



**Testimony of Mark Cronin
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**Partnership for Coverage Hearing
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Commissioner Daines, Superintendent Dinallo, and esteemed members of the panel: Thank you for the opportunity to testify today on the issue of health care access. We are here to demonstrate our firm belief that the health care crisis is also a cancer crisis.

Cancer is a tragic, and increasingly chronic condition, which requires significant contact with the medical system. In the absence of a system that ensures adequate, affordable coverage, a cancer diagnosis can translate to bankruptcy for families and in the worse case scenarios, the inability to access potentially lifesaving treatments. As such, we must ensure that healthcare reforms in New York State meaningfully meet the needs of an individual diagnosed with cancer.

To help guide you on what we consider ‘meaningful’ health coverage, we have previously spoken at length about our standards for health care reform – **our four A’s: Adequacy, Affordability, Availability and Administrative Simplicity**. Our evaluative tool employs these four A’s, creating a practical means by which we can assess reforms for their ability to meet the full needs of someone with cancer. Today, we share with you our conclusions using this tool to date.

We have entered into the record three analyses: an analysis of Family Health Plus, an analysis of Healthy New York and an analysis of the Massachusetts approach to health care reform. The two New York programs have been suggested as opportunities for expansion to cover more New Yorkers; Massachusetts is often looked to as a model for universal coverage. Briefly, I will relate to you our conclusions regarding these plans. Significantly more detail can be found in the submitted analyses.

Family Health Plus

I will begin with existing New York programs. First, upon analysis of **Family Health Plus**, we conclude that this plan would provide meaningful health coverage to an individual diagnosed with cancer. The plan provides **adequate** coverage, in the way of comprehensive, evidence-based benefits, including prevention and early detection services. In addition, there are no lifetime limits or service-specific limits on member benefits. While traditional Family Health Plus eligibility is contingent on income, recent law has expanded the program to include individuals employed by a participating employer. **Availability**, outside of these requisite income or employer restrictions, is good. All employees and dependents *must* be accepted into the plan regardless of prior health status or claims.

With regard to **affordability**, the plan has no deductibles, reasonable co-pays and reasonable premiums for those electing coverage through the employer buy-in option. Basic Family Health Plus information is accessible via the web and a Department of Health-administered information phone line. Other components of **administrative simplicity**, including accessing detailed information, explanation of benefits, claims procedures and comparison of plans varies based on the administering health plan.

Because our evaluation suggests that Family Health Plus is ‘meaningful insurance,’ from the perspective of the American Cancer Society, we recommend expanding Family Health Plus such that all people below 250% of the federal poverty level would be covered at no cost, those between 250 and 300% would pay some premiums, and those with higher incomes would be afforded buy-in to public coverage and pay a sliding-scale premium.

Healthy New York

With regard to **Healthy New York**, on the other hand, we find fewer positive aspects. While the program is widely **available** to individuals who qualify, and appears to suffer from few problems with **administrative simplicity**, it is our opinion that it falls short in terms of its **adequacy** and **affordability**.

Specifically, Healthy New York does not have a sufficient drug plan to prevent substantial costs from accruing for individuals with chronic disease; co-payments for inpatient and outpatient hospital visits are high and could easily result in financial hardship for individuals with chronic conditions; and while the plan does cover many preventative screenings and services relevant to the cancer community, there are other basic services, such as mental health coverage, vision and dental, which are excluded.

Thus, while our evaluation of Family Health Plus suggests that it is ‘meaningful insurance,’ from the perspective of the American Cancer Society, we would be hesitant to assign this designation to Healthy New York in the absence of reforms to its benefit structure and cost-sharing mechanisms.

Massachusetts

Moving across the border to Massachusetts, we find another source of ideas for expanding insurance coverage. In general, recent Massachusetts reforms stand up well to the criteria set forth by the American Cancer Society.

In efforts to achieve nearly universal health insurance coverage, Massachusetts is the first state in the nation to implement an individual insurance mandate. To expand access to affordable, quality insurance products, a number of methods have been employed, including: increased employer responsibility, facilitated enrollment through the state’s Connector, expanded public and subsidized insurance programs and insurance market reform.

As in New York, Massachusetts’s law requires that plans be guaranteed issue, giving the Massachusetts reforms high initial scores on **availability**. Other positive components contributing to wide availability include raised caps on Medicaid, facilitated application processes, and relatively few barriers to enrollment or renewability. The Connector has set affordability schedules, which effectively dictate the percentage of income a person or family can reasonably spend on health insurance. This combined with the fact that existing legislation mandates community rating, have contributed to increased **affordability** for plans in the Commonwealth.

The Connector has additionally set forth criteria for minimum creditable coverage, ensuring that benefits are **adequate** for those individuals enrolled in creditable plans. Core major medical benefits, including preventive and primary care, emergency services, hospitalization, ambulatory patient services, prescription drugs and mental health services, will be mandated beginning in January 2009.

From the perspective of **administrative simplicity**, Massachusetts has been exceptionally innovative. The creation of the Connector, and the website which it operates, has been a significant step in easing the process by which consumers find and enroll in insurance plans. Large-scale outreach efforts across the state have also informed consumers of the individual mandate and of the availability of health plans. Thus, we find a number of positive ideas in our analysis of the Massachusetts health reforms, including the Connector, affordability schedules and mandated benefits.

However, there are also concerns that emerge. As pointed out in an article in the New York Times yesterday, while affordability schedules have been set in the state, bids from some insurers have been higher than originally anticipated and actual affordability for all residents has been questioned. While preventive care is a required benefit for all plans that are considered ‘creditable coverage’ under the new mandate, nowhere are preventive cancer screenings explicitly mentioned. And, it must be noted that the state has capitalized on high existing levels of employer-sponsored insurance, a situation that is not necessarily mirrored in the New York insurance market.

As a whole, the reforms in Massachusetts are, in our opinion, a creative, bipartisan and largely meaningful approach to expanding coverage. Inspiration can be drawn from the fact that the state has made an effort, and lessons can be learned from its implementation.

Conclusion

In conclusion, please note that none of the analyses above directly addresses the issue of financing for these programs. A few concerns have been expressed with regard to the Massachusetts plan, but our expertise is not economics. It is cancer, and our criteria reflect this.

Finally, we would like to be clear that, in presenting to you our analyses today, **we are by no means endorsing a specific approach for achieving universal access to health care in New York State.** What we **are** endorsing is continued exploration of ways in which to ensure that the cancer perspective is taken into account in the process of reform. And of course, we fully endorse meaningful action toward the eventual goal of universal access.

Given the nature of care needed by an individual with cancer, we are confident that health care reform which meets the needs of cancer patients is likely to measure up to the needs of most other individuals. We would urge you to consider this as you review the materials presented to you today. These criteria, here applied to existing plans, may also serve as guidelines for new approaches yet to be conceived. As always, we appreciate the opportunity to inform this process and are available to answer any questions you may have regarding our analyses.

With me today is Robin Salerno, one of the nearly 90,000 New Yorkers who was diagnosed with cancer last year. Robin is here to share her story about being unable to afford the health insurance that she needs to treat her disease.

Thank you.