



Public Health Committee
March 2011
American Cancer Society Testimony

RE: SB 1204 – An Act Establishing The Connecticut Health Insurance Exchange

The American Cancer Society supports **SB 1204 – An Act Establishing The Connecticut Health Insurance Exchange**.

The American Cancer Society is in the business of saving lives, which means preventing cancer or finding it early, seeking new cures, and caring for those in treatment. Throughout the health care reform legislative process, we have used the “cancer lens” to focus our efforts on achieving specific goals within the legislation. Now, as we shift to implementing the law, we will continue to use the “cancer lens” to guide all of our recommendations.

The Patient Protection and Affordable Care Act (“PPACA”) requires the creation of state-based health insurance exchanges for individuals and small businesses to purchase insurance by January 1, 2014. Exchanges are essentially organized insurance marketplaces, which, if they are designed and function well, could provide consumers with a “one-stop shop” to compare and purchase health insurance and enroll in public coverage programs, as well as use the power of a large risk pool to generate competition among health plans based on quality and cost.

While the federal government (primarily through the Department of Health and Human Services (“HHS”)) will set minimum standards, the new law delegates primary responsibility for governance and operation of the exchanges to the states.

Through provisions in SB 1204, Consumers and small business owners will be able to compare and purchase insurance plans in person, through the mail, phone or a web portal that contains comparative information about participating insurers, including eligibility, availability, covered benefits, premium rates, cost-sharing, provider networks, and critical financial information such as the amount plans spend to pay claims relative to administrative costs (also known as the “medical loss ratio”).

Consumers will be able to use an electronic calculator to determine their actual cost of coverage, taking into account any premium assistance they receive. SB 1204 requires the exchange to maintain a toll-free consumer assistance hotline and make information available in a culturally and linguistically appropriate manner. The comprehensiveness of coverage in the bill is standardized into four “tiers”: bronze, silver, gold and platinum, with bronze plans being the least generous and

platinum being the most generous. All participating plans must offer at least a silver and gold level option.

Proper governance being critical to the success of the exchange SB 1204 establishes a seven member Board of Directors. The bill reduces the potential for a conflict of interest by specifying that the Directors may not be employed by the insurance industry, health care providers or hospitals. In a further effort to strengthen the exchange and minimize the potential for abuse, SB 1204 provides that all members with ties to specific groups, including industry and providers, are barred from serving as directors, but instead may be appointed, along with consumers, by the board to serve on advisory committees charged with specific tasks or issue areas relating to their expertise.

We are also pleased SB 1204 takes needed steps to minimize the potential for adverse selection, an essential key to the long-term viability of exchanges. In past state experiments, exchanges have tended to attract sicker and more costly enrollees. These sicker enrollees tend to drive premium prices higher, causing healthier individuals to seek coverage elsewhere, compounding the problem of increasing premium costs. In insurance terms, this is known as a “death spiral”.

Because the PPACA allows an insurance market to exist outside of the new exchanges, there is a high risk that health plans and employers will take advantage of the rules to “dump” people with high health costs into the exchange. PPACA includes some provisions to try to mitigate this risk, but additional safeguards are necessary.

PPACA requires health plans to treat individuals in all of their plans (except for grandfathered plans) as part of a single risk pool, and must agree to charge the same premium rate for a plan they market both inside and outside the exchange. However, these provisions would not affect to health plans that operate exclusively outside the exchange, and plans are not required to offer the same products in and outside the exchange. That doesn't mean they cant, however. Keeping the rules the same for plans inside and out of the exchanges is critical to discouraging them from using differences in the rules to game the system and divide the sick from the healthy.

The new health insurance exchanges are critical to the success of health care reform. In order for cancer patients and their families to experience real changes in their ability to access, choose, and purchase comprehensive health insurance that meets their needs, policymakers at the national and state level must tackle critical challenges related to the design, implementation and governance of these new exchanges. As always, we appreciate the opportunity to inform this process and are available to work with the members of these committees to ensure greater access to health care for all of Connecticut's citizens.

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