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TO: JOINT SPECIAL COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE
SENATOR RUTH TEICHMAN, CHAIR

FROM: CHRISTOPHER J. MASONER
GOVERNMENT RELATIONS DIRECTOR—KANSAS
AMERICAN CANCER SOCIETY

DATE: NOVEMBER 14, 2011

RE: CREATION OF A HEALTH BENEFITS MARKETPLACE IN KANSAS

Senator Teichman, Members of the Committee, thank you for the opportunity to provide testimony today regarding the potential implementation of a health insurance marketplace in the State of Kansas. Long before the 2008 presidential election, and before the terms Affordable Care Act or "Obamacare" had ever been coined, the American Cancer Society realized that the healthcare system in this country—including the health insurance industry—was not adequately meeting the needs of those diagnosed with cancer. Given the fact that 1 in 2 men and 1 in 3 women in America will be diagnosed with cancer in their lifetime, and the fact that cancer can be a very difficult and costly disease to treat, fixing the broken system is vital to our mission.

The Affordable Care Act passed by Congress and signed into law in 2010 is not perfect, but it does do a lot to improve the lives of cancer patients. I have distributed a brochure titled "The Affordable Care Act: How It Helps People With Cancer and Their Families", which contains a summary. More detailed information can be found at the American Cancer Society's Cancer Action Network website: www.acscan.org/healthcare.

But we are not here to debate the merits and criticisms of the Affordable Care Act. We are here to discuss one aspect of the law that gives the State of Kansas an opportunity to provide its citizens with a greatly improved marketplace for purchasing health insurance. We know that those with health insurance experience better health outcomes because they are more likely to catch their cancer at an earlier stage and receive better care. Therefore, reducing the number of uninsured in Kansas will also help reduce the burden of cancer in our State.

I have attached a document entitled "Threshold Questions for State Exchanges." It was jointly developed by the American Cancer Society Cancer Action Network and the American Heart Association, and it sets forth several ways in which the State of Kansas can implement a state-based exchange in a way that truly benefits Kansas healthcare consumers. If the Legislature chooses to

proceed, we urge you to keep these questions in mind and work toward developing an insurance marketplace that will improve the lives of the people you represent. We also believe that the Governance proposal adopted by the Steering Committee of diverse stakeholders provides a good first step in this process that could be taken by the Legislature in the 2012 Session. If, however, the Legislature chooses to do nothing in 2012, the opportunity will be lost and the federal government will create an exchange for us. It may or may not incorporate all of consumer-focused aspects we encourage, but we are confident Kansans would rather have control over their own insurance marketplace, rather than having that control resting in Washington.

For these reasons, we ask that you take this opportunity to create a health insurance marketplace in Kansas that is strongly focused on the needs of Kansas consumers.

Threshold Questions for State Exchanges

The Affordable Care Act (ACA) creates state health benefit exchanges that will be the central marketplace for many people to compare and buy insurance plans in the individual or small-group markets. As states consider how to create and implement an exchange, these are the most important questions for them to address.

1. Is the exchange governance board properly structured to ensure that its decisions serve the best interest of consumers, patients, workers, and small employers?

Rationale: 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 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. Other stakeholders, including patients and consumers, are best involved through advisory boards. Finally, the governance board must be held publicly accountable through open meeting laws and solicitation of public comments.

2. Do the rules for the insurance market outside the exchange complement those inside the exchange to mitigate "adverse selection"?

Rationale: 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.

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

Rationale: Under the ACA, 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.

4. Is the exchange structured to emphasize administrative simplicity for consumers?

Rationale: A major goal of the ACA is to make information about insurance more accessible. Consumers must be able to easily access not only information such as premium rates and enrollment forms, but also critical additional information, such as each plan's benefits, provider networks, appeals processes and consumer satisfaction measures. This information should be available in multiple languages and literacy levels.

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

Rationale: 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. One option is to establish fees on insurers, which should be assessed on plans inside and outside the exchange, so carriers outside the exchange are not afforded an unfair financial advantage that could lead to adverse selection.

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

Rationale: To best promote high quality care, innovative delivery system reforms, and for slowing the rate of growth of health care costs, exchanges should have the authority to be "active purchasers" when selecting participating health plans, as opposed to being required to allow every health plan that can meet the minimum requirements to participate. 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.