

Testimony on SB 693 -- Senate Health Policy Committee

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Good afternoon Senators and thank you for the opportunity to testify. My name is Stephen Finan, Senior Director of Policy for the American Cancer Society Cancer Action Network (ACS CAN), the advocacy partner of the American Cancer Society (ACS).

We know that the health insurance system prior to the Affordable Care Act left too many cancer patients and survivors without the ability to obtain affordable and adequate coverage. In developing a position on reform, the American Cancer Society developed as a fundamental principle that all Americans should have meaningful public or private health insurance. By meaningful insurance, we mean that coverage is 1), available...2), affordable...3), adequate...and 4), administratively simple.

With that in mind I can tell you that I am here in support of SB 693.

I believe this bill is an excellent start, however, I do have a few recommendations that should be considered to ensure that cancer patients, and patients with other chronic diseases, have the best choices possible when it comes to selecting their health insurance.

These recommendations come from a series of questions that ACS CAN developed to ask legislators and the public to consider when establishing their health insurance exchange. The purpose of the questions is simple... to assure the exchanges are set up "RIGHT" from the beginning.

1. The first question that we ask is: **Is the exchange board properly structured?**

The governance board will make the critical management and policy decisions that determine the direction and success of the exchange. It is important that the members have appropriate management experience to successfully make the many critical administrative decisions that must be made by 2014.

It is imperative that board members not have a conflict with their business or professional interests. We are happy to see that in SB 693 any person with a conflict, including agents (producers), health care providers or employees of health benefits plans are not eligible to serve on the board. However, **we suggest taking it a step further to exclude former or retired employees of health plans and those with personal financial investments.** Finally, the governance board must be held publicly accountable through open meeting

laws and solicitation of public comments. **SB 693 states that the board is required to conduct open meetings, however, we believe that the meetings should also be subject to the Michigan Open Meetings Act and the Freedom of Information Act.**

2. Is the Medicaid program well integrated with the exchange?

Under the Affordable Care Act, all individuals with incomes under 133 percent of the federal poverty level are eligible for coverage under Medicaid. The exchanges are responsible for screening and enrolling eligible people in the program. It will be critical that the exchange is well integrated with the state Medicaid program to ensure seamless enrollment. Further, because many individuals will move between Medicaid and the exchange over time due to fluctuation in income, it is crucial that exchange rules allow for coordination of plans, benefits, and physician networks to ensure continuous coverage.

In SB 693, the marketplace is required to be fully integrated with Medicaid. The marketplace is required to inform individuals of their Medicaid or health subsidy eligibility, and if requested by the individual, enroll the individual in Medicaid or the relevant subsidy program. **As the federal law explicitly requires, we believe there should be seamless auto-enrollment into Medicaid for those who are eligible.**

3. Does the exchange have a continuous and stable source of funding?

To facilitate good management and planning, it is important that the exchanges have a predictable and steady source of funding. Otherwise, there is a risk that funding will become vulnerable to the often unpredictable legislative appropriations process.

SB 693 does not create an appropriation, but allows the marketplace to charge "assessments or user fees" to carriers. **We believe that no fees should be placed upon consumers and that fees should be established on all health insurers inside and outside the exchange, so carriers outside the exchange are not afforded an unfair financial advantage that could lead to adverse selection.**

4. Does the exchange have authority to be an active purchaser?

As written, SB 693 does not. All eligible health benefits plans may participate in the exchange.

To best promote high quality care, innovative delivery system reforms, and for slowing the rate of growth of health care costs, **the exchange should have the authority to be "active purchasers" when selecting participating health plans.** With this authority, exchanges could use their considerable market power and certification authority to limit exchange participation only to plans with a high level of quality and/or value when market conditions permit.

5. Do the rules inside the exchange complement the rules outside the exchange?

In SB 693 they do not. It allows all eligible health benefit plans to participate in the marketplace. It is essential that the insurance rules are comparable for plans inside and outside the exchanges, thus promoting a level playing field. If plans outside the exchanges can sell products under more favorable terms, those plans can cherry pick the healthiest consumers, with the exchanges ultimately becoming an insurance pool of primarily high-risk individuals. This would result in high and potentially unaffordable insurance premiums for those consumers who need care the most. **We recommend that the exchange board and the insurance department be directed to prepare a report by January 1, 2014 that specifically addresses potential adverse selection problems and makes appropriate recommendations for mitigating them.**

As your state considers how to create and implement an exchange, I hope that you keep these important questions and recommendations in mind. Thank you for your time.

