

HB 318

Testimony by Colleen Senterfitt, MSN, New West Health Services

March 4, 2005

SENATE PUBLIC HEALTH, WELFARE & SAFETY

EXHIBIT NO. 2

DATE: 3-4-05

BILL NO. HB 318

Background on New West's Demonstration Project

Under the legislation that was passed two years ago New West developed its Bridge Plans to "bridge" the gap between the uninsured and insured.

New West completely funds the plans; we receive no subsidy.

Affordability: We designed the plans to be affordable by limiting benefits and not including high cost services such as hospitalization and emergency care.

The average Montanan needs hospital services an average of once every seventeen years, while they need office-based care an average of three times a year.

The Bridge Plan covers unlimited office-based care for primary care and specialist providers, basic lab and x-ray, outpatient therapies (including mental health care) and generic prescription drugs.

Removed common barriers: New West designed the Bridge Plans to remove common barriers to obtaining health insurance that include:

- There are no deductibles
- There is no consideration of pre-existing disease
- There is no income cap to be eligible
- There is no maximum benefit level

The Bridge Plan offers routine physical exams, early diagnosis and disease management for a wide range of health care needs. In the past year, our Bridge members received routine exams, screening tests (some of which led to early diagnosis of cancer), treatment for high blood pressure and diabetes, prenatal care, treatment of a broken bone, mental health therapy and prescription drug coverage. That is wide range of services – and without coverage, the kinds of services that are often put off and then the problems become more severe and more expensive.

Mandate exemptions

The original legislation allowed us to offer a limited benefit plan at an affordable cost because we were exempted from certain Mandates. However, there are two mandates that were not included that should have been, that we discovered - the hard way - when we had to cover a very high cost item for diabetes – an insulin pump which costs around \$6,000.00. New West had to stop enrollment in the plan at that point – because the plan design and premiums were not intended to cover such expensive services.

The second mandate not previously exempted covers inborn errors of metabolism. The most common condition it addresses is PKU which is an enzyme deficiency that babies can be born with and the treatment includes special nutritional food supplements which are very expensive.

Neither of these two mandates impact individuals to any greater degree than the other mandates for which exceptions were previously made. The need for services for Diabetes and inborn errors of metabolism are not more frequent or more significant than those addressed by the other mandates.

Insurers already have ways in which they can avoid covering such medical services; they can apply pre-existing condition rules that either raise premium costs significantly or exclude eligibility completely.

With the passage of this bill, New West will continue to offer diabetes services in the form of office visits, diabetes education, insulin and supplies, but would be able to continue to keep premiums low by limiting coverage for very high cost items. We know that early and regular care is essential to diabetic management and it's cost effective, so we want our members to get that care.

Requirement for uninsured status

The other intent of this bill relates to the requirement that an individual must be uninsured for at least 90 days. The purpose of that requirement was to not create an incentive for someone to drop a comprehensive health insurance policy in order to just get a cheaper plan.

Bill 318 would create an exception to the requirement that one be uninsured for 90 days for those who

- lost eligibility for a health plan because of age; or
- lost coverage under a federally funded health insurance program, such as Medicare, Medicaid, or the CHIP program, because of age or failure to meet financial guidelines.

Young adults are particularly affected by the 90-day requirement.

- 19 to 25 year olds make up 40% of the uninsured in Montana.
- Many of them do not hold jobs that provide benefits such as health insurance.
- The ones who are on their parents plans aren't eligible to continue when they reach a certain age.
- Those who are covered under CHIP or other federally funded plans also age out or
- may become financially ineligible.

We believe that when someone is insured, they're interested in staying insured. However, after just three months of being uninsured, that status can become "normalized" for them and they lose interest in becoming insured.

The growing number of uninsured is contributing to the rising cost of health care. The uninsured are less likely to obtain preventive care and early diagnosis and treatment. That means when they do seek care they are sicker and the cost of their care is more expensive.

New West hopes to expand this demonstration project throughout the state. But, without passage of this Bill, we will have to stop offering these plans.

Protections are built into the law and remain – the Department of Insurance retains approval authority over all demonstration projects and it will sunset in 2009.

We ask that HB 318 be passed so that we can proceed with the project to serve the uninsured of Montana.