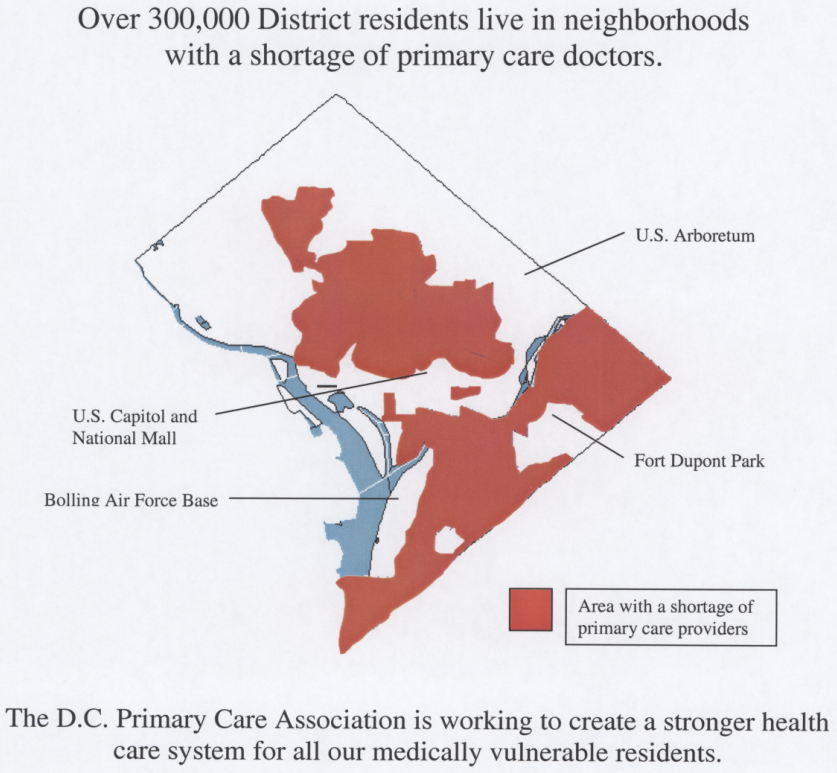
as dramatically as for children. Then again, while almost every child is now insured, we can't say the same for adults. Coverage clearly matters.

Second, the disparity in rates of key chronic diseases—such as asthma in children—is beginning to be eliminated with greater coverage and access to quality care. Five years ago, there was a stark difference in rates of asthma depending on whether a child lived in high or low poverty—almost a five-fold increase for children living in high poverty. Now, asthma rates have been decreased and are nearly identical to children living in low poverty.

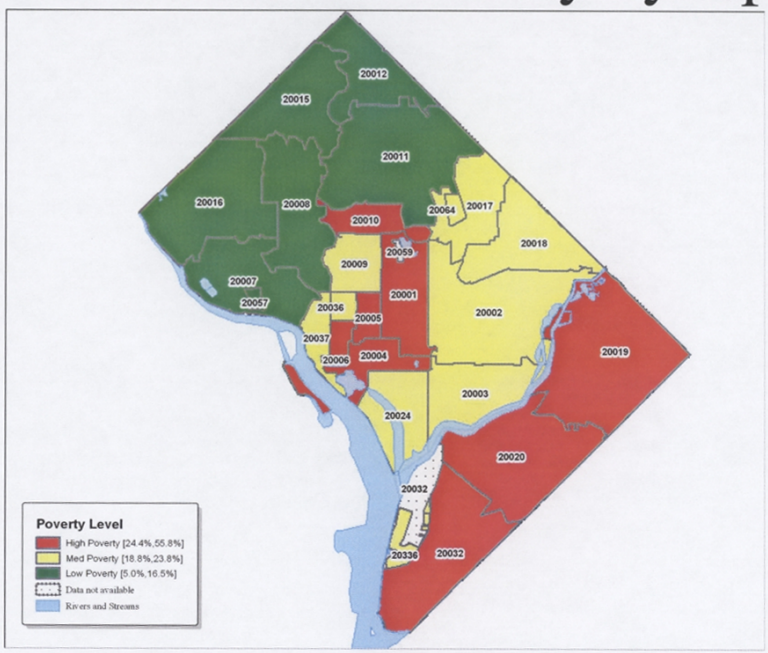
There obviously remains a lot of work, but it is clear that the targeted efforts taking place in the District are making improvements for the medically vulnerable.

The District of Columbia Primary Care Association remains an innovator in these and other health care reform efforts across the District. We've recently launched an Adolescent Health Initiative to get teens and young adults more closely involved in determining their own health care. We've convened a Mental Health Task Group to work on improving and more closely integrating primary care with mental health care services. We're one of the leaders of the Regional Health Information and Technology efforts to develop health information and electronic medical record sharing across providers. And we've recently committed to working with the administration and hospital providers to develop an Emergency Room Diversion pilot program to help more people seek care more appropriately in a primary care setting.

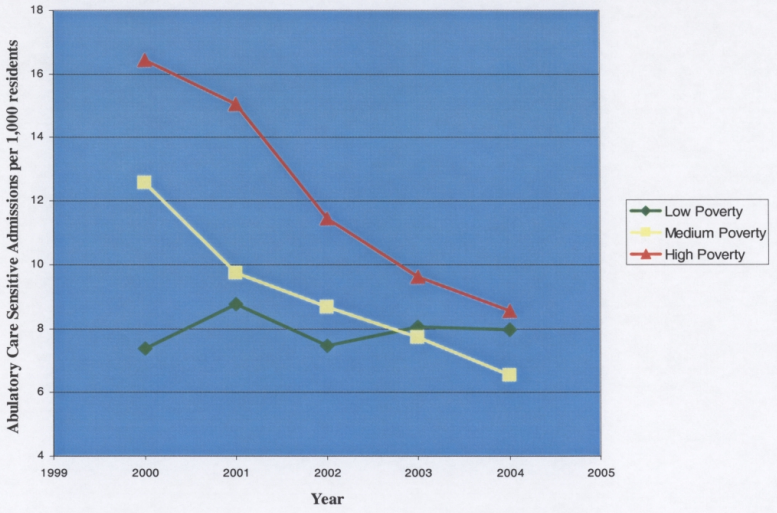
As you can see, we remain committed to reforming not just health insurance coverage, but truly the system that the District of Columbia residents depend on for their health care needs. Thank you for the opportunity to testify and I'm happy to answer any questions you may have.

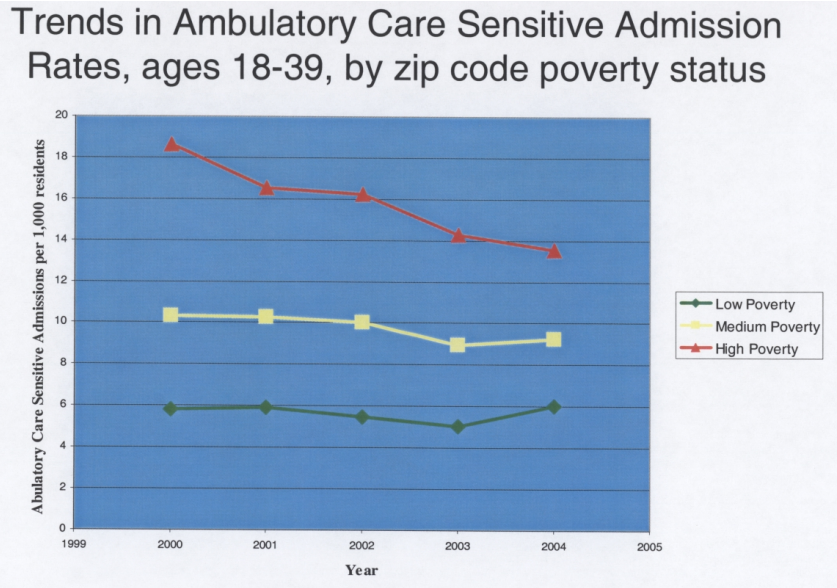


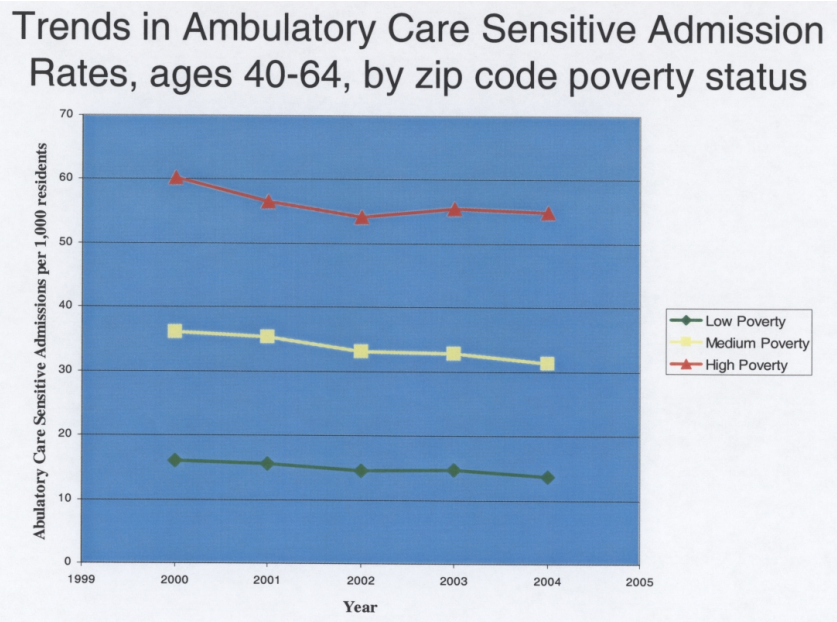
Distribution of Poverty by zip

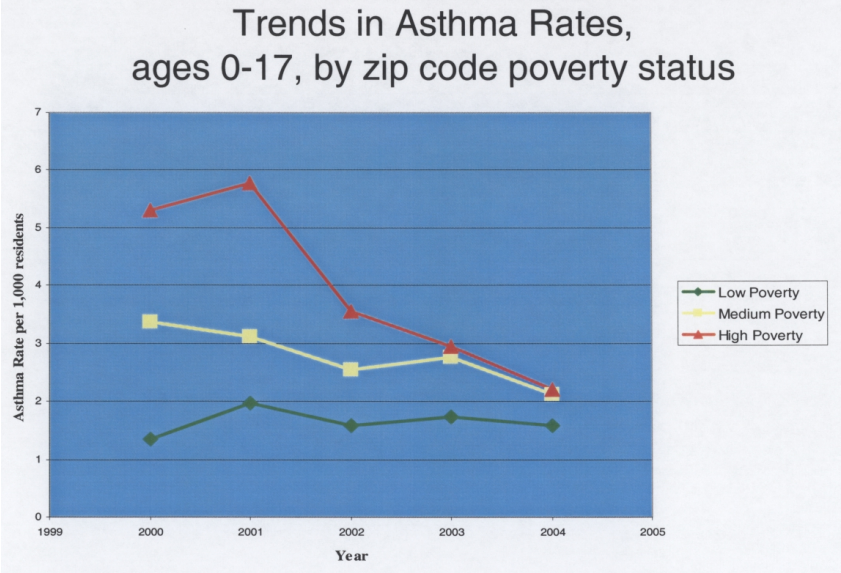


Trends in Ambulatory Care Sensitive Admission Rates, ages 0-17, by zip code poverty status




Trends in Ambulatory Care Sensitive Admission Rates, ages 18-39, by zip code poverty status
Abulatory Care Sensitive Admissions per 1,000 residents
20
18
16
14
12
10
8
6
4
2
0
1999
2000
2001
2002
2003
2004
2005
Year
Low Poverty
Medium Poverty
High Poverty


Trends in Ambulatory Care Sensitive Admission Rates, ages 40-64, by zip code poverty status
Abulatory Care Sensitive Admissions per 1,000 residents
70
60
50
40
30
20
10
0
1999
2000
2001
2002
2003
2004
2005
Year
Low Poverty
Medium Poverty
High Poverty



Senator BROWNBACK. Ms. Gomez, welcome.

STATEMENT OF MARIA GOMEZ, PRESIDENT AND CHIEF EXECUTIVE OFFICER, MARY'S CENTER FOR MATERNAL AND CHILD CARE

Ms. GOMEZ. Thank you, Mr. Chairman and staff. I appreciate the opportunity to appear before the subcommittee today to share with you my perspective on the hurdles facing the Latino community in accessing primary healthcare and health insurance.

My name is Maria Gomez, CEO of Mary's Center for Maternal and Child Care.

The center was initiated in 1988 as a nonprofit prenatal care center for immigrant women displaced by the civil wars in Central America in the 1980s. Today, we are a federally qualified health center serving over 14,000 families. Our target population continues to be low income and recent immigrant living throughout the region of this area.

Mary's Center operates two primary care centers, a school-based health center and a mobile unit, each located in the heart of the District of Columbia's immigrant communities. In addition to our comprehensive family healthcare, services also include mental health, a mobile health outreach unit, dental care, a teen program focused on pregnancy prevention and youth development, home visitation, with an emphasis on preventing child abuse and neglect, family literacy, and an intensive case management to facilitate integration and civic participation of families in their respective communities.

At Mary's Center, we have learned that the lack of access to care is one of the greatest challenges facing Latinos in the region, as we have said here today. The lack of access is due to the high cost of health insurance and the inability of potential patients to leave work to see a provider and inaccessibility of being able to get on Medicaid. Workers who leave work for regular healthcare are, one,

not paid, and, two, fearful that their job will quickly be filled by someone who is not attending to their healthcare needs.

Our community does not qualify for Medicaid, mostly, because most are born outside of the United States, many with very complex immigration status. Even though we are largely minimum-wage earners, we are ineligible for other entitlement programs, since, by working at least two jobs, our combined salaries may be—slightly exceed the Federal income requirements of 150 or 200 percent in the regional area of the Federal poverty level.

A community-based research study done last year about—from about 800 families, by the Council of Latino Agencies in the District, showed that we are a population with a high rate of obesity, which translates to a greater potential risk for chronic disease, including type 2 diabetes, cardiovascular disease, kidney, prostate, stomach, and colon cancer, along with an increased risk, of course, of premature death. We are a population with 20 percent of the women reported being diagnosed with gestational diabetes. This is nine times the rate of U.S. Latinas, and 17 and 60 times the rate of white women in the United States and in the District of Columbia, respectively.

We are a population with a rising rate of teen pregnancy and a low rate of abortions. Thirteen percent—as a matter of fact, 13 percent of the Hispanic births are to teens.

We are a population——

Senator BROWNBACK. What's that percentage again?

Ms. GOMEZ. Thirteen percent. Thirteen.

We are a population with negligible access to dental care for the uninsured or Medicaid recipient, and the few clients that do offer dental care—clinics that do offer dental care do not have the capacity to perform root canals and more specialized care.

We are also a population with more than double the national rate of breast cancer among women.

But there is good news. We are a population with higher than national rates of screening for HIV/AIDS, breast and cervical cancer, flu shots among seniors and knowledge about HIV transmission. This, of course, indicates to us that there have been some striking successes in the delivery of healthcare to this community, largely via Latino-serving community health centers which serve the uninsured.

Some further demographics and health-related data has been included in your—for the record.

The lessons we have learned in the past 18 years for improving and increasing the number of Latinos who have access to healthcare systems are the following:

Using bilingual outreach workers to enroll Latinos in health insurance programs. It is a community that accesses the services if they are given to them. They access it early and appropriately.

Increase the pool of young Latinos going into healthcare careers, who are the ones who are going to be the most likely ones to return to the community. I am an example of that.

In the meantime, fund interpretive services to guarantee clear communication between providers and patients, which clearly, clearly correlates to the quality of care.

Conduct education campaigns to reach Latinos in health clinics, schools, churches, and workplaces, using individuals from the community as the experts.

Fund efforts to collect data on Latinos—Latino health. Community-based research by Latinos must be done in our own community.

Expand the pool of private providers and hospitals that accept patients with Medicaid and the D.C. Health Care Alliance insurance by providing reimbursement rates that at least cover the expense of the visit.

Fund, replicate, and expand Latino-serving community health centers that can have the capacity to stay open extended hours and weekends.

Promote immigration policies that are civil and humane in order to guarantee that immigrants are not forced to be in the shadow, neglecting their health, giving rise to unnecessary public health illnesses, and increasing the rate of emergency-room visits and costly curative care.

The data clearly shows that when preventive and primary care is offered kindly, near their home, and in a culturally and linguistically appropriate manner, Latinos respond and take responsibility to stay healthy, working and engaged in their community.

Thank you for the opportunity to be here with you today.

Senator BROWNBACK. Thank you.

[The statement follows:]

PREPARED STATEMENT OF MARIA GOMEZ

Thank you, Mr. Chairman. I appreciate the opportunity to appear before the subcommittee today to share with you my perspective on the hurdles facing the Latino community in accessing primary health care and health insurance.

I founded Mary's Center in 1988 as a non-sectarian, non-profit prenatal care center for immigrant women displaced by civil wars and earthquakes in Central America. Now a Federally Qualified Health Center, Mary's Center today serves over 14,000 families with primary health care and a wide range of wraparound services. Our target population is low-income families, most of whom are recent immigrants from all over Latin America.

Mary's Center operates two primary care centers, a school-based health center, and a mobile unit, each located in the heart of the District of Columbia's immigrant communities. Our services include comprehensive family and pediatric health care, prenatal care, mental health services, a mobile health and outreach unit, dental care, a teen program focused on pregnancy prevention and youth development, a nutrition education and supplemental food program, comprehensive services for young children with special needs, family case management, home visitation with an emphasis on preventing child abuse and neglect, family literacy, and vocational training.

At Mary's Center we have learned that the lack of access to care is one of the greatest challenges facing Latinos in Washington, DC. The lack of access is due to the high cost of health insurance and the inability of potential patients to leave work to see a provider. Workers who leave work for regular health care are (1) not paid, and (2) fearful that their job will quickly be filled by a another worker who does not take time off to meet their health care needs.

This is a population that does not qualify for Medicaid because they are born outside of the United States. And even though they are largely minimum wage earners, they are ineligible for other forms of federal assistance, since by working two to three jobs their combined salaries may slightly exceed the federal income requirements of 150–200 percent of the Federal Poverty Level. For these working poor, WIC—which has a higher income threshold—is the only staple and constant food source at their table.

This is a population with a high rate of obesity—which translates to greater potential risks for chronic disease, including cardiovascular disease, type 2 diabetes

and breast, kidney, prostate, stomach and colon cancers, along with increased risk of premature death.

This is a population where 20 percent of women reported having been diagnosed with gestational diabetes. This is nine times the rate of U.S. Latinas and 17 and 60 times the rate of white women in the United States and the District of Columbia respectively.

This is a population with a high rate of teen pregnancy and a low rate of abortion.

This is a population with no access to dental care for the uninsured, and the few clinics that do offer dental care do not have the provider capacity to perform root canals and more specialized care.

This is a population with more than double the national rate of breast cancer among women.

But this is also a population with higher than national rates of screening for HIV/AIDS, breast and cervical cancer, flu shots among seniors and knowledge about HIV transmission. This indicates that there have been some striking successes in the delivery of health care to this community—largely via Hispanic serving community health centers which serve the uninsured.

What are my suggestions for improving the increasing the numbers of Latinos who have access to the health system? Use bilingual outreach to enroll Latinos in health insurance programs; conduct education campaigns to reach Latinos in health clinics, schools, churches and workplaces; fund efforts to collect data on Latino health; expand the pool of private providers and hospitals that accept patients who have DC Health Care Alliance insurance; and fund, replicate and expand Hispanic serving community health centers. Thank you.

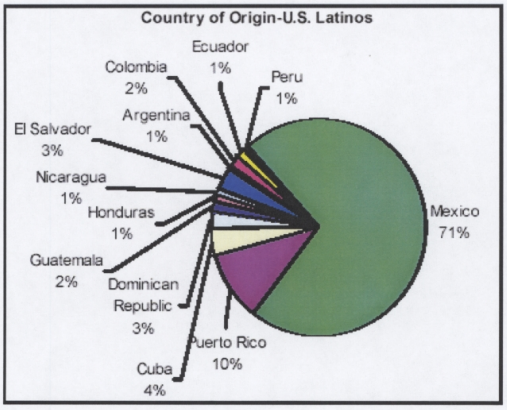


Figure 1
Dept. of Health,
State Center for Health Statistics Administration

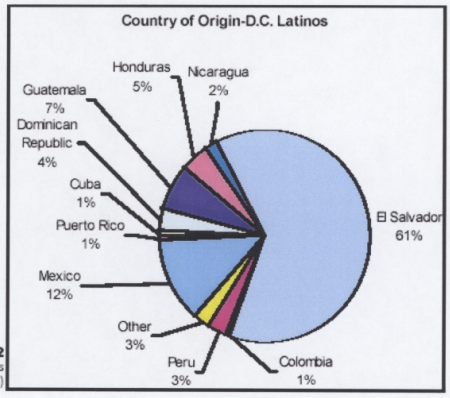


Figure 2
Council of Latino Agencies
(source: U.S. Census, American Community Survey, 2003)

AGE

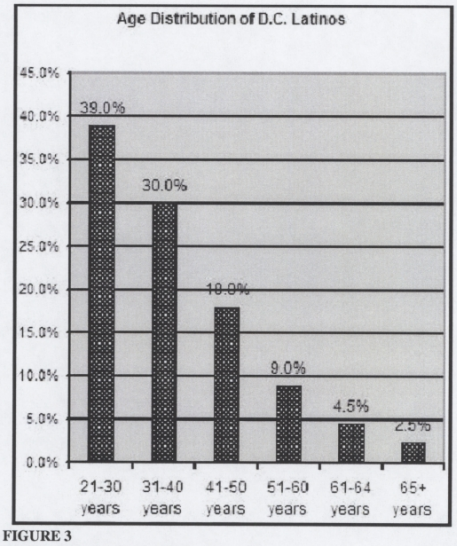


FIGURE 3
COUNCIL OF LATINO AGENCIES

On the whole, D.C. Latino respondents were relatively young, with 69 percent of the population aged 40 years or younger, and less than three percent aged 65 years or older **(Figure 3)**. The proportion of 21 to 30 year olds among D.C. Latinos was roughly two to three times higher than among Latinos in the U.S. and whites in D.C. **(Figure 4)**. In contrast, the proportion of D.C. Latinos aged 65 and older was nearly six times lower than that for D.C. whites.

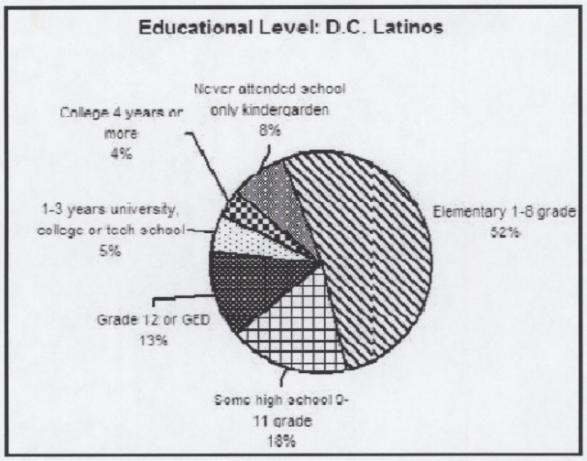


Figure 5
Dept. of Health, State Center for Health Statistics Administration (source: LHCC)

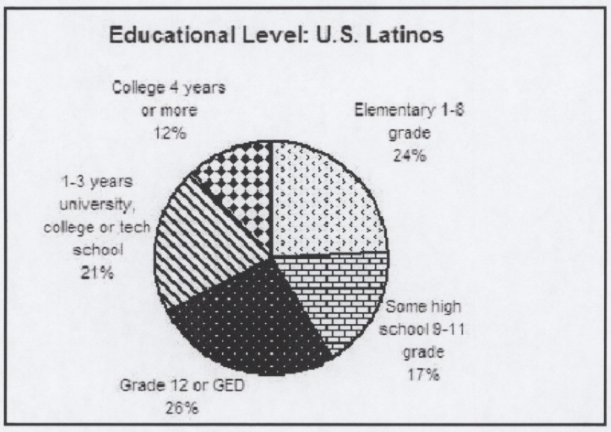
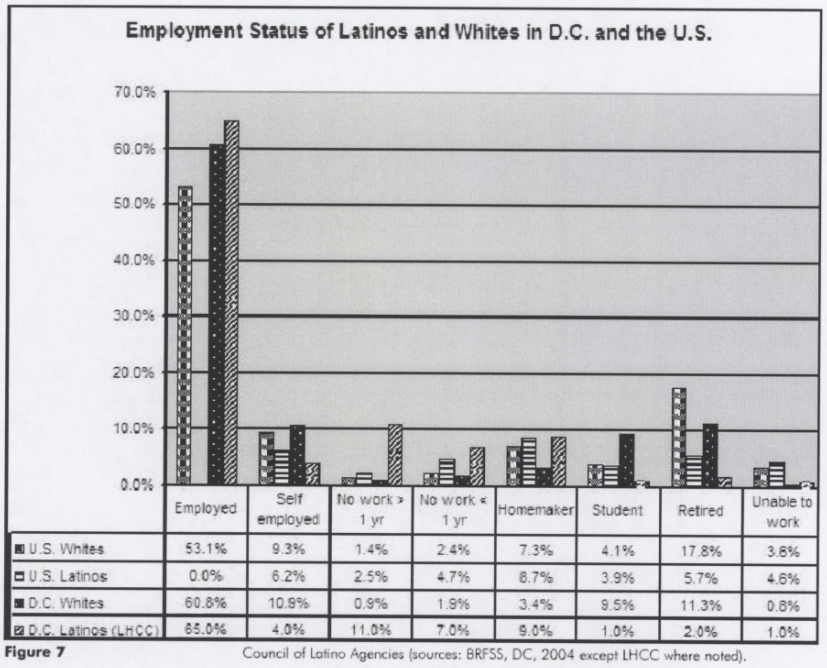
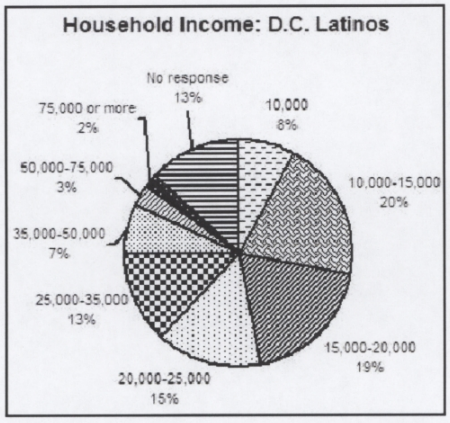


Figure 6
Council of Latino Agencies (source: BRFSS, CDC, 2003)



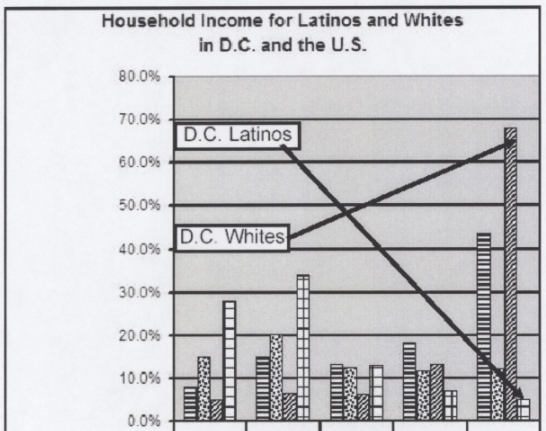
	Employed	Self employed	No work > 1 yr	No work < 1 yr	Homemaker	Student	Retired	Unable to work
U.S. Whites	53.1%	9.3%	1.4%	2.4%	7.3%	4.1%	17.8%	3.8%
U.S. Latinos	0.0%	6.2%	2.5%	4.7%	8.7%	3.9%	5.7%	4.6%
D.C. Whites	60.8%	10.9%	0.9%	1.9%	3.4%	9.5%	11.3%	0.8%
D.C. Latinos (LHCC)	65.0%	4.0%	11.0%	7.0%	9.0%	1.0%	2.0%	1.0%

Figure 7 Council of Latino Agencies (sources: BRFSS, DC, 2004 except LHCC where noted).



While employed at similar rates, household income levels differed substantially. Within the District, the proportion of Latino households earning under $25,000 was five times greater than that of whites, and the proportion of white households earning $50,000 or more was nearly nine times higher than that of Latinos. **Figure 8** shows that the economic status of a large proportion of the District's Latino community is extremely precarious; nearly two-thirds of respondents reported total household incomes of $25,000 per year or less, while only five percent reported total household incomes of $50,000 or more. In comparison, **Figure 9** shows that 11.8 percent of D.C. white, 23.1 percent of U.S. white and 35.3 percent of U.S. Latino households earned less than $25,000.

Figure 8
Dept. of Health, State Center for Health Statistics Administration (source: LHCC)



	Less than $15,000	$15,000 - 24,999	$25,000 - 34,999	$35,000 - 49,999	$50,000+
U.S. Whites	7.9%	15.2%	13.5%	18.2%	43.7%
U.S. Latinos	15.1%	20.2%	12.6%	11.6%	12.2%
D.C. Whites	5.2%	6.6%	6.4%	13.5%	68.1%
D.C. Latinos (LHCC)	28%	34%	13%	7%	5%

Figure 9
Council of Latino Agencies (sources: BRFSS, CDC, 2004 except LHCC where noted).

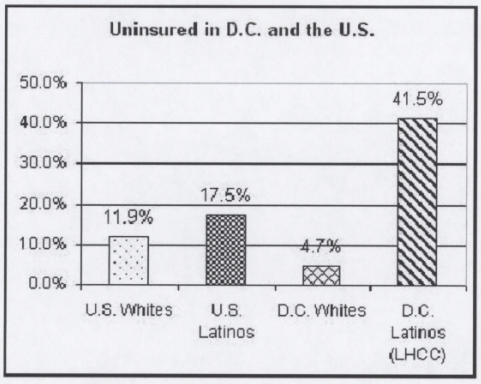


Figure 12
Council of Latino Agencies (sources: BRFSS, CDC 2004, except LHCC where noted)

Table 4. Type of Place Health Care is Sought

	N	%
Doctor's Office or HMO	150	24.8
Clinic or Health Center	416	68.8
Hospital Outpatient Department	24	4.0
Hospital Emergency Room	1	0.2
Urgent Care Center	2	0.33
Other	6	1.0
No Response	223	27.2
TOTAL	819	100

D.C. Department of Health, State Center for Health Statistics Administration

The high percentage of uninsured within D.C.'s Latino population suggests that Latinos disproportionately face barriers to accessing health care in the District. An implication of these barriers for this study is that Latinos in D.C. may receive diagnoses of both acute and chronic illnesses at comparatively lower rates than if they had reliable access to health practitioners, and, if so, the prevalence rates of these diseases reported here (which must be diagnosed by a health professional) may be obscured by poor access to health care.

Barriers

As shown in **Table 5**, the principal barrier to access to health care when it was needed was cost (30.5 percent)- a finding that is consistent with the high proportion of respondents who lack health insurance. This rate was higher than the national average of 26.3 percent of Latinos who, because of cost, were unable to access care when it was needed within the last 12 months (Centers for Disease Control and Prevention 2004).

A second economic barrier that is less recognized is the inability of many people to leave work in order to secure health care services (11.6 percent), reflecting the low occupational status of many respondents-their jobs provided neither health insurance nor time off for health care. The high number of negative responses to these questions indicates that some of the reasons for not accessing health care were not listed in the questionnaire.

Table 5. Reason for Not Accessing Health Care

Reason	%
Cost	30.5
Transportation/Distance	7.6
Lack of Time Off Work	11.6
Family Care/Family Responsibility	6.2

n= 819 Dept. of Health, State Center for Health Statistics Administration

Senator BROWNBACK. Ms. Reesor.

STATEMENT OF CHRISTINE REESOR, MEDICAL CLINIC COORDINATOR, D.C. SPANISH CATHOLIC MEDICAL CLINIC OF CATHOLIC COMMUNITY SERVICES

Ms. REESOR. Good afternoon, Mr. Chairman and members of the subcommittee.

My name is Christine Reesor. I am a nurse practitioner. I am the medical clinic coordinator for the D.C. Spanish Catholic Medical Clinic of Catholic Community Services.

We serve more than 120,000 people annually in the Archdiocese of Washington, including 30,000 immigrants in the Washington area. Our D.C. medical clinic provides adult primary care and outpatient surgical services for people who otherwise would go without medical care. During fiscal year 2005, the clinic logged 3,324 patient visits. Our annual budget is just over $500,000. The clinic employs a staff of 10, and relies heavily on volunteer physicians and nurses who give generously of their time and talent. Our medical team provides primary care and specialty services. The clinic also conducts a host of wellness and disease prevention and outreach programs in the community.

Allow me to begin by saying thank you for this opportunity to testify. I would like to make two main points today.

First, the rising costs of malpractice insurance represents a major challenge for nonprofit medical clinics like the Spanish Catholic Center, which serves the working poor, people who are indigent, and the uninsured.

Second, more attention and resources must be focused on overcoming cultural, economic, and language barriers that keep immigrants from seeking medical care.

On the latter, allow me to share a real-life example of what I'm talking about.

On two occasions in the recent past, clients have come to the clinics with tubes sticking out of their backs after having sought care in a local emergency room. In both cases, the tubes were placed because of obstructions in the urinary system, and the patients were told to seek specialty follow-up care in 2 to 3 days. Both did not, because of cost and language barriers. The patients came to the Spanish Catholic Center after 1 month, with serious infections that could have become life threatening.

Why did these patients come to our medical clinic? The major reason is that we are particularly user friendly and culturally relevant to the growing Latino population of Washington, DC. The people who come to our clinic find staff and volunteers who speak their languages, understand their cultural context, and, in many cases, know what it is like to be a newcomer, themselves.

In summary, the Spanish Catholic Center Medical Clinic is an inviting place where immigrants who could otherwise not seek the medical care can receive affordable care in a compassionate and culturally sensitive environment. With all humility, this is a model of service that we should all work together to expand.

Now, let me turn to medical practice insurance. As I mentioned earlier, the cost of malpractice insurance is a major challenge for the Spanish Catholic Center's Clinic. It is our largest expenditure, outside of salaries.

Again, a real-life scenario. One of our physicians, Dr. Dierdre Burn, is a former family practitioner in the U.S. Army who received additional training as a general surgeon. She's also a Catholic nun with an extensive network of physicians and medical resources that she leverages for our patients. For example, she has developed a relationship with Sibley Hospital, whereby she can perform surgeries for our seriously ill patients free of charge. Our ability to keep this amazing surgeon translates into an annual malpractice insurance bill of $60,000, which is 12 percent of our annual budget.

Given our clientele, costs like these cannot be passed along to Federal—to people who are already struggling to access primary care. Mr. Chairman, clinics like ours look to the Federal and local government for leadership on this issue to help provide relief from this significant cost.

I would like to close by commending the subcommittee for assembling this diverse panel. I can attest to the importance of healthcare alliances. Our medical clinic is part of the D.C. Healthcare Alliance, which enhances our ability to serve the poor, working uninsured, and those ineligible for Medicare and Medicaid. Well organized and financed healthcare alliances work, and they should be replicated.

Thank you, Mr. Chairman.

Senator BROWNBACK. Thank you, Ms. Reesor, very interesting.

[The statement follows:]

PREPARED STATEMENT OF CHRISTINE REESOR

Good afternoon Mr. Chairman and Members of the subcommittee. My name is Christine Reesor and I am a nurse practitioner and the medical clinic coordinator for the DC Spanish Catholic Center Medical Clinic of Catholic Community Services. We serve more than 120,000 people annually in the Archdiocese of Washington, including 30,000 immigrants in the Washington area. Our D.C. medical clinic provides

adult primary care and outpatient surgical services for people who otherwise would go without medical care. During fiscal year 2005, the clinic logged 3,324 patient visits, with an annual budget of about half a million. The clinic employs a staff of 10, and relies heavily on volunteer physicians and nurses who give generously of their time and talent. Our medical team provides primary care and specialty services such as dermatology, surgery, nephrology, geriatrics and ear, nose and throat care. The clinic also conducts a host of wellness and disease-prevention outreach programs in the community.

Allow me to begin by saying thank you for this opportunity to testify, and I look forward to your questions on health care issues in the District of Columbia.

I would like to make two main points today:

First, the rising cost of malpractice insurance represents a major challenge for non-profit medical clinics like the Spanish Catholic Center, which serves the working poor, people who are indigent, and the uninsured.

Second, more attention and resources must be focused on overcoming cultural, economic and language barriers that keep immigrants from seeking medical care.

On the latter, allow me share a real-life example of what I am talking about. "On two occasions in the recent past, clients have presented to the clinic with tubes sticking out of their backs, after having to seek urgent care in an emergency room. In both cases, the tubes were placed because of obstructions in the urinary systems and the patients were told to seek specialty follow-up care in 2 to 3 days. Instead of securing the specialty care—for fear of cost, and difficulty communicating to obtain the appointment, the patients approached the Spanish Catholic Center after 1 month, on both occasions with infections and the need for interventional radiology and specialty care."

Why did these patients come to our medical clinic?

A major reason is that we are particularly user-friendly and culturally-relevant to the growing Latino population of Washington DC. Partly, it's because we are part of the Catholic Church, which has such a strong place in Hispanic and Latino countries. Partly, it is because we are not a government entity, and governments are often not viewed as trustworthy sources of aid in the countries that immigrants leave. Churches and non-governmental organizations are often seen as more reliable and trustworthy sources of assistance. Perhaps most important, the people who come to our clinic find staff and volunteers who speak their languages, understand the cultural context they are working from, and in many cases, know what it is like to be a newcomer themselves. In summary, the Spanish Catholic Center medical clinic is an inviting place where immigrants, who would otherwise not seek the medical care they need, can receive affordable care in a compassionate and culturally sensitive environment. With all humility, this is a model of service we should all work together to expand.

Now let me turn to medical malpractice insurance. As I mentioned earlier, the cost of malpractice insurance is a major challenge for the Spanish Catholic Center's medical clinic. Malpractice insurance is our largest expenditure outside of salaries. Again, allow me to give a real-life scenario. One of our physicians, Dr. Deirdre Byrne, is a former general practitioner in the U.S. Army who received additional training as a general surgeon. She is also a Catholic nun with an extensive network of physicians and medical resources that she leverages for our patients. For example, she has developed a relationship with Sibley Hospital whereby they allow her to perform surgeries for our seriously ill patients free of charge. Unfortunately, our ability to keep this amazing volunteer depends on our ability to cover her malpractice insurance—an annual bill of $60,000. And, given the financial status of our clients, costs like these cannot be passed along to people who are already struggling to access primary care. Clinics like ours look to the federal and local government for leadership on this issue to help provide relief from this significant financial burden.

I would like to close by commending the subcommittee for assembling this diverse panel. I can attest to the importance of healthcare alliances that bring together government, insurance providers, hospitals, and community-based organizations like our medical clinic. Well organized and financed healthcare alliances work, and they should be replicated.

The Spanish Catholic Center participates in the DC HealthCare Alliance. It enables our clinic to provide free services, regardless of citizenship or national origin, to the uninsured and severely poor who are unable to access Medicare or Medicaid. The Alliance guarantees access to primary care services, specialty referrals, laboratory analysis, and pharmaceuticals—the exact services needed to support continuity of care in chronic diseases like Diabetes. In reality, it reduces emergency room visits by the uninsured, keeps medical conditions from spiraling out of control, and offers a sense of dignity to people who can't afford medical care. It also provides our clinic

a modest reimbursement for the services we perform. This is a program we are happy to participate in, and believe the subcommittee and the D.C. government should consider strategies that would create new alliances and expand those that are already successful—like the DC HealthCare Alliance.

Thank you Mr. Chairman. I look forward to the opportunity to answer your questions.

Senator BROWNBACK. Mr. Mirel.

STATEMENT OF LAWRENCE MIREL, FORMER COMMISSIONER OF INSURANCE, SECURITIES AND BANKING FOR THE DISTRICT OF COLUMBIA

Mr. MIREL. Thank you, Senator Brownback. Thank you for inviting me, and thank you for all of your interest in, and support for, the people of the District of Columbia. We really do appreciate that.

I am Larry Mirel. I'm a partner in the Washington law firm of Wiley Rein & Fielding. Until October of last year, I served for more than 6 years as the commissioner of insurance, securities, and banking for the District of Columbia.

The views I am presenting today are my own, and do not necessarily represent those of either the District government or of my present employer.

As commissioner, I became involved in health insurance issues and tried to find better ways to make insurance coverage available for the citizens of the District of Columbia. As you can imagine, that's not an easy task.

Medical providers are being increasingly squeezed, as you heard a minute ago, between the limited amount of payment that health insurers will provide and the ever-increasing costs of medical malpractice insurance. And many of these clinics are on the edge of financial disaster.

It's hard to think in terms of comprehensive solutions. What I tried to do when I was commissioner was to deal with two of the more significant parts of the problem, and those are the two I want to talk to you about briefly today.

One is the unfair and unreasonable discrimination, in my view, between people who work for large employers, government or private, and those who work for small employers or who are self-employed or who don't work at all. Insurance obeys the law of large groups, and that says that if you're in a group—health insurance group that's large enough, you can be covered, even if you may have health problems. That's because most people are healthy, and, therefore, their premiums help to pay the costs of those who are not. If you're in a small group, however, or if you are self-employed, that logic does not apply. And if you have health issues, real or potential, or if you are of a certain age, you may find it very much more expensive to get insurance, and, in some cases, you may not be able to get it at all.

Of course, small groups and large groups, as—the difference is an artificial one. If you lump enough small groups together, you get a large group. And one of the initiatives I wanted to tell you about was our equal access to health insurance law, which essentially would say that everyone who lives or works or goes to school in the District of Columbia will be considered part of a large group, and they will have access to a menu of private insurance plans. It

would be a little bit, Senator, as if the Federal plan, to which you and your staff belongs, was opened up to everyone, and everyone had the same kinds of choices. That would be the idea behind it. That act was introduced—the bill was introduced in the District Council, but no action was taken on that.

The other—well, let me tell you a little more about that one before I get into the other initiative.

Some of the problems that small employers have in finding insurance is due to the difficulty of obtaining insurance for small groups of people, the need to try to find new insurance every year, to price it out, to make choices about what kinds of things to cover, and what things not to cover. Under the equal access approach, employers would not have to do that. They would simply be able to take their employees to this program, where the employees could choose the kinds of plans they wanted, and the employer would make a contribution of whatever amount the employer wanted to make.

We think this is an innovative idea. It has been—it is part of the recently announced program in Massachusetts that Governor Romney talked about. And we think there is potential in the District and elsewhere.

The other initiative I want to mention just briefly has to do with dealing with this problem of medical malpractice insurance. Many of the clinics are very small, and have very small budgets, and their ability to find insurance is extremely limited. What we have proposed is the creation of a captive insurance plan, a captive insurance company owned by the District of Columbia that would combine together all of the malpractice risks of the various clinics and of the District itself into one company, and that company then could provide good risk management and could provide good—and has good bargaining power to get better rates from the malpractice insurers.

Thank you very much.

Senator BROWNBACK. Thank you, Mr. Mirel. I want to talk some more about this kind of health-mart concept that you've mentioned.

[The statement follows:]

PREPARED STATEMENT OF LAWRENCE H. MIREL

Senator Brownback, Members of the subcommittee, I am Lawrence Mirel, a partner in the Washington, DC, law firm of Wiley Rein & Fielding. Before joining the firm in October of 2005 I served for more than 6 years as the Commissioner of Insurance, Securities and Banking for the District of Columbia. The views I am presenting today are my own, and do not necessarily represent those of the District of Columbia Government or of my law firm.

As Commissioner I became involved in health insurance issues, and I spent a considerable amount of time and effort trying to find better ways to make sure that the citizens of the District of Columbia had access to reasonable and affordable health insurance. That is no easy task. Advances in medical science and technology assure that health care costs continue to rise, as people receive more expensive care and live longer as a result. In addition the District's unlimited tort recovery system means that premiums for medical malpractice insurance go up every year, adding further costs to the system. Medical providers—doctors, hospitals and clinics—are increasingly being squeezed between rising costs for medical malpractice insurance and flat or even declining reimbursement by health insurance companies that are trying to hold down the cost of health insurance. For some, and especially those physicians and clinics that serve the poor, the squeeze is threatening their survival.

Comprehensive solutions are hard to come by. I did undertake two separate initiatives, however, as Commissioner aimed at ameliorating some of the more egregious problems with the current system, and I would like to briefly describe each of them

today. Both of these initiatives are still in the works, so their value has yet to be proven. But I hope you will agree that they hold out real promise for improving our health delivery system in the District of Columbia.

The first is aimed at what I consider to be unfair discrimination between persons who are employed by large employers—private or government—who have reasonable health insurance options, regardless of their medical history, and persons who are employed by small employers, are self employed, or are not employed at all. People in this latter group have a much tougher time finding decent insurance coverage, usually pay more for the coverage they do get, and if they have a history of medical problems may not be able to get insurance at all.

There is no good reason for this discriminatory treatment. Insurance is subject to the "law of large numbers," which simply means that the larger the number of people in a group of insureds, the easier it is to cover them all, even those who have or will have medical problems. That is because most people are healthy, meaning that the premiums they pay for health insurance can cover the costs for the much smaller number in the group who become ill. For those in small groups, however, or those who are self-employed, there is no large body of healthy people to share costs with. They pay according to their individual health status.

This distinction between large and small groups is entirely artificial. If we lump enough small groups together we end up with a large group. That is the basic idea beyond a bill that was drafted in the D.C. Insurance Department known as the "Equal Access to Health Insurance Act." Under that bill, which was introduced in the Council of the District of Columbia but has not been enacted, all persons who live, work, or go to school in the District of Columbia would be treated as a single group for purposes of health insurance rating. Members of this large group would be able to choose from among a wide array of private health plans—HMOs, PPOs, high deductible plans, etc.—the particular policy that best suits their needs. But they would pay group rates for those policies and would not be individually underwritten.

Looked at another way, the legislation would require that the District of Columbia Employees Health Benefits Plan, which provides a menu of options at standard rates to all District Government workers, be opened up to all persons who live, work or go to school here. No longer would someone who works for a restaurant or small retail business have fewer choices and pay higher prices for health insurance than people who work for the District of Columbia Government. No longer would someone who is self employed be individually underwritten, while someone with exactly the same medical history but who works for the District Government pays standard rates regardless of that medical history.

The Equal Access bill is designed to create a structured market for providing personal, portable health insurance in the District. Under the Equal Access bill small employers would no longer have to negotiate health plans for their employees each year, deciding whether it would be better to include dental coverage or maternity benefits, and whether they can afford either. Instead small employers could provide defined health benefit payments for their employees, and those employees could then sign up for one of the policies offered under the District-wide program that would be set up under the act. Not only employers but also churches, civic organizations and social service agencies could help their members and constituents purchase insurance through this program. We think just the ease of being able to access the health insurance system without having to find, design and negotiate individual plans on a yearly basis will increase the number of people who are insured.

The legislation would create a District of Columbia Health Benefits Program, which would be a central clearinghouse through which anyone who lives, works, or attends an institution of higher education in the District of Columbia, and their dependents, could obtain health insurance coverage. Any District employer could designate the program as its "employer-group" health insurance plan for its workers and their dependents—both those who live in the District of Columbia and those who live elsewhere. District residents could also enroll in the program directly.

Once enrolled, individuals would be able to select coverage from a menu of health insurance plans offered through the program, and could elect to change coverage during an annual open season.

All of the insurance plans offered through the program would be private plans offered by health insurers licensed to do business in the District. They would be regulated by the D.C. Department of Insurance, Securities and Banking and would have to comply with all applicable DC health insurance laws, just like any other licensed health insurance plans. The program itself would operate much like the Federal Office of Personnel Management does in making private health insurance plans available to federal employees; that is, it would administer the offering of a menu of private insurance options.

Although the D.C. Health Benefits Program would be similar in some ways to health insurance purchasing or pooling arrangements established by some States, it also differs in that it is designed to be considered "employer-group" insurance for purposes of federal tax and employee benefit law. In extensive discussions with the Federal Departments of Labor, Treasury and HHS, we worked out a novel approach as follows:

—Any employer could contract with the D.C. Health Benefits Program to make the program its "employer-group" health insurance "plan." For purposes of Federal law, that employer's "plan" would consist of the menu of insurance product choices offered through the program and the premium subsidy provided to its workers by the employer.

—This means that any contribution made by the employer to the premium for a policy purchased through the program would be tax-free to the worker. It also means that employees and dependants covered through the program would receive all of the protections afforded by federal law to workers covered by "employer-group" health insurance. However, because the policies offered through the program are personal, portable, D.C.-regulated insurance products, workers would be able to keep their coverage when they switch employers.

The program would also operate a payroll withholding system to facilitate collection of premium contributions by workers and/or their employers. Employers could choose to augment the coverage offered through the program with their own, separate, supplemental plans providing additional benefits such as vision care, dental care, long-term care, and health care flexible spending accounts.

As the legislation is currently drafted, the program would offer a choice of 10 to 15 health plans selected so as to offer a choice of plan types (e.g., indemnity, HMOs, PPOs, consumer directed, etc.). All plans offered through the program would have to provide major medical coverage (defined as: hospital benefits, surgical benefits, in-hospital medical benefits, ambulatory patient benefits, and prescription drug benefits), and meet the District of Columbia mandates, but within these broad parameters insurers would be free to design specific benefit packages in response to consumer preferences.

Policies sold through the program would charge standard, age-adjusted rates, without underwriting, to all enrollees who had at least 18 months of previous coverage, or who enrolled in the program as part of a participating employer-sponsored group. Each participating plan would be free to set its own table of standard, age-adjusted rates, subject to review by the D.C. Department of Insurance, Securities and Banking (DISB) to ensure that the rates reasonably reflected the anticipated costs of the offered benefits.

Persons who joined the program as part of a participating employer-group would be able to obtain coverage at standard rates and without underwriting, regardless of previous coverage. Persons who enroll in the program directly as individuals would be able to buy coverage at standard rates without underwriting if they have at least 18 months prior creditable coverage. Individual enrollees with less than 18 months prior creditable coverage could be charged premiums of up to 150 percent of standard rates for up to 2 years and could be subject to pre-existing condition exclusions of up to 12 months, reduced by the number of months of creditable coverage.

The program would be a self-governing, separate legal entity, sponsored by the D.C. Government and subject to regulatory oversight by DISB. The administrative costs of the program would be financed out of assessments on participating carriers, apportioned according to the share of enrollees electing coverage offered by each carrier through the program.

Any enrollee who ceased to be eligible to participate in the program by reason of a qualifying event (e.g., employment termination, divorce, loss of dependent status, etc.) would be permitted to continue participating in the program for up to 36 months, on the same terms as other enrollees, regardless of the loss of eligibility.

Insurance agents who brought individuals or groups to the program would be paid a 5-percent commission by the plans selected by those individuals. Associations and private social service organizations that enrolled groups or individuals in the program would be similarly compensated.

The legislation specifies that the D.C. Government would put its employees into the program. Thus, the program would start with a core group of about 30,000 lives (about 19,000 D.C. workers and their dependents). The presence of this large, stable, initial core group in the program would be a strong inducement to insurers to participate in the program and to offer attractive rates and benefit packages. Then, as private businesses and individuals join the program, its growing size would make it even more attractive to insurers and encourage even more vigorous competition for enrollees.

Finally, the Equal Access legislation would also establish a separate Health Insurance Risk Transfer Pool. The pool would be a "back-end reinsurance pool" structured as an industry-run, mandatory association. It would allow participating carriers to transfer claims for high cost enrollees to the pool, and then evenly spread those expenses across all insured individuals. That way, no single carrier would bear a disproportionate share of the costs associated with high-risk individuals. This would also permit high-risk individuals to have the same health plan choices as everyone else.

The pool would be self-governing and financed by assessments on all health insurance carriers selling health insurance in the District of Columbia market, both in and outside of the DC Health Benefits Program, as well as any self-funded employer plans that also elected to participate in the pool. I have attached to this testimony a copy of the Equal Access legislation as introduced in the D.C. Council.

The other initiative is designed to help the economic viability of the network of clinics that serves the District's population, and especially its less affluent members. Because of the District's unlimited liability tort system, the cost for medical malpractice insurance continues to rise astronomically. Obstetricians, for example, now pay more than $150,000 a year for medical malpractice insurance, while health insurers hold down the amount paid for deliveries, making the practice of obstetrics in the District of Columbia financially unviable.

Particularly at risk in this financial squeeze are the dozen or so independent clinics that provide much of the city's primary care for its poorer citizens. Especially since the demise of the old D.C. General Hospital these clinics have become the major source of primary health care for a large portion of the city's most vulnerable citizens. If they were to fold, the people they serve would have no choice but to take their medical problems directly to hospital emergency rooms—a most dangerous and uneconomical way to provide the care they need.

Medical malpractice insurance premiums have become a huge burden to these clinics. I know of one clinic, the Family Health and Birth Center in Northeast Washington, which provides essential pre-natal, birthing, post-partum and pediatric care to hundreds of District residents, that recently saw the cost of its medical malpractice insurance go from $90,000 to $175,000 in one year. The total budget of this clinic is only a million dollars a year. These clinics must have malpractice insurance, if for no other reason than that the District cannot contract with them to provide their health services unless they do. And much of their business is done under contract with the District Government.

In my former position as D.C. Insurance Commissioner I proposed that the District set up its own medical malpractice insurance company—a "captive" insurer—to cover all medical malpractice risks to which the District Government is exposed, either directly because of health services it provides to its citizens or indirectly because of health services provided by clinics under contract with the government. Individual clinics have little or no leverage with malpractice insurers. They are generally so small that there are few insurers willing to even make them an offer of insurance. They are victims of the same inflexible insurance "law of large numbers." But the District Government is a large player, and it can negotiate among insurers for good rates. By sweeping the private clinics into the District's own insurance mechanism the clinics can enjoy the better rates that the District can command, and the District can subsidize those costs when necessary. Moreover the "captive" insurance company will be able to provide important risk management services to those clinics. At present the District may be liable for malpractice committed at those clinics, but because they are independent organizations the District Government cannot insist that they properly mitigate their risks.

Currently the District Government is self-insured for tort claims, including medical malpractice. Since there is no sovereign immunity for the District Government, and no legal limits in District law on tort claims, the Government has open-ended exposure for claims of medical malpractice committed by District employees or contractors. What it pays out in judgments and settlements each year comes from a "settlements and judgments fund" in the District's annual Congressional appropriation. There is little ability for the government to control or account for the amount of money paid out each year, or to engage in the kinds of rigorous risk management that could reduce those claims. By setting up a wholly-owned captive insurance company, that would be professionally managed, the District will be able to budget better and to better manage its liability risks.

By allowing clinics to buy insurance from the captive insurance company, the District will enable these private entities to realize the market stability and savings that will come from the pooling of risks with the Government. Moreover the District will have the ability to subsidize the insurance costs for those clinics that cannot afford to pay them without jeopardizing their ability to provide patient care. Those

subsidies will be a bargain for the District Government because they will ensure that the private clinics will be able to continue their mission to serve the District's poorest population, without the need for more expensive and cumbersome programs that the Government would have to establish if they did not exist. Finally, having a professionally managed insurance company involved in providing liability coverage for these clinics will ensure that the best risk management practices are required, thus providing maximum safety to the patients of the clinics as well as to the District Government.

Senator Brownback, these are modest but important initiatives that I believe can help the District provide better medical care for its citizens on a more rational and cost effective basis. Because they are innovative ideas they naturally meet with some resistance from persons who do not understand what they are trying to do, or who are genuinely concerned that matters not be made worse. But innovation is what is needed, and these are ideas that will work.

Thank you for giving me the opportunity to appear before you today. I will be happy to answer any questions.

Government of the District of Columbia
Department of Insurance, Securities and Banking

Lawrence H. Mirel
Commissioner

March 29, 2004

Jim Mayhew
CMS
Center for Medicaid and State Operations
Private Health Insurance Group
7500 Security Boulevard, Mail Stop S3-16-16
Baltimore, Maryland 21244-1850

Re: Application for Seed a Grant to Establish
a Qualified High Risk Pool

Dear Mr. Mayhew:

Enclosed is the official application from the District of Columbia to apply for a seed grant to establish a qualified high-risk pool pursuant to the United States Trade Adjustment Assistance Act (TAA), P.L. 107-210 (2003). The District of Columbia has not established a health insurance risk pool. The District estimates that the costs of creating the pool will be approximately $1,537,000. Enclosed is a copy of the legislation that Mayor Anthony Williams will submit to the Council of the District of Columbia in April 2004.

If you have any questions, please call Kathy Rickford, Health Insurance Policy Advisor, on (202) 442-7758 or me on (202) 442-7776.

Sincerely,

Lawrence H. Mirel
Commissioner

Enclosures

810 First Street, NE, #701•Washington, DC•20002•Tel: (202) 442-7776•Fax: (202) 535-11196•
Email: lawrence mirel@dc gov

District Of Columbia's Application For A Seed Grant To Establish A Qualified High Risk Pool Pursuant To United States Trade Act Of 2002

I. Authority for the Establishment and Implementation of the Pool

Enclosed are copies of the Equal Access to Health Insurance Act of 2004. This legislation establishes the District of Columbia's qualified high-risk pool mechanism in the Health Benefits Program (Program) and Reinsurance Risk Transfer Pool (Pool). It also establishes the requirements for the Program and the Pool that include eligibility for enrollment in the Program, benefits structure, cost sharing arrangements, consumer protections, responsibilities of the carriers that participate in the Program, mandatory requirements for carrier membership in the Pool, and revenue sources.

II. Administration of the Pool

The components of the District of Columbia's Program and the Pool unite to meet the requirements of a qualified high risk pool pursuant to the requirements in § 2744 (c) (2) of the PHS Act. The Program makes available to all eligible individuals (as defined in § 2741 (b) of the PHS Act) health coverage that does not impose any pre-existing condition exclusion. Also, the Program provides for premium rates and covered benefits consistent with the "Health Plan for Uninsurables" model regulation established by the National Association of Insurance Commissioners (NAIC), in effect as of August 21, 1996, the date of enactment of the Health Insurance Portability and Accountability Act of 1996. The Pool strengthens the Program by allowing carriers to cede high risk to the Pool so that the risk can be spread among all carriers, except Medicaid carriers, that sell health insurance in the D.C. market. The high-risk enrollee is treated like other enrollees (pays the same premium) and the transfer of the risk is invisible to that enrollee. The risk transfer is a mechanism protects carriers that offer coverage in the Program, as well as, carriers that offer products in the D.C. commercial health insurance market.

The Program:

The Program will be an independent instrumentality of the District with a separate legal existence from the District Government. The Program will be administered by a Program Director, governed by the Program Board and subject to the regulatory supervision of the Commissioner of the Department of Insurance, Securities, and Banking. The Program Board will consist of the Director of the D.C. Department of Health or designee, Director of the D.C. Office of Personnel or designee, three individuals experienced in running health insurance programs appointed by the Mayor, four individuals appointed

by the Mayor who represent the interests of the enrollees in the Program, two members of the Pool's Board of Directors or designees, and the Commissioner of the Department of Insurance, Securities, and Banking or designee (as an ex-officio member).

The Pool:

The Pool will be an independent instrumentality of the District with a separate legal existence from the District Government. It will be an industry-run mandatory association that will allow carriers, participating self-funded employers, stop loss and reinsurance carriers to transfer risks to the Pool. The Pool will be financed by assessments on all health insurance carriers selling health insurance in the District of Columbia market, except Medicaid carriers. The Pool will be administered and governed by the Board of Directors and subject to the regulatory supervision of the Commissioner of the Department of Insurance, Securities, and Banking. The Board will consist of at least 5 individuals, each of whom is a full-time employee of a member plan. The Commissioner of the Department of Insurance, Securities, and Banking or designee will be an ex-officio member of the Board.

III. Steps Taken

The following action has been taken to create the qualified high-risk pool:

- Review other states' risk pools.
- Discuss the District of Columbia's idea for a qualified high-risk pool with federal, state and national health insurance experts, consumer representatives, insurers, and business leaders.
- The District of Columbia was awarded the 2003-2004 HRSA Grant for $990,000. The Equal Access to Health Insurance Act is part of the proposal upon which the District was awarded the grant. It is hoped that the D.C. Department of Health (lead agency for the grant) will perform needed surveys concerning health insurance to help support the program.
- The Commissioner is exploring various avenues to have a risk analysis performed on the Equal Access to Health Insurance mechanism.

IV. Remaining Steps

D.C. Department of Insurance and Securities Regulation must obtain letter of legal sufficiency from the Office of Corporation Counsel, the fiscal impact statement from the Chief Financial Officer and the Mayor submit the act to the Council of the District of Columbia (Council). This is anticipated to occur in April 2004. The Council will review the bill and agendize it for regular session. There will be a first reading - Council considers amendments, takes first vote. If majority votes no - bill fails. If Majority votes yes - bill passes and is engrossed. Then there will be a second reading - Bill must not be substantially altered at this consideration. Council takes a second vote. Majority no - bill fails. Majority yes - bill passes and bill is enrolled. The Mayor has ten (10) days to sign the bill. Once it is signed, the bill goes to the United States Congress for review (30 consecutive days are allowed for the review). After the 30-day period has expired the bill becomes law.

Below are itemized financial considerations which indicates some of the remaining steps to implement Equal Access to Health Insurance Act of 2004:

Financial Considerations

Cost Item	Cost $	Comments
Plan of Operation	25,000	Use risk pool Plan of Operation as a model
Market Survey to determine average large employer rates	50,000	Use Actuarial Consultant
Marketing and Communication Plan	75,000	Use marketing consultant
Criteria for Participation by Carriers	5,000	Use Operations Committee resources
Plan menu and contract forms for benefit plans	20,000	Assumes use of FEHBP benefits and contract forms and use of resources from Benefits Committee
Standard Application Form	5,000	Use resources of Benefits Committee along with other states' prototype applications
Participating Carrier and Administrator Contracts	10,000	Use resources of Legal Committee along with prototype contracts from other states
Operations and Procedures Manual	10,000	Use other states' Operations and Procedures Manual as prototype
Line of Credit Commitment Fee	75,000	The fee some Banks charge for a $10 million line of credit secured by assessments to carriers that is cited in the Law.
Conversion of in force business from current DC plan	96,000	The IT project to plan, test and convert the data files from the current carrier records to the new participating carrier records. Use carrier resources.
Agent and Broker Training	15,000	Education of Brokers and Agents regarding the Program
HIPAA Compliance Manual	90,000	Use prototype HIPAA Compliance Manual

Cost Item	Cost	Comments
Plan of Operation*	15,000	Use prototype Plan of Operation
Operations and Procedures Manual*	10,000	Use prototype Operations and Procedures Manual
Line of Credit Commitment Fee*	75,000	The fee some Banks charge for a $ 10 million line of credit secured by assessments to carriers that is cited in the Law.
HIPAA Compliance Manual	10,000	The Pool is not considered a Covered Entity under HIPAA but Carriers are Covered Entities and Protected Health Information will be sent to Plan
Committee Member Reimbursement (*25% of the Costs)	200,000	Reimbursement of committee members@ 4 per committee with 4 committees meeting for six face to face meetings@ 8 hrs each. Includes reimbursement of time
Carrier Training*	60,000	Includes one general workshop with the option for one on one workshops with individual carriers
Market Survey to Determine Standard Risk rate*	50,000	Use Actuarial Consultant
Administrator Start Up Costs	144,000	Use Administrative Pool Consultant
Advertising	260,000	Ad creation and placement costs
Program Director	110,000	
Administrative Assistant/Consumer Specialist	57,000	
Compensation of Board Members	70,000	Non-insurer board members @ $10,000 per member
Total Estimated Start-Up Expenses	1,537,000	Total of above itemized costs

* The set-up costs of the Risk Transfer Pool are $302,900(which includes administrator start-up costs of $32,900 and items with an asterisk above).

It is anticipated that the open season will begin November 2004 with an effective date of January 2005.

V. Contact Persons

- Lawrence H. Mirel
  Commissioner
  (202) 442-7773
  lawrence.mirel@dc.gov
  D.C. Department of Insurance, Securities and Banking
  810 First Street, N.E., Suite 701
  Washington, D.C. 20002

- Katheryne S. Rickford, Esq.
  Health Insurance Policy Advisor
  (202) 442-7758
  katheryne.rickford@dc.gov
  (Same mailing address as above)

APPLICATION FOR FEDERAL ASSISTANCE

OMB Approval No. 0348-00

2. DATE SUBMITTED: March 29, 2004		Applicant Identifier
3. DATE RECEIVED BY STATE		State Application Identifier
4. DATE RECEIVED BY FEDERAL AGENCY		Federal Identifier

1. TYPE OF SUBMISSION:

Application: ☐ Construction ☒ Non-Construction

Preapplication: ☐ Construction ☒ Non-Construction

5. APPLICANT INFORMATION

Legal Name: District of Columbia

Organizational Unit: Department of Insurance, Securities & Banking

Address (give city, county, State, and zip code): 810 First Street, N.E., Suite 701, Washington, D.C. 20002

Name and telephone number of person to be contacted on matters involvi this application (give area code): Lawrence H. Mirel (202) 442-7773; Katheryne S. Rickford (202) 442- 7758

6. EMPLOYER IDENTIFICATION NUMBER (EIN): 53-6001131

7. TYPE OF APPLICANT: (enter appropriate letter in box) C

A State, B County, C Municipal, D Township, E Interstate, F. Intermunicipal, G Special District, H Independent School Dist., I State Controlled Institution of Higher Learning, J Private University, K Indian Tribe, L Individual, M Profit Organization, N Other (Specify) ____

8. TYPE OF APPLICATION:

☒ New ☐ Continuation ☐ Revision

If Revision, enter appropriate letter(s) in box(es) ☐ ☐

A Increase Award, B Decrease Award, C Increase Duration, D Decrease Duration, Other (specify).

9. NAME OF FEDERAL AGENCY: Centers for Medicare & Medicaid Services

10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: 93-781

TITLE: Seed Grant for Qualified High Risk Pools

11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT: Equal Access to Health Insurance Act of 2004

12. AREAS AFFECTED BY PROJECT (Cities, Counties, States, etc.): District of Columbia

13. PROPOSED PROJECT: Equal Access Healt

14. CONGRESSIONAL DISTRICTS OF: District of Columbia

Start Date	Ending Date	a. Applicant	b. Project
April 2004	Nov. 2004	District of Columbia	To create greater access to health insurance

15. ESTIMATED FUNDING:

a. Federal	$ $ 1, 000,000 .00
b. Applicant	$ .00
c. State	$ .00
d. Local	$ .00
e. Other	$ .00
f. Program Income	$ 129,000 .00
g. TOTAL	$ 129,000 .00

16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?

a. YES. THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON:

DATE ____

b. No. ☒ PROGRAM IS NOT COVERED BY E. O. 12372

☐ OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW

17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?

☐ Yes If "Yes," attach an explanation. ☒ No

18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT, THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.

a. Type Name of Authorized Representative: Lawrence H. Mirel	b. Title: Commissioner	c. Telephone Number: (202) 442-7773
d. Signature of Authorized Representative: Lawrence H. Mirel		e. Date Signed: March 29, 2004

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Prescribed by OMB Circular A-102

BUDGET INFORMATION - Non-Construction Programs

OMB Approval No. 0348-0044

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. Equal Access to Ins		$	$	$ 1,000,000	$ 129,000	$ 1,129,000.00
2.						
3.						
4.						
5. Totals		$	$	$ 1,000,000.00	$ 129,000.00	$ 1,129,000.00

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY (1)	(2)	(3)	(4)	Total (5)
a. Personnel	$ See Financial	$ Considerations	$ Enclosed	$	$
b. Fringe Benefits					
c. Travel					
d. Equipment					
e. Supplies					
f. Contractual					
g. Construction					
h. Other					
i. Total Direct Charges *(sum of 6a-6h)*					
j. Indirect Charges					
k. TOTALS *(sum of 6i and 6j)*	$	$	$	$	$
7. Program Income	$ 1,129,000	$	$	$	$

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Prescribed by OMB Circular A-102

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SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8. Equal Access To Health Insurance	$ 129,000	$	$	$ 129,000.00
9.				
10.				
11.				
12. TOTAL *(sum of lines 8-11)*	$ 129,000.00	$	$	$ 129,000.00

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$ 1,000,000	$ 250,000	$ 250,000	$ 250,000	$ 250,000
14. Non-Federal					
15. TOTAL *(sum of lines 13 and 14)*	$ 1,000,000.00	$ 250,000.00	$ 250,000.00	$ 250,000.00	$ 250,000.00

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (Years)			
	(b) First	(c) Second	(d) Third	(e) Fourth
16.	$	$	$	$
17.				
18.				
19.				
20. TOTAL *(sum of lines 16-19)*	$	$	$	$

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:	22. Indirect Charges:

23. Remarks:

OMB Approval No. 0348-0040

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

NOTE: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for Federal assistance and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project cost) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and, (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally-assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
Lawrence H. Mirel	Commissioner
APPLICANT ORGANIZATION	**DATE SUBMITTED**
District of Columbia Department of Insurance, Securities and Banking	March 29, 2004

Standard Form 424B (Rev. 7-97) Back

DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. Type of Federal Action:
[b] a. CONTRACT
b. GRANT
c. COOPERATIVE AGREEMENT
d. LOAN
e. LOAN GUARANTEE
f. LOAN INSURANCE

2. Status of Federal Action:
[b] a. BID/OFFER/APPLICATION
b. INITIAL AWARD
c. POST-AWARD

3. Report Type
[a] a. INITIAL FILING
b. MATERIAL CHANGE
FOR MATERIAL CHANGE ONLY:
YEAR _____ QUARTER _____
DATE OF LAST REPORT _____

4. Name and Address of Reporting Entity:
[X] PRIME [ ] SUBAWARDEE
TIER _____, *IF KNOWN:*
D.C. Depart. of Insurance, Securities & Banking
810 First Street, N.E., Suite 701
Washington, D.C. 20002
Congressional District, *if known:* District of Columbia

5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of
Congressional District, *if known:*

6. Federal Department/Agency
Department of Health and Human Services
Centers for Medicare & Medicaid Services

7. Federal Program Name/Description:
Seed Grant for Qualified High Risk Pools
CFDA Number, *if applicable:* 93-781

8. Federal Action Number *if known:*

9. Award Amount *if known:*
$

10a. Name and Address of Lobbying Entity
(If individual, last name, first name, MI)
N/A

b. Individual Performing Services *(including address if different from No. 10A) (last name, first name, MI)*
N/A

(attach Continuation sheet(s) SF-LLL-A, if necessary)

11. Amount of Payment *(check all that apply):*
$ _____ [ ] actual [ ] planned

12. Form of Payment *(check all that apply):*
[ ] a. cash
[ ] b. in-kind; specify: nature _____
value _____

13. Type of Payment *(check all that apply):*
[ ] a. RETAINER
[ ] b. ONE-TIME FEE
[ ] c. COMMISSION
[ ] d. CONTINGENT FEE
[ ] e. DEFERRED
[ ] f. OTHER; SPECIFY:

14. Brief Description of Services performed or to be Performed and Date(s) of Service, including officer(s), employee(s), or Member(s) contacted, for Payment indicated in Item 11:

(attach Continuation sheet(s) SF-LLL-A, if necessary)

15. Continuation Sheet(s) SF-LLL-A attached: [ ] Yes [ ] No

11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Signature: Lawrence H. Mirel
Printed Name: Lawrence H. Mirel
Title: Commissioner
Telephone No.: 202-442-7776 Date: 3/29/04

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Standard Form - LLL

ADDITIONAL ASSURANCES

CERTIFICATIONS

1. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that it will provide a drug-free workplace in accordance with regulations implementing the Drug-Free Workplace Act of 1988: 45 CFR Part 76, Subpart F

The certification set out below is a material representation of fact upon which reliance will be placed when HHS determines to award the grant False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or governmentwide suspension or debarment.

Certification Regarding Drug-Free Workplace Requirements

The grantee certifies that it will or will continue to provide a drug-free workplace by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about --
   (1) The dangers of drug abuse in the workplace;
   (2) The grantee's policy of maintaining a drug-free workplace;
   (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
   (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a);

(d) Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the grant, the employee will --
   (1) Abide by the terms of the statement; and
   (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing, within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted --
   (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e) and (f).

The grantee certifies that, as a condition of the grant, he or she will not engage in the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance in conducting any activity with the grant.

2. CERTIFICATION REGARDING LOBBYING

Title 31, U.S. Code, Section 1352, entitled "Limitation on Use of Appropriated funds to Influence Certain Federal Contracting and Financial Transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or

cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR 93)

The undersigned certifies, to the best of his or her knowledge and belief, that:

(a) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement

(b) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

(c) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

3. CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND OTHER RESPONSIBILITY MATTERS

NOTE: In accordance with 45 CFR Part 76, amended June 26, 1995, any debarment, suspension, proposed debarment or other government exclusion initiated under the Federal Acquisition Regulation (FAR) on or after August 25, 1995, shall be recognized by and effective for Executive Branch agencies and participants as an exclusion under 45 CFR Part 76.

(a) Primary Covered Transactions

The undersigned (authorized official) signing for the applicant certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principles:

(1) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

(2) Have not within a three-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(3) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (1)(b) of this certification; and

(4) Have not within a three-year period preceding this application/proposal had one or more public transactions (Federal, State or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation should be placed under the assurances page in the application package.

(B) Lower Tier Covered Transactions

The applicant agrees by submitting this proposal that it will include, without modification, the following clause entitled, "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion--Lower Tier Covered Transaction," (Appendix B to 45 CFR Part 76) in all lower tier covered transactions and in all solicitations for lower tier covered transactions

Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion--Lower Tier Covered Transactions

(1) The prospective lower tier participant certifies, by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.

(2) Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
Lawrence H. Mirel	Commissioner
APPLICANT ORGANIZATION	DATE SUBMITTED
District of Columbia Department of Insurance, Securities and Banking	March 29, 2004

Biographical Information on Lawrence H. Mirel

Lawrence H. Mirel, Commissioner of the District of Columbia Department of Insurance, Securities and Banking (DISB), was appointed to his position by Mayor Anthony A. Williams in July of 1999. Commissioner Mirel directs the government agency responsible for enforcing all laws of the District of Columbia relating to the conduct of the businesses of insurance, securities and banking in the jurisdiction. The agency has a budget of more than $13 million a year and a staff of approximately 129. Under Commissioner Mirel's leadership the District has made a bid to become a major national and international center for insurance and other kinds of financial services. A strong legal and regulatory modernization program is underway, including a state-of-the-art captive insurance law geared toward the District's unique market as the nation's capital and the home of thousands of trade and non-profit associations.

Since his appointment Commissioner Mirel has focused on improving the efficiency of regulation in the District of Columbia to better protect its citizens. In 2000 DISR was reaccredited by the National Association of Insurance Commissioners (NAIC). In that year it also received the NAIC's State Regulation 2000 Award for participating in all of the NAIC's automated information systems. Over the past several years the Department has become completely computerized and now handles virtually all information electronically. It also has an interactive web site at www.disr.dc.gov and has developed a substantial community education program.

Commissioner Mirel plays an active role in the National Association of Insurance Commissioners, serving as Chair of the NAIC/Industry Liaison Committee and of the International Regulatory Cooperation working group of the International Insurance Relations Committee. Commissioner Mirel also chairs the Class Action Litigation working group and is co-chair of the Government Affairs Task Force which was set up to provide liaison between the NAIC and the U.S. Congress. He is a member of the North American Securities Administrators Association (NASAA) and the Conference of State Bank Supervisors (CSBS).

Before becoming Commissioner Mr. Mirel was a lawyer in private practice, and the founder and executive director of the District of Columbia Insurance Federation (DCIF), a state insurance trade association. Earlier he served as a Federal Government official with the Peace Corps and the Department of Labor and he worked on Capitol Hill as an aide to a U.S. Senator and to a Member of the House of Representatives. In the early 1980s he was General Counsel to the Council of the District of Columbia, the District's local legislature. He has also been an Adjunct Professor of Law at George Washington University Law School and at American University School of Law. Mr. Mirel is a native of Connecticut and is a member of the Bars of the State of Connecticut and the District of Columbia. He is admitted to practice before the U.S. Court of Appeals for the District of Columbia Circuit and the U.S. Supreme Court. He is a graduate of Oberlin College and Columbia Law School.

District of Columbia Department of Insurance, Securities and Banking, 810 First Street, N.W. Washington, DC 20002

Senator BROWNBACK. Mr. Haislmaier.

STATEMENT OF EDMUND HAISLMAIER, RESEARCH FELLOW, CENTER FOR HEALTH POLICY STUDIES, THE HERITAGE FOUNDATION

Mr. HAISLMAIER. Thank you, Senator.

My name is Ed Haislmaier. I'm a visiting research—well, actually, a research fellow, not visiting—at the Center for Health Policy Studies at The Heritage Foundation. I would also say two other things. I was born in Columbia Hospital for Women in the waning days of the Eisenhower administration, so I am a District native.

So I am a District native, though I grew up in—just across the line, in suburban Maryland, but then I went to high school at St.

John's, here in the District, and I have been a resident of Capitol Hill for 15 years. So, what I am testifying on is a matter of not only professional interest, but of personal interest. And I should also add that I've had the pleasure of working, for a couple of years, with then-Commissioner Mirel on developing some of his ideas and proposals.

Let me make a couple of brief comments excerpted out of my longer testimony.

Randy Bovbjerg presented data on the uninsured. And there is much more data out there, both nationally and locally. But I think what we can do is reduce it down, in my mind, really, to a couple of points, and that is to say that if—in the case of any given uninsured person, they—the reason they are uninsured is one or more of the following three reasons. It's an issue of affordability or availability or value.

Now, what do I mean by that? Well, for some people, it's clearly affordability. Even if you made the insurance cheaper, even if you, you know, made it more available, they still are going to have trouble paying for it. And that's often the focus of discussions over policy solutions for the uninsured.

But that's only a subset of the uninsured. For some people, it's not so much a question of affordability as it is a question of availability. And this is what Mr. Mirel touched on, the fact that they work in the kinds of jobs that don't provide them coverage. And, frankly, the way our system's organized, that's where most people get their coverage. They don't fit the pattern that we've operated on in this country since the 1930s, really—well, late 1930s, early 1940s—of assuming that everybody goes to work out of high school for a large employer like General Electric or General Motors, stays there 30 years, gets all their benefits, and then retires with a company pension and healthcare.

Now, if you, or anybody you know, doesn't fit that model, they're at risk of running into these availability problems. And I should say that I remember talking to some of the Senate staff, who I know, from previous years, had worked on the HIPAA legislation Senators Kassebaum and Kennedy put together, and I said, "You know, what you guys did in HIPAA was, you made a great—you did a great job of making sure coverage was portable if people went from GM to General Electric, but that doesn't work when going from Home Depot to McDonald's to Joe's Pizza, that's a one-off."

Value is the third point. There are people who we know can afford to buy the insurance, and for whom it is available, and they simply don't purchase it. In large measure, they don't purchase it, because they don't value it. There are a number of reasons why they might not value it. There are rules, in some cases—I—happy to say not in the District of Columbia—but in some States there are rules that make the insurance artificially expensive, and, thus, make it less valuable to them. In some cases, they just think, "Hey, you know, I'm healthy, I don't need it."

Perversely, to the extent that we have a national policy, which we do, EMTALA, the Emergency Labor Treatment Act, which says that, "If you show up without insurance, you'll get treated," we're rewarding that behavior. We're saying, "Don't worry. If something

happens, you'll get treated, and somebody else will pay for it." So, you know, if you're young and healthy, why not skip it?

The fact of the matter is, in any given instance it's probably a combination of those three. But I think outlining those three gives us some idea of how we could proceed with a set of reforms to address the pieces of the problem.

The other key point that I would make in this context is that the longitudinal research on the uninsured—in other words, there were studies where they took the uninsured population, over 4 years—and it was about 85 million, as opposed to the 40 million reported every year—and they looked, and they said, "Well, how do those people's coverage patterns work out?" Well, they found only 12 percent were uninsured for the full 4 years, but 33 percent went in and out, in and out, in and out of coverage repeatedly. And another 29 percent were basically covered, but had some gap in the middle. So, right there, you're looking at two-thirds of these people, if we could just make the insurance stick to them instead of the job, you could—instead of to their employer, you could solve a lot of the problem right there. They would keep the insurance.

Now, how does this come down to what we're talking about here in the District? The equal-access legislation that Mr. Mirel was talking about is designed to address the continuity problem precisely. It is designed to stop pounding the square peg of small business into the round hole of employer group insurance, and say, "Let's make something that fits better for everybody," so that it's employer group insurance for purposes of it being tax free, but everybody goes into one big pool that looks like FEHBP, and once a year they get to pick the coverage they want. The more people you get in there, the more people show up with insurance, either in public clinics or private physicians and hospitals, and the money to pay for it.

You then move to the next piece, which is the D.C. Alliance. I think the District did the absolute right thing in moving from a provider safety net, which was D.C. General, saying, basically, "We'll pay to make sure you don't go broke," to a people safety net, which is, "We're going to use the money to make sure people get treatment." They need to take the next step, which is exactly what Governor Romney is proposing in his State, in Massachusetts, and what the legislature up there just agreed to, and that is to convert that into subsidies to buy insurance.

We have the money. It's there. It's the next step. The equal access provides the framework for it.

Finally, once you have those two pieces in place, I think the other pieces, which have already been discussed—reforming the malpractice, helping our clinics get the right infrastructure so they can get paid by the insurance companies—I think could really tie the package together very neatly. And I think, as Mr. Bovbjerg pointed out, it is not unrealistic to envision that we could, indeed, achieve universal access here in the District of Columbia.

I would simply say that I think this is a vision in which the incentives in the system are aligned to put patients first, in which the health insurers are given incentives to compete for customers, not just to try to, you know, knock down the premium by paying providers less, but to meet the needs of their patients, not the em-

ployer; and the providers, of course, are incentivized to offer the best quality care that they can to their patients and to create those kind of medical homes and long-term relationships that we do know do yield better outcomes and lower cost. I think that it also is a vision in which patients, providers, and insurers have incentives to collaborate together to manage appropriately the patient's care. We know that health—that disease management works best when the individual is an active co-manager. I think it's a vision worthy of our Nation's Capital.

Thank you, Mr. Chairman.

[The statement follows:]

PREPARED STATEMENT OF EDMUND F. HAISLMAIER

My name is Edmund F. Haislmaier. I am a Research Fellow in the Center for Health Policy Studies at The Heritage Foundation. The views I express in this testimony are my own, and should not be construed as representing any official position of The Heritage Foundation.

Thank you Mr. Chairman and Members of the committee for the opportunity to testify before you today on he subject of access to primary care and health insurance in the District of Columbia.

I will begin my testimony by offering a perspective on the three basic factors that contribute to the lack of health insurance coverage. Then, I will outline the elements of what I believe to be a promising strategy for expanding health insurance coverage, while simultaneously creating the right incentives for the health care delivery system to deliver better quality, lower cost care. Finally, I will conclude with a number of observations on how such a strategy could be implemented in the District and the benefits that could result.

There exists a substantial body of data and analytical research on health insurance coverage, including analyses of the demographics of the insured and uninsured populations according to various demographic factors such as income, age, race, sex, geography and employment.

However, the vast majority of that analysis and research can be summarized by saying that in the case of any given uninsured person, his or her lack of coverage is attributable to one or more of the following three basic factors; the affordability, the availability and the perceived value, of health insurance.

Affordability.—Some of the uninsured simply do not have sufficient incomes to pay for coverage. Furthermore, even if coverage could be made less expensive than it currently is, many of those individuals would still be unable to afford health insurance absent additional assistance in the form of some kind of public subsidy. The biggest public policy issue in this regard is the current binary, or "all or nothing," structure of publicly funded health coverage programs. Those who qualify get full coverage, while those who do not qualify get nothing. In the case of the District, this applies to Medicaid, DC Healthy Families (the District's S–CHIP program) and the Alliance. It should be noted in passing that the Federal Medicare program works the same way.

For income-related programs, the reality is that some individuals with incomes just under a program's eligibility thresholds could probably afford to contribute something towards their coverage, while many of those just above the eligibility thresholds will certainly need some subsidy to afford health insurance. In recognition of this reality some States have expand their public programs by permitting income-related "buy-in" arrangements. For example, Maryland permits families with incomes between 200 percent and 300 percent of poverty to "buy-into" S–CHIP coverage for their children by paying a partial premium. Less common, is the alternative approach of providing qualified individuals with income-related contributions to subsidize private coverage.

Availability.—For other uninsured individuals, the issue is as much or more one of availability as it is one of affordability. In general, these are persons who lack access to employer-provided insurance. For many of them the availability problem quickly translates into an affordability issue. That is because the current system of Federal tax subsidies for employer-sponsored coverage, combined with State insurance laws that divide the market into small-group, large-group, and non-group segments, each with different regulations, make employer-group insurance significantly less expensive than the alternative of non-group insurance. However, it is important to keep in mind that non-group insurance does offer the advantage of coverage port-

ability, while employer-group insurance is never truly portable. Thus, were governments to equalize the costs of employer-group insurance versus non-group insurance through public policy changes, the purchase of non-group insurance would likely become the preferred solution for many individuals, particularly those who change jobs more frequently.

Value.—Finally the principle issue for some of the uninsured is one of perceived value. Those are individuals have access to coverage and can afford to pay for it, but still decline to purchase health insurance (either group or non-group) because they perceive it to have low value for the price charged (premium). This perception of health insurance as a "poor value for money" can result from several factors, including:

—Community rating practices that make coverage more expensive for younger and better risk individuals

—Regulations that prevent the offering of less comprehensive, and thus less expensive, plans

—A system of public subsidies for uncompensated care that perversely encourage the healthy uninsured to go without coverage, knowing that someone else will pay for their treatment should they in fact happen to need care

—A general market structure that results in the offering of plans that focus on near-term protection at the expense of long-term protection, such as by applying underwriting in the non-group market equally to those with and without continuous, prior coverage.

Given the interaction of these three basic factors, it is not possible to simply subdivide the uninsured into three groups. Rather, the reality for any given uninsured individual is that one of these three factors is the dominant reason for a lack of coverage while one, or both, of the remaining factors also influence the coverage decision.

However, this analysis is useful in suggesting a three-prong approach that policymakers can take to measurably expand health insurance coverage. The most promising strategy is to systematically address the three basic factors that produce uninsurance with three complementary sets of reforms:

Set One.—Undertake reforms designed to moderate the cost of coverage in general and to permit health insurance markets to better align premiums with perceived value.

Set Two.—Institute reforms in the ways that health insurance is bought and sold to make coverage more accessible and available, particularly for those whose employment patterns do not match the premise of long-term employment at a large firm offering employer-group coverage that underlies the current market structure.

Set Three.—Reform public programs to provide subsidies to more individuals, but scale them according to income and need. Also, convert existing subsidies for uncompensated care currently directed to medical providers into coverage subsidies directed to individuals.

The data indicate that many of the uninsured are part-time or contingent workers, including significant numbers employed by Federal, State, and local governments and large private employers. Anther significant share consists of those working for small businesses, particularly "micro" businesses with 10 or fewer employees and the self-employed. Finally, almost all of the remaining uninsured individuals are the dependents of workers in the first two categories.

National research also shows that the long-term uninsured comprise only a small portion of the total uninsured population. A recent study that looked at the total population experiencing one or more spells of uninsurance over a 4-year period found that only 12 percent were consistently uninsured. In contrast, fully one-third cycled repeatedly in and out of insurance coverage and another 29 percent experienced coverage gaps during the 4-year period. These results lead the authors to conclude that continuity of coverage should be an explicit and principal policy goal for health reform.[1]

The simple reality is that employment-based health insurance only works well for those who are long-term employees of large firms, and Medicaid is reliable coverage only for the very poor. Neither system, alone or in combination, is doing an accept-

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[1] Short, Pamela Farley and Graefe, Deborah R., "Battery-Powered Health Insurance? Stability In Coverage Of The Uninsured," *Health Affairs*, November/December, 2003. See also: Short, Pamela Farley, Graefe, Deborah R. and Schoen, Cathy, "Churn, Churn, Churn: How Instability of Health Insurance Shapes America's Uninsured Problem," *The Commonwealth Fund*, Issue Brief No. 688, November, 2003 and Klein, Kathryn, Glied, Sherry and Ferry, Danielle, "Entrances and Exits: Health Insurance Churning, 1998–2000," *The Commonwealth Fund*, Issue Brief No. 855, September, 2005.

able job of ensuring health care coverage for the people who don't fit either of those categories.

The DC Equal Access to Health Insuranc legislation is designed to make health insurance coverage more readily available to District residents, and to explicitly promote greater continuity of coverage. It would create a single "clearinghouse," in the form of a new DC Health Benefits Program, through which those who live and work in the District could obtain the health insurance plan of their choice. In the case of individuals whose employers elected to make the DC Health Benefits Program their "group-health insurance plan," they would be able to buy coverage through the program using tax-free contributions by their employer.

The effect would be that, as those individuals changed employers, they could keep their chosen health insurance policy and take it with them from job to job—just as they now do with their auto, home or life insurance. Thus, as they changed jobs the only thing that would differ from one employer to the next is the arrangement for paying for coverage with tax-free dollars. Instead of standardizing the insurance benefit package, as Maryland and some other States have done in their small-group markets, the DC Equal Access bill would standardize and centralize the administrative functions involved in offering a menu of plan choices, managing an annual open season, handling enrollment, and transmitting premium payments to the chosen insurers.

In short, the DC Health Benefits Program would provide for all District residents and participating employers the same kinds of administrative services that the Federal Employee Health Benefits Program now provides for workers throughout the Federal Government.

As I noted, studies of the data on health insurance coverage over time have led researchers to conclude that, "To the extent that job turnover undermines coverage stability, designing ways for employers to contribute to the cost of coverage, without directly administering health insurance, could enhance continuity."[2]

The DC Equal Access bill is designed to implement precisely the solution called for by these researchers. Furthermore, the researchers also point out how such an approach can provide benefits beyond simply reducing the number of uninsured. They note that reducing coverage gaps will also aid efforts to improve continuity of care, which can in turn result in better health outcomes, improvements in health status and potentially lower system costs. Specifically, they concluded that,

> Efforts to reduce churning in public and private plans or to assure more seamless transitions from one source of coverage to another would also enhance the efforts of physicians and other clinicians to provide effective care. The possibility of changing networks of care, frequent transitions from one insurance program to another, and losing coverage entirely are likely to undermine the continuity, timeliness, and appropriateness of care.

Thus, another, and very important, benefit of the proposed DC Health Benefits Program is that it would facilitate and reinforce delivery system initiatives designed to improve the effectiveness of care, specifically the "medical homes" initiative of the District's primary care clinics.

The design of the Equal Access legislation and the DC Health Benefits Program would offer a number of other advantages as well.

For example, the DC Health Benefits Program would administer "premium aggregating" mechanisms, including a uniform payroll withholding system, to facilitate the collection of premium payments. Those mechanisms would be able to combine contributions from multiple sources. Thus, a two earner couple would no longer have to choose coverage from one spouse's employer and forgo the coverage contribution offered by the other spouse's employer. Instead they could combine the contributions from the two employers and use the total amount to buy the coverage they real want for their family through the exchange. Similarly, an individual with two part-time jobs could ask for a pro-rated contribution from each employer and then combine them to buy coverage through the program.

With these features in place, small employers would no longer face the risks and administrative burdens associated with trying to obtain group coverage for their handful of employees. Rather, a business could designate the program as its "group" health insurance plan and give its employees whatever tax-free contribution the business can afford to help them buy coverage.

Under the Equal Access legislation, insurance brokers would continue to receive commissions for bringing employer groups and individuals to the program. They

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[2] Short, Pamela Farley, Graefe, Deborah R. and Schoen, Cathy, "Churn, Churn, Churn: How Instability of Health Insurance Shapes America's Uninsured Problem," *The Commonwealth Fund*, Issue Brief No. 688, November, 2003.

would earn their commissions by providing workers with benefits counseling on picking the best plan for their personal situations, and by assisting employers in setting up arrangements, currently permitted under Federal and State tax law, that make the share of the premium paid by their workers also tax-free to the workers. While such arrangements are common among large firms, today small firms rarely offer them.

Furthermore, the Equal Access bill is designed to open up additional avenues for providing coverage to hard to reach subpopulations. One provision would allow private social service entities, such as clinics or church groups to subcontract with the program to handle enrollment for populations that they serve. Another provision stipulates that if membership groups bring their members into the program, that those groups would be paid the same commission as insurance brokers. In other words, business and professional associations as well as civic, religious or social service organizations would be rewarded for ensuring that those they serve get health insurance coverage. That could greatly augment outreach and enrollment efforts.

The Equal Access bill would also require the District Government to take the lead by providing health insurance to its own employees through the program. This provision would have several positive effects. First, District of Columbia government workers would gain a wider choice of coverage options. Second, it would facilitate getting coverage to those government employees, particularly contractual and contingent workers, who are currently uninsured. Third, the presence of such a large number of workers plus their dependents (about 30,000 in total) would be a catalyst for ensuring the program's success. Insurers would have a huge market incentive to offer attractive benefit packages at attractive premiums through the program, while small businesses and their employees would be eager to join.

Finally, the costs of coverage for the District of Columbia government workers might actually decline somewhat under such an arrangement. This is because the average age of workers with employment-based insurance tends to be significantly higher that the average age of the uninsured. Thus, expanding coverage to uninsured workers who are generally younger and healthier should have a favorable impact on premiums for all covered individuals.

The remaining missing piece of the puzzle is how to address the needs of the low-income uninsured for whom affordability of coverage is a major barrier. The good news is that the District took the first step in the right direction when it transferred the subsidies it was paying DC General Hospital for uncompensated care to the new DC Healthcare Alliance. The next step would be to convert the DC Healthcare Alliance funding into premium support payments to assist the target population in obtaining personal, portable health insurance through the DC Health Benefits Program.

That is precisely the strategy embodied in the comprehensive health reform package given final approval by the Massachusetts legislature just the other day. The Massachusetts legislation includes a health insurance exchange that is taken, with some modifications, directly from the DC Equal Access bill, which we shared with them. But the Massachusetts bill also takes the next step of converting that State's present system of provider subsidies, currently paid out of a hospital uncompensated care fund, into income-related premium support payments.

The final, still missing, piece would be to assist the District's primary care clinics in creating the necessary infrastructure to accept insurance reimbursement.

When all of these elements are put together, the vision emerges of a District of Columbia in which all residents can easily obtain and keep personal, portable health insurance, those with low-incomes have the cost of their insurance subsidized through the redirection of existing public funding, and individuals use their insurance to obtain necessary medical care provided or coordinated by the doctor or clinic that is their "medical home."

It is a vision in which all of the incentives in the system are aligned to put the needs of the patient first, in which health insurers compete for customers by offering the best value for money, and in which providers compete for patients by offering the best quality of care at the best price. It is a vision in which patients, providers and insurers all have incentives to collaborate in together managing the patient's care to achieve optimum long-term benefits at the lowest long-term cost. It is a vision worthy of the Nation's Capitol.

Mr. Chairman, that concludes my prepared remarks. I will be glad to try to answer any questions the Members of the committee may have.

Senator BROWNBACK. Thank you, Mr. Haislmaier.

Ms. Walker, what do you think of this proposal that he's put out, that you basically have everybody have health insurance, and if they can't afford it, you subsidize the purchase of it?

Ms. WALKER. Well, certainly we'd—we support the concept, and we certainly want to do what we can and look at different options for expanding coverage even beyond what we already have, which is actually very good.

But we did look into the equal-access proposed model a couple of years ago, and we have had conversations with Larry Mirel and others about that. And there are a couple of things that, kind of, have given us pause. One is that we think it wouldn't necessarily attract those who really need to be in the pool, who need to have insurance coverage, because they can't afford it, they're unemployed. And this is—the equal-access model goes to people who are employed. And so, that would be a large group. But even if you look at cost—and we did have actuarial studies on this—showed that the people who we believe would be inclined to participate would be those with higher health risks and would, in fact—could contribute to higher costs that would make it a little untenable for us to do.

But we'd be willing to look at it. We certainly would like to explore some more and really kind of tease it out and see if maybe, with a subsidy, if there's something that would make sense. There also are some administrative challenges. And, of course, the District government is—as a public employer, we have unions to negotiate with and all of those kinds of things, so that we'd—we would have to build all of that into a model.

Senator BROWNBACK. Let me get to a finer point on this, because I'm hearing you say, "It's an interesting idea, but we think there's a lot of problems with it." How else are you going to get that remaining 17 percent covered?

Ms. WALKER. Well, as I said, we have a couple of—this year, in the Mayor's budget—or the Mayor's budget proposal for fiscal year 2007 is to increase coverage up to 300 percent for all children, which——

Senator BROWNBACK. Would you do that under Medicaid and SCHIP?

Ms. WALKER. Yes.

Senator BROWNBACK. And just go on that model——

Ms. WALKER. We're proposing additional—yes, to do it through that.

Senator BROWNBACK [continuing]. Instead of doing it under an insurance purchase model?

Ms. WALKER. Right, for kids who would qualify at that level.

Senator BROWNBACK. Okay. Have you looked at the cost of doing it your way, versus the way I hear Mr. Mirel and Haislmaier suggest?

Ms. WALKER. We had actuarial studies. And I don't know what the exact dollar comparisons were, but we can revisit those. And I think our State planning grant group also looked at it independently.

Senator BROWNBACK. Do you know what the differences are in cost, Mr. Mirel, for your type idea? Or Haislmaier?

Mr. MIREL. The District, I believe, applied for a grant from Roger—Robert Wood Johnson Foundation, to do an actuarial study. And I think that that's in the works. Is it?

Mr. HAISLMAIER. Yes, I——

Senator BROWNBACK. It seems like, to me, that would be a very interesting question to ask. Do you get better and cheaper insurance compared to Medicaid and SCHIP?

Mr. HAISLMAIER. Yeah, Senator, to answer your question specifically, the grant that Mr. Mirel's referring to, his department, while he was still there, applied to the State coverage initiative project, funded by Robert Wood Johnson. The city—the department was awarded—these are planning grants. This is a project of the Robert Wood Johnson Foundation, where the grants only go to State or local governments for trying to, you know, get answers to these kinds of questions. The grant request was to fund an actuarial analysis. We—you know, in the process of developing—and I know Mr. Mirel had lots of meetings—I sat in on some of them—with various stakeholders, including different parts of the D.C. government——

Senator BROWNBACK. Has this been costed out anywhere?

Mr. HAISLMAIER. A lot of—well, no, the answer is—the answer is, we—the answer is, it hasn't, but there's $150,000 that the city is currently sending out the RFP for—it's all been written and sent out—for actuarial analysis to be done to do exactly that. So, hopefully, in a few months, that will be done. I don't know where it is in the process. I could check on that for you. But I know that the RFP was signed off on, the city has the grant money, and it's been sent out to about seven or eight different leading actuarial firms to ask them to bid on it.

Senator BROWNBACK. It would be great for the District to be the first city in the country that has 100 percent coverage. Not all that far off, actually, relative to some other areas, at 17 percent. Now, that last 17 percent can be a killer. But it looks like this is a reasonable, achievable goal.

I do want to ask Ms. Reesor, in particular about the Latino population, in which one in three are uninsured. What's the size of the Latino population in the District? Do we know the approximate size? Ms. Gomez, do you know?

Ms. GOMEZ. I think it's about—I'm sorry—I think it's about 850,000 in the region.

Senator BROWNBACK. But that's—okay, but that's——

Ms. GOMEZ. Not the District, but just——

Senator BROWNBACK. D.C.'s——

Ms. GOMEZ [continuing]. D.C.——

Senator BROWNBACK [continuing]. Population is——

Ms. GOMEZ [continuing]. 60 to 80.

Senator BROWNBACK. 60,000 to 80,000?

Ms. GOMEZ. Yes.

Senator BROWNBACK. And you're saying one in three are not covered.

Ms. Reesor, you were saying that a number of those have kind of complicated immigration status, and that drives some of this. Is that right?

Ms. REESOR. It's a good question. There are definitely some who have complicated immigration status. The D.C. Healthcare Alliance has not made that a consideration in—they are eligible for Alliance, in spite of that.

Senator BROWNBACK. So, then, that's not an issue. Why are such a high percentage uninsured in that population pool, if this isn't an issue? Are they in that working-poor category?

Ms. GOMEZ. Yes. And I think that that's—that's what's in my graphs, and I'm—unfortunately, I didn't send them soon enough to be blown up. But it—they're—it is, there's—a very large population actually is just above that income of 200——

Senator BROWNBACK. So, if they bounce up to 300 percent, will that cover a lot of this group?

Ms. GOMEZ. It might. And I think that one of the things that I always argue in the city is that it is so extremely expensive to live in the city that, even at 300 percent of Federal poverty level, it will be hard for people to be able to be—you know, to live at that level and qualify for this. And so, I think, you know, it's—that is one of the big reasons why, you know, folks don't qualify for this benefit. And now, in addition to—of course, on the Medicaid side, of course, is the fact that many of the adults are undocumented.

Senator BROWNBACK. Are what?

Ms. GOMEZ. Are undocumented.

Senator BROWNBACK. So that they can't qualify for Medicaid, then, at all?

Ms. GOMEZ. Not for Medicaid, no.

Senator BROWNBACK. Okay.

Mr. Mirel, how should we address this undocumented population in the District that's substantial?

Mr. MIREL. Well, part of the equal-access concept is to get away from strictly employment-based insurance. The way the act is designed, various groups could put their population into this plan, even though they are not getting insurance through their employer. For example, the Spanish Catholic Center could do so. Mary's place could do so. That is, they could sign up these people through this plan, and there could be a subsidy program through the District government to allow them to buy it, but they would be—they would have available to them insurance, variety of private plans, at group rates. And that would be a great advantage, we think, because many of them work for employers that just don't want to be bothered getting insurance, or don't get around to it, or they—or the people who are working for them are working only part time, perhaps two or three different jobs, and none of—and, therefore, are not eligible for employer-based insurance. Under the equal-access concept, they would be able to get insurance through the D.C. program, with the help of the agencies that serve them.

Senator BROWNBACK. So that it would cover even an undocumented population?

Mr. MIREL. Yes.

Senator BROWNBACK. Okay. It seems like that's going to be an issue here and in a lot of urban areas across the United States, to get that population pool somehow in a system that can work for them, and work in the country, and be affordable.

Ms. GOMEZ. Yes. And I think that that's the big piece, is it's—it really has got to be affordable, because, you know, you really have to have a very large pool of people to be able to have the cost. And, I mean, I'm—and I support—I mean, I think that there's—this population, especially the immigrant population, could actually benefit from this. But it's the affordability, again, because even with the two or three jobs, they're just barely making it.

Mr. MIREL. But we're going to pay for the health costs of that population, one way or another. We're either going to pay for them by helping subsidize their ability to buy insurance, or we're going to pay for them in the emergency room. And it's a lot better to pay for them through insurance than it is in the emergency room.

Senator BROWNBACK. Can you document that, Ms. Baskerville, that we're seeing Latino population in the emergency room that we're paying for?

Ms. BASKERVILLE. Well, we are certainly seeing both the Latino, the other immigrant population, and the African-American population all disproportionately, in the emergency room.

Let me just say that I don't think cost is the primary driver of whether equal access works or not. It's a great idea. We have a 5-page analysis here, that we're happy to submit to you later on, about what our concerns are.

The reality is that with the chronic disease burden that we have, and the fact that, you know, we have a system that's now beginning—a locally funded system with the Alliance, you know, that's funded, but we, every year, look at whether they're going to cap it or whether there's going to—I mean, it's hard to fund out of all local dollars. The funding for this kind of project, our fear is, will suck up all those kinds of dollars that do fund some very good programs, to a model that we don't think speaks to either the poverty level or the burden of chronic disease level in the city.

So, while you may be a consultant in the city who's uninsured, and have some options on insurance, if you run a T-shirt store on H Street, it's not going to help you cover your two or three employees, because, more than likely, it's not going to happen. And so, Commissioner Mirel and I have spent a couple of years debating this back and forth, but——

Mr. MIREL. On a very friendly basis, I must say.

Ms. BASKERVILLE. Yes, very friendly basis. But we think you'll see some of the subtler issues that we think will make this an unsuccessful program in the long run. Great idea. But, in practicality, we don't think it'll solve the uninsured—the problem of that last 17 percent. And, you know, the number is always a moving target. We—you know, the Alliance isn't called "insurance," so what—you hear it's 17 percent, but if you add the Alliance in, it's actually 9 percent. So, you have to watch those numbers.

It doesn't mean I don't want to cover everyone in the District of Columbia, but, you know, there are many pieces to it, and we're attacking all the pieces, including the malpractice, in all kinds of ways. But we don't have a system yet. And until we build a system that guarantees whether you're covered or not, and that we can capture and maximize reimbursement while guaranteeing care, then none of these things will do much of anything but draw off resources and build more administrative cost.

Senator BROWNBACK. Okay. Well, thank you. I wanted to get this as kind of an overview of where we are in D.C. healthcare. I know there are a number of people working on different models of it. And, for me, I wanted to get an overview. I don't have solutions to put on the table in front of you, but I wanted to hear what the situation is. And I think you've all identified it. And it's interesting to me some of the different pieces to the puzzle that you're looking at. It'll be interesting to see what this is costed out of going up to 300 percent of poverty, Medicaid and SCHIP, versus going through a health insurance model, or maybe you can provide some alternatives. It might be interesting to try to get that number of uninsured in some sort of pool or covered in the old system.

And then, we've got a particular problem, too, in the immigrant population, in any urban area in the United States. It is in Kansas City, in our urban areas back home, and it is across the country. And a lot of the not-for-profit groups are providing that front line of care, but it's a population that can have some pretty significant health problems, as you identified in your—pretty significant in quantity and impact. So, it can be pretty expensive to do, and we need to do a better job of that.

ADDITIONAL PREPARED STATEMENTS

Thanks for being out today. If you have further statements that I should hear, please feel free to submit them for the record.

[The statements follow:]

PREPARED STATEMENT OF SENATOR MARY L. LANDRIEU

Good afternoon, to our panel, and thank you Chairman Brownback for calling this hearing to discuss the challenges to adequate healthcare in the District of Columbia. Today we will hear from government officials who must tackle the day to day health needs of residents of this city and seek to form policy which would improve health access for all and hopefully improve the overall health of this city. It is a tough job, but I am glad to welcome Deputy Mayor of the District of Columbia for Children, Youth and Families Brenda Donald Walker who prior to this post did a tremendous job improving the Child and Family Services Agency.

In addition today we will hear from local and national best practice experts and several care providers whose work in the community is the crux of care in this city. I welcome you to the committee and thank you for your important work.

This is a listening hearing. We know there is a critical nation-wide challenge of access to healthcare services, especially in vulnerable populations such as the elderly and poor, and also the mass lack of health insurance coverage which makes care affordable. We know the problem exists. Today I hope that we can examine the nature of the problem in the District and some potential areas for the Congress to provide a catalyst for improvement. The most vulnerable populations in the District have acutely higher levels than the national average of chronic illnesses. For example, 7.6 percent of District residents reported being diagnosed with diabetes in 2002 and the rate is 6.7 percent nationally. In 2002, over 14 percent of residents report having been diagnosed with asthma, with the national median being less than 12 percent. And the most devastating of all statistics, HIV infection in the District is 10 times the national average (40.1 cases per 100,000 in the District of Columbia compared to 14.8 cases per 100,000 for the United States).

This committee is responsible for the state-level functions in the District—primarily the courts and offender supervision. However, we have worked with the city to improve another area of care—the care of abused and neglected children. And across the country States have stepped in to improve the health of their residents. Just this week Massachusetts passed a bill to require all residents to have health insurance, just like drivers are required to carry automobile insurance. And the State recognized that affordability is the key barrier to insurance so they are investing in options to make health insurance more accessible. It seems the District has taken many similar steps, such as forming the Alliance, to provide health insurance coverage for many more residents. But we know there are gaps in those who do not

qualify, do not subscribe, or cannot afford the only options presented to them. I understand some of the witnesses today will address the challenge of insuring the uninsured and I hope we can find some avenues for relief.

Today 43 million Americans are without health insurance and nationwide 1 out of every 5 of those uninsured are children. In the District of Columbia, the rate of uninsured is 12.9 percent of the population (73,714 people), compared to the national average of 21 percent. I know in my home State of Louisiana, even before the hurricanes, more than 813,000 people are without health insurance, of which 187,000 of those are children and 80 percent come from working families. In the District of Columbia it seems there are slightly more uninsured working families (83 percent), which 25 percent are families who are at the poverty line. I would like the witnesses to identify these gaps in health insurance coverage and how to target working families.

Mayor Williams has worked diligently to provide insurance to children through the Alliance and the State Children's Health Insurance Program through Medicaid. For children, the issue of uninsured children may not be as acute as diminished access to primary care. I would like our panels today to address the effect on children, especially of access to primary care health services.

I understand that regular access to a source of health care is particularly limited in Wards 7 and 8 (nearly 25 percent of adults have no regular access). Ward 5 is also limited, with 21 percent of adults with no regular access to health care. Adults in Wards 1, 4, and 6 do not fare much better, with 15–20 percent have no access to regular health care. I would like to know what steps the city is taking, and what the outside groups recommend, in order to improve access.

Chairman Brownback, thank you for calling this hearing today. We recognize there is a challenge to insuring residents who are currently uninsured and many more who have limited access to health care. What we need to determine is how to overcome these barriers to improve health in the city. I look forward to the witnesses' testimony and working together with the city and the Chairman this year.

PREPARED STATEMENT OF THE HSA COALITION

Mr. Chairman, and Members of the committee, thank you for the opportunity to appear before the United States Senate Committee on Appropriations, Subcommittee on the District of Columbia on this important issue of providing health care for the uninsured, and I ask that my statement appear in the record as if read.

The question of how to best help those who are uninsured has been addressed by the Federal and State governments, primarily by S–CHIPs and Medicaid. What has not been explored is a Health Savings Account vehicle to help the uninsured, and this testimony may help begin that discussion.

After the failure of the Clinton health care plan, and the loss of the House of Representatives by the Democrats in the election immediately preceding the failure of the Clinton health plan, there remains a general consensus in the United States that government provided health insurance is certainly better than no health insurance, but is less desirable and less optimal than private sector health insurance and care.

Two of the most recent health care reform efforts that have become law, HIPAA and the Medicare Prescription Drug plan, contained HSA legislation that has been garnering attention from employers, banks, insurers, hospitals and doctors. (HIPAA contained the Medical Savings Account (MSA) pilot program and the Medicare Prescription Drug plan expanded MSAs in to Health Savings Accounts.)

While Health Savings Accounts have been in place for a little more than 2 years, the MSA pilot, which began in 1997 and ended in 2003, yielded some interesting data, specifically around their attraction to the uninsured.

One of the criteria of the MSA pilot legislation was to determine if the uninsured would be attracted to purchasing MSAs, and it turns out, from data collected by the Clinton and Bush administrations, the uninsured were attracted to MSAs.

While the percentage of uninsured bounced around year by year, between a quarter and a third of those who purchased MSAs were previously uninsured.

This trend of converting the uninsured into the insured has continued during the first 2 years of HSAs. There are numerous studies that show about a third of those purchasing the HSA qualified health insurance plan were previously uninsured.

This data should put aside any concerns that HSAs are for the wealthy, since, in the main, the uninsured are not wealthy.

Essentially, there are a number of reasons MSAs and HSAs appeal to the uninsured.

The number one reason, without question, is that the health plans are affordable.

Affordable is a relative term that means different things to different people, but as the cost of traditional health insurance has grown rapidly over the last decade, the appeal of lower cost health insurance has also grown.

The average cost of a family health insurance plan in the United States in 2005 was roughly $11,100. Of those who have employer provided health insurance, the average employer pays for 73 percent, with the remaining 27 percent picked up by the employee.

However, for those who do not have employer provided health insurance, the $927 a month family plan is simply unaffordable—that is—they do not have health insurance because it is too expensive. In addition, many employers are finding it difficult to continue to offer their employees health care, given its rising cost.

This rising cost also makes it difficult for the government to step in and provide traditional health insurance.

However, the cost of HSA qualified health plan, with a deductible in the $3,000 range varies by geography, but can be purchased for between $350 and $450 a month, assuming the primary insured is in their 40s.

(As merely a point of comparison, a single female in her 30s could purchase a $2,000 deductible health plan for about $75 a month.)

Furthermore, recent data from both the individual market and the group insurance market has shown—starkly—that HSA qualified health plans in the group insurance market have had premium increases of about 3 percent a year, and the largest and most recent study of health insurance premiums in the individual market—where the uninsured are obviously concentrated—showed that HSA qualified health insurance premiums dropped in cost 15 percent from 2004 to 2005.

Not only do HSAs attract the uninsured because the health plans are affordable, but HSAs continue to be affordable over time. This is no small point. For example, a 3.4 percent increase on a $400 a month family HSA qualified plan is $13.60 a month, or $163 a year. However, a 9.6 percent increase on the average cost of a family plan in 2005, which costs $927 a month, is a monthly increase of $88.99 or an annual increase of $1,067.90.

One insurer, which participated in the MSA pilot, did not raise its premiums for the first 5 years they sold MSAs, and in the 6th year, when they finally did raise their premiums, it was by 7 percent.

So, we know the uninsured are attracted to HSAs, and we know that the uninsured purchase HSAs at a higher percentage than any other type of health insurance, and we know HSA premiums increase a much slower rate than traditional premiums, and we know the HSA premiums are affordable.

It is on this basis, that a reasonable approach to helping the uninsured purchase health insurance may be to consider this existing preference for HSAs, expressed in the marketplace, by the uninsured.

There are those who believe that the HSA qualified insurance is a less desirable product than traditional health insurance. There are also those that believe a car that costs twice as much as another car is probably better than the less expensive car.

But if the car that is less expensive is the only one you can afford, would you tell the person without a car that they have to buy the more expensive car, even if it means they will have to go without any car?

Of course not.

In general, HSAs are attractive to the uninsured because they provide affordable health insurance, and provide a product to part of the health insurance market that has been unable to purchase traditional insurance.

How would a HSA plan for the uninsured work? How could it work?

HSA qualified plans where the maximum out-of-pocket amount equals the deductible (for example, after a health plan with a $3,000 deductible is met, all costs are covered 100 percent) should be considered.

Assuming that this plan would be directed at the low income who cannot afford health insurance, a percentage of the federal poverty level could be agreed upon, and, if for example, this program was directed at uninsured children, an annual amount would be provided by the Federal Government to those parents of children who were uninsured, and who would qualify for the assistance.

Such an HSA plan would be optional to be chosen by the parents, who would not be able to have their child enrolled in such a HSA, and in any other program to assist the uninsured like Medicaid or S–CHIP.

Insuring children with an HSA plan would make the premiums very affordable, allowing a reasonable amount of assistance to go a long way.

For example, if each child had a health plan with a $2,000 deductible, with 100 percent coverage thereafter, then the Federal Government could pay the insurer on

behalf of the insured, and deposit the remaining funds in the Health Savings Account that is the child's name, but is controlled by the parents.

The total amount of the funds allocated by the Federal Government on an annual basis per child, and the cost of the premium—which likely would not be significant—would determine how much of the deductible could be funded by an annual contribution to the account.

Since the beneficiaries in this case would be low income and uninsured, any annual dollar amount settled on, should be high enough to fund the account up to 100 percent of the deductible.

This means the funds in the account would equal the deductible, in this case, $2,000, which would be used by the parents to meet the child's health care expenses, and if the child had a serious health problem, the health plan would cover all costs above the $2,000 deductible.

Finally, there are those who assert that HSAs are not good for the less healthy, and therefore cause "adverse selection."

In fact, adverse selection does not occur with HSAs because the less healthy do choose HSAs, and have two very good reasons to do so, one financial, and the other non-financial.

Let's start with the financial reason, again using the $11,100 cost for an average family health plan in 2005. Those less healthy would choose an HSA with 100 percent coverage above the deductible because they assume, correctly, that they will be into their insurance coverage at some point in the year.

If the less healthy picked a deductible of $4,000 they would take $4,000 from the $11,100 they would have to spend on traditional health insurance, and deposit it into their Health Savings Account. The remaining $7,100 left would go toward the HSA qualified health plan, which would likely cost less than the $7,100 left over from funding their account at 100 percent of their deductible.

Let's assume that the less healthy would not save one dime in their HSA, they would spend the entire $4,000—because they are less healthy.

In comparison, the less healthy could purchase a traditional health insurance plan with a $500 deductible and a 20/80 co-insurance up to $5,000—meaning the less healthy will pay $1,500 plus the $11,100 premium, for a total of $12,600.

This is why in some cases the less healthy are better off financially with an HSA—even if they do not have any funds left in the account at the end of the year—than they would be with traditional health insurance.

The non-financial reason that the less healthy choose HSAs is that they want control over their own health care and they want the flexibility of the choice of doctors, choice of treatments to receive, the choice of prescription drugs to take.

These are highly educated health care consumers, because of their extensive interaction with the health care system. They value the control that an HSA gives them. This is the second reason that HSAs are chosen by the less healthy.

Finally, there have been a number of studies that have looked at the effects of a high deductible health plan on the less healthy. One of the most credible and extensive was done by McKinsey & Company, which found that the less healthy became more engaged in their health care treatment, more closely followed their treatment regime, and generally took better care of them selves.

I believe the financial incentive posed by the money coming out of their pocket provides an additional incentive to take better care of them selves—and results in the less healthy becoming more engaged in their own care, they have a financial incentive to do so.

Mr. Chairman, it is for these reasons that legislation should be introduced to make HSAs an option for those who are uninsured, particularly for uninsured children, with their deductible funded by the Federal Government through a deposit into their HSA.

CONCLUSION OF HEARING

Senator BROWNBACK. And we'll be in touch with some of you as proposals move forward, and just see if there are ways that we can help out with that.

Thanks for being here. Hearing's recessed.

[Whereupon, at 2:31 p.m., Thursday, April 6, the hearing was concluded, and the subcommittee was recessed, to reconvene subject to the call of the Chair.]

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