Testimony of Hilary Schneider, Regional Government Relations Director, Atlantic/Northeast States American Cancer Society Cancer Action Network

In Support of LD 1150 "An Act To Eliminate Insurance Rating Based on Age, Geographic Location or Smoking History and To Reduce Rate Variability Due to Group Size"

April 8, 2021

Good morning, Senator Sanborn, Representative Tepler, and members of the Health Coverage, Insurance and Financial Services Committee. My name is Hilary Schneider and I am the Regional Government Relations Director for the Atlantic/Northeast States for the American Cancer Society Cancer Action Network (ACS CAN). ACS CAN, the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. As the nation's leading advocate for public policies that are helping to defeat cancer, ACS CAN ensures that cancer patients, survivors, and their families have a voice in public policy matters at all levels of government.

On behalf of ACS CAN, I would like to thank you for the opportunity to submit the following testimony in support of LD 1150.

The American Cancer Society's peer-reviewed scientific research has shown that uninsured and underinsured people are more likely than those with insurance to be diagnosed with cancer at a more advanced stage when treatment is costlier, and patients are more likely to die from the disease. As such, ACS CAN believes that cancer patients, survivors, and individuals who will be diagnosed with cancer in the future must have access to affordable, comprehensive health insurance coverage.

Maine and federal law allow health insurers to charge up to 50 percent more than standard rates for people who use tobacco (a ratio of 1.5 to 1).[1] States can impose stricter standards and could choose to disallow tobacco rating entirely or limit the tobacco-rating factor to lesser amounts. Ten states and Washington, DC have passed legislation or imposed regulations eliminating or limiting the tobacco rating in their individual and/or small group health insurance market.[2] These states include California, Vermont, Rhode Island, Massachusetts, New Jersey, Arkansas, New York, North Carolina and Colorado. ACS CAN places high priority on evidenced-based tobacco control policies that prevent cancer and save lives.

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[1] Maine law: Title 24-A, §2736-C and §2808-B; Federal law: 45 C.F.R. § 147.102(a)(1)(iv); Final Rule: Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review, 78 Fed. Reg. 13405 (Feb. 27, 2013), available at https://www.federalregister.gov/articles/2013/02/27/2013-04335/patient-protection-and-affordable-care-act- healthinsurance-market-rules-rate-review

[2] U.S. Centers for Medicare and Medicaid Services, The Center for Consumer Information & Insurance Oversight, Market Rating Reforms: State Specific Rating Variations, Updated June 2, 2017, http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-rating.html

Any questions about this testimony should be directed to Hilary Schneider at hilary.schneider@cancer.org or 207-373-3707

Charging tobacco users higher health insurance premiums is not proven to reduce smoking. In fact, it likely results in reduced access to health care for those who need it most, including low-income tobacco users who are more likely to have serious health problems from smoking. Because they can't afford the potentially thousands of dollars in extra premiums, they likely remain uninsured and lose access to treatment to stop smoking or help them with the variety of smoking-related health conditions. Since 95% of smokers started before the age of 21, this is a costly price to pay for an addiction that began in childhood.

A January 2015 Commonwealth Fund article stated, "For a nonsmoker who earns around $17,000 a year and receives federal premium assistance, for example, annual premiums equal 4 percent of income (about $700); for a similarly situated smoker, the tax credit stays the same, but the price tag for coverage nearly quadruples. Given this calculus, those who might be especially well-served by coverage—and the access to cessation services it provides—may be unable to afford it."[3] Similarly, another study which examined the effect of tobacco surcharges on insurance status and smoking cessation found that among those most likely to purchase coverage on the health insurance exchange, smokers facing medium or high surcharges had significantly reduced coverage, but no significant differences in smoking cessation.[4] The researchers found an even more significant reduction in coverage among younger adults under age 40. The study's authors concluded that the findings suggest that "tobacco surcharges conflicted with a major goal of the ACA—increased financial protection—without increasing smoking cessation."

In terms of tobacco prevention and control efforts, instead of raising insurance rates for tobacco users, Maine will see greater public health and economic benefits by raising tobacco excise taxes, protecting and closing loopholes in our strong smoke-free laws and adequately funding state prevention and cessation programs.

In terms of geography and age as rating factors, it is important to consider that the risk of being diagnosed with cancer increases with age and cancer rates are often higher in rural areas. Thus, insurance rating factors such as age, geography and tobacco status can all serve in some way as proxies for health status. Higher insurance premiums for those who are older and live in geographic areas with higher health costs and rates of health conditions can lead to more people who are most in need of medical care being priced out of the market. This can lead to a greater percentage of older adults and those living in rural areas without health insurance. Those without health insurance are substantially more likely to be diagnosed with cancer at a later stage, when treatment can be more extensive and more costly, and where survival can be less likely.

It is important to consider how these rating factors interact. Health coverage policy decisions should take into account affordability for those who are most likely to need health coverage in the first place. As such, ACS CAN support proposals to limit health insurance premium variation based on age and geographic area. Policymakers must look for a balanced approach that ensures the largest possible risk pool, including not only those who are sick but also those who are healthy, and ensures coverage is affordable for all.

For these reasons, we ask you to vote "ought to pass" on LD 1150. I would be happy to answer any questions you have about this testimony.

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[3] Giovannelli J, Lucia K and Corlette S, "Insurance Premium Surcharges for Smokers May Jeopardize Access to Coverage," January 13, 2015, http://www.commonwealthfund.org/publications/blog/2015/jan/insurance-premium-surcharges-for-tobacco-use

[4] Friedman, A.S., Schpero, W.L., Busch, S.H.; "Evidence Suggests That The ACA's Tobacco Surcharges Reduced Insurance Take-Up And Did Not Increase Smoking Cessation," *Health Affairs*, July 2016 vol. 35 no. 7, 1176-1183.