[LR546]

The Committee on Health and Human Services and the Committee on Appropriations met at 1:30 p.m. on Tuesday, November 27, 2012, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LR546. Senators from the Health and Human Services Committee present: Kathy Campbell, Chairperson; Mike Gloor, Vice Chairperson; Dave Bloomfield; Tanya Cook; and Gwen Howard. Senators absent: Bob Krist and R. Paul Lambert. Senators from the Appropriations Committee present: Lavon Heidemann, Chairperson; Tony Fulton; Tom Hansen; Heath Mello; and Jeremy Nordquist. Senators absent: John Harms, Vice Chairperson; Danielle Conrad; John Nelson; and John Wightman.

SENATOR CAMPBELL: I'm Kathy Campbell and I serve as the Chair of the Health and Human Services Committee, and to my left is Senator Heidemann who serves as the Chair of Appropriations. Both of our committees have been convened this afternoon for the purpose of a public hearing. I would like to go through a few ground rules for you all. First and foremost, everyone get out the cell phone, double-check, on silent or turned off. And you are very fortunate today, however, I will be watching the clock. Because of the number of senators, we are not using the light system. Although if pressed into service, Senator Bloomfield will run the light system. (Laughter) So if you start getting too long and you see me give the wave to Senator Bloomfield, you're going to know you're going to get on the light system. So I hope that you will be mindful of the testifiers that come after you. If you are testifying today, you need to complete one of the bright orange sheets, print legibly. You can give that to the page. Evan is our page today so he will come forward and get that from you. If you have printed documents, he will also distribute those for you. As you come forward and testify, I would ask that you identify yourself, first and last name, and spell first and last name for the transcribers so that it's easier for them when they put together the transcription of this hearing. We will follow the practice of the Health and Human Services Committee and do self-introductions. And if my far right wouldn't mind...no comments (laughter). Senator, would you

introduce yourself, please.

SENATOR MELLO: It would be my pleasure. Thank you. Senator Heath Mello, Omaha, District 5.

SENATOR FULTON: Tony Fulton, District 29 in Lincoln still.

SENATOR HANSEN: Tom Hansen, District 42, Lincoln County.

SENATOR GLOOR: Mike Gloor, District 35, most of Grand Island.

SENATOR HEIDEMANN: State Senator Lavon Heidemann, District 1, southeast Nebraska.

SENATOR HOWARD: Senator Gwen Howard, District 9 in Omaha.

SENATOR COOK: I'm Senator Tanya Cook from District 13, northeast Omaha and northeast Douglas County.

SENATOR BLOOMFIELD: Dave Bloomfield, District 17 in northeast Nebraska--Wayne, Thurston, and Dakota Counties.

SENATOR CAMPBELL: So we want to welcome all of you this afternoon, and I will formally convene the public hearing on LR546, introduced by Senator Nordquist, for an interim study to examine the potential impact of implementing the federal Patient Protection and Affordable Care Act on the state budget in upcoming years. And Senator Nordquist will open on his hearing.

SENATOR NORDQUIST: (Exhibit 3) Thank you, Madam Chair. Senator Campbell, Senator Heidemann, members of the committee, thanks for making this hearing a

priority in what I know is a very busy time for everyone. We're here today to discuss the fiscal impacts of the Affordable Care Act on the state of Nebraska, on our state budget, and the broader impacts of healthcare reform to the state's economy. As now is the appropriate time to have this discussion, now that this summer the Supreme Court upheld the Affordable Care Act and with the election outcomes in November, it seems that at least for the foreseeable future the Affordable Care Act is the law of the land. And while we know that there are costs up-front to implement the mandatory provisions and also additional costs to implement the optional provisions, we do need to get a firm understanding and come to some consensus, both inside the Legislature and with the executive branch, on what those costs are, but also what the potential cost savings, the cost offsets are, by significantly increasing the number of Nebraskans who have insurance, whether that be through the private market, the health insurance exchanges, or through Medicaid expansion. We know that...I don't think anyone in this room was satisfied with the status quo in our healthcare system. Since 1999, healthcare spending, personal healthcare spending in Nebraska had gone from $3,500 to over $7,000 a year in 2009. Over that decade, it doubled. So we are looking at how we move forward, how we best implement this in the state of Nebraska, and how we can get today a better understanding of those budget impacts. As Joy Wilson said this morning, a number of the initial looks at Medicaid expansion only focused on the up-front cost to the states. But as I said, what we need is a more nuanced, comprehensive understanding of what the potential cost offsets are. We need that as policymakers to be able to make the right policy decisions for our state. Other states are moving forward with that type of analysis. In Michigan, recently a study came out from the University of Michigan, a colleague in the Big Ten, and in partnership with Blue Cross Blue Shield, which looked at the enrollment potential and the costs and the savings. Under Medicaid expansion in their state they estimated over ten years under moderate assumptions a $983 million savings, and those came from reduction in non-Medicaid mental health spending; reduction in prisoner/inmate medical spending; increase in tax revenue from health facilities and professionals. They also noted that the state government, like other employers that provide health coverage to employees, is projected to realize savings in

health premiums. With a reduction in the number of uninsured individuals and attendant uncompensated healthcare hospital costs, there should be a reduction in the transfer of such costs to employers who provide health coverage. The state of Maryland, also now through the University of Maryland, another future Big Ten colleague, estimated a $670 million savings due to Medicaid expansion. And recently Arkansas Department of Health and Human Services came out with an estimate of a savings of $372 million during the first eight years. And Idaho recently contracted with Milliman, who did our report in the summer of 2010, I handed that out to you. This came out November 9, 2012. And this report that the state's HHS in Idaho contracted with Milliman which showed a net savings of $6.5 million over ten years. But this estimate, unlike the other ones, does not include any additional revenue generated, potentially generated, by the significant inflow of Medicaid dollars that would come to the state through expansion. The whole...again, I know this is going to be an ongoing issue that probably starts today or it started already with correspondence with a number of our agencies. I did invite representatives of the administration to be here. Unfortunately, they were not able to attend. We'll continue to correspond with them through letters or hopefully hearings early in the legislative session to look at these cost offsets. For example, one of the e-mails very preliminarily was that in our inmate population the potential is to save at least a few million a year in inmate population that, if we did Medicaid expansion, that population would then be Medicaid eligible and their health services provided outside the...in a 24-hour...at least over a period of 24 hours outside in a hospital, would then be covered. That would be a reduction that our Fiscal Office has corresponded with the Department of Corrections on. So that's just one example of a number of potential savings that if we are going to have a true fiscal picture of this we need to really drill down on and come up with the ultimate costs. Certainly there are costs. Even though the federal government would fund Medicaid expansion with federal dollars for the first three years 100 percent, there would be costs for additional staffing in the first three years and potentially IT upgrades. I know it looked like in the HHS budget request that there was some of that included, but hopefully the Fiscal Office, who will be testifying after me, can speak to what they understand of that. And as I said, we can certainly

follow up with the department to try to get a more concrete understanding of that. So after the Fiscal Office today, we'll also hear from Dr. Stimpson from UNMC who recently conducted comprehensive research on the impact of the Affordable Care Act. We have a representative of Lancaster County to speak of the perspective from counties, the impact of the uninsured on general assistance to our counties. The Hospital Association will talk about what they see as the impacts potentially of reducing uncompensated care and that cost being shifted on to those who do have health insurance. And then there will be a few other groups to speak, and obviously this is open to the public for any additional comments. So that's all I've got. [LR546]

SENATOR CAMPBELL: Any questions for Senator Nordquist before we begin? Thank you for opening. [LR546]

SENATOR NORDQUIST: Thank you. [LR546]

SENATOR CAMPBELL: I would like to remind the audience that this morning those of you who were here heard Joy Wilson give a presentation. And then a copy of that PowerPoint is available in our office, Room 1402, which is in the center corridor. All the senators received an electronic copy. But if you would like one, you should feel free to stop down at the office at any time this afternoon and pick one up. I also would like to welcome any of our colleagues that have joined us this afternoon. I'm certainly seeing a lot of senator-elects here and we appreciate it. We know you have a lot of orientation and appreciate you coming today. So we will begin with our next testifier. Welcome. [LR546]

LIZ HRUSKA: (Exhibit 4) Good afternoon, Senator Campbell and Senator Heidemann. It is a pleasure to have this opportunity to present to you information on the Affordable Care Act and the implications it potentially has on the state budget. My name is Liz Hruska, first name is L-i-z, the last name is H-r-u-s-k-a. And with me is Tom Bergquist, the deputy director of the Fiscal Office. The Fiscal Office has used a team approach in

tracking the ACA. Tom has been working on the cost estimates. He's studied other projections made by various organizations, including Kaiser, the University of Nebraska Medical Center, and Milliman. Sandy Sostad, who works on insurance issues in our office, is tracking information on the exchange. Doug Nichols, who handles Corrections, is checking into the impacts on the Corrections budget relating to the ACA. I am following Medicaid policy and guidance that's being issued at the federal level and also tracking what hasn't been answered yet. Sometimes that's just as significant. And Mike Calvert, our director, is overseeing the work of all the analysts. We meet with him periodically and he reads all of the material that comes across his desk and forwards it to the analysts. In fact this morning I was sitting next to him and a study that just came out he was marking up as we were meeting this morning. So the Fiscal Office has put a substantial amount of time and resources into trying to understand the Affordable Care Act. I will be presenting to you just a brief overview of the Medicaid provisions of the ACA. Since most of you were here this morning to hear Joy, and she did an excellent job, I'll be fairly brief but just to kind of give an overview for those of you that were not present this morning. And then I will describe what's been requested in the Health and Human Services budget. And then Tom will present next on the cost estimates that he has been working on. You were given a handout labeled "The Affordable Care Act and the Medicaid Budget Request." And the back sheet is a spreadsheet with the costs that were included in the department's budget. So first I will do again a brief review of just some of the provisions. As you all are aware, the Supreme Court on June 28 ruled that the Medicaid expansion up to 138 percent of poverty for single childless adults, nondisabled, and parents who are in excess of state income guidelines that that expansion is optional for the state. Since then, the Centers for Medicare and Medicaid have come out with a ruling that states can opt in at any point and they can opt out at any point. If the states do opt in, there is an enhanced match rate, and that is shown on that sheet for you, starting at 100 percent in calendar year 2014 and ratcheting down to 90 percent in 2020 and thereafter. And it is mandatory for states to cover foster children up to age 26. There was some discussion as to whether or not they might move into a different category. I know earlier in the summer I had looked up that statutory reference,

and I think they are categorically eligible; that income really is not a factor with the kids. So if they would want to move to another category, I think that would be voluntary on the individual's part as opposed to anything that the law would require. Payment rates for primary care physicians are required to be at 100 percent of Medicare rates beginning this January and that goes through December 2014, and that's paid 100 percent with federal funds. There haven't been...Tom and I met yesterday with Director Chaumont. There haven't been guidelines or regulations that have come out on these payment rates yet. But once we do have the regulations, the payment rates will be in effect retroactively to January 1. So the primary care providers will receive that funding. Medicaid eligibility for all individuals except for the elderly and persons with disability will now be based solely on the modified adjusted gross income, so resource requirements will be removed for all other individuals. And as it was mentioned this morning, if states don't expand Medicaid, there will not be penalties assessed to the individuals that would have otherwise qualified under the Medicaid expansion. If Medicaid is expanded in the state, we do have a state disability program which is paid 100 percent with General Funds. And this is a program that covers medical costs for people with low income who are not qualified yet for federal disability, which is from 0 to 6 months, where they are unable to work and not eligible for SSI at that point. That program, if we would expand Medicaid, would no longer be needed so we would have savings for that. States also would have the option to reduce Medicaid coverage for pregnant women to 133 percent of poverty. Currently we cover them up to 185 percent of poverty. And the women above 133 percent could be put into the exchanges, but then they would have costs to them which they do not have if the state continues the Medicaid coverage up to 185 percent. We also have the Medicaid program for breast and cervical cancer which covers women at higher income levels than the regular Medicaid program, and at a state option we could also move them into the exchange. Now I will present an overview of what is in the Health and Human Services budget. We did just meet with Director Chaumont yesterday so I don't have a lot of detail on this. And the budget narrative that accompanied the budget request really did not provide a lot of details. The budget request does not contain the Medicaid expansion. It does contain the mandatory

coverage for children up to age 26. The budget request does have a significant amount of money, $43.1 million in federal year '14 and $89.3 million for...assuming that there would be both insurance switchers and woodwork for both parents and children. And Tom will go into more detail on those two categories. The administrative costs were calculated per the Milliman report at 3.75 percent of aid costs. And when the mandatory provisions as they have included in their budget request, as they define the mandatory provisions, are fully implemented, this would equate to 144.5 FTE and related operating expenses. The staff would be in both the eligibility determination area and also in the payment processing area. In addition to those costs, which are $2.1 million in FY '14 and $4.3 million in FY '15, there is $23.1 million at a 90/10 match for IT implementation. So the state General Fund cost for that is $2.3 million in both fiscal years. Disproportionate share is being reduced per the ACA. There hasn't been any federal guidance issued on that as to how they will handle the reductions. So the department in their request used the estimate last year by Milliman which is $450,000 in the first year and $678,000 in FY '15. The budget does also include the payment for primary care providers at 100 percent of Medicaid rates, but that is all federal funds so there isn't a General Fund impact. The budget request, once that does expire December 31 of 2014, does not assume that those enhanced payment rates will be continued, however. And the budget also requests, and this is the first I knew of this was yesterday, $3.4 million in General Funds the first year and $7.3 million relating to an insurer fee that's part of the Affordable Care Act. And I'd asked Vivianne for the federal site, which she provided to me at about 5:00 last night. I tried to look through it and it would have taken me quite a few hours to figure it out. I did find a report that Milliman had prepared for the Medicaid Health Plans of America organization estimating this impact on state Medicaid programs. There is some insurer fee in the Affordable Care Act. How that's passed on is not clear to me, but they did put an estimate in our budget of the $3.4 million and $7.3 million. And the ACA-related provisions in the budget request do not have anything that would require a statutory change. And I'm done with my presentation. Are there any questions? [LR546]

SENATOR CAMPBELL: Before we go on, are there any questions for...questions? Senator Nordquist. [LR546]

SENATOR NORDQUIST: If you've got a second, yeah. Hopefully, they won't be too lengthy. So the insurance fee is because we have managed care. It would be on our managed care providers. [LR546]

LIZ HRUSKA: Right. [LR546]

SENATOR NORDQUIST: Okay. The 144 FTE staffing, that's just for staffing for the woodwork population that is... [LR546]

LIZ HRUSKA: It's actually...I had asked Vivianne that. Yesterday, I said is this the same client-to-worker ratio as ACCESS and also supervisor-to-worker ratio? And she said, no, it's totally based on a 3.75 percent administrative cost compared to aid. So they didn't add up the projected number of new clients and project out the staffing from that. It's really just a percentage of total costs. [LR546]

SENATOR NORDQUIST: Did you get any sense on the IT if that amount would be different under expansion or not? [LR546]

LIZ HRUSKA: I didn't ask her that so I don't have that information. [LR546]

SENATOR NORDQUIST: Okay. And then sort of a final one, did they show any cost savings for the transition to MAGI because maybe (inaudible). For like children right now, we do 200 percent, but we have discounts. Well, now there's going to be no more discounting. It's just a flat percentage of poverty so you'd think that would simplify their administration. Did they show any savings for that? [LR546]

LIZ HRUSKA: No. And again, the administrative costs were solely a percentage so they

didn't do any analysis as to any savings that might result from simplification or what the staff/client ratio may be. They just... [LR546]

SENATOR NORDQUIST: Okay. But for current eligibles, though, there would be some people who would fall under the new calculation, right? [LR546]

LIZ HRUSKA: Right. [LR546]

SENATOR NORDQUIST: So she just...they just said... [LR546]

LIZ HRUSKA: But they didn't do any...that is not part of their request. [LR546]

SENATOR NORDQUIST: Okay. Thank you. [LR546]

SENATOR CAMPBELL: Any other questions? Senator Mello. [LR546]

SENATOR MELLO: Thank you, Chairwoman Campbell. Liz, just looking at the HHS budget request, it appears that most of it is based on the woodwork and the insurance switchers. Wouldn't it be safe to say that since these people in theory are already eligible that the department in some form or fashion at some point had to have accounted for these people in previous budget appropriations? I mean these are all eligible people now for Medicaid. [LR546]

LIZ HRUSKA: That's the $100 million question. I think every person working on this, every state, is trying to answer that question. And we don't really know. There are several studies out there that are trying to project that. I think all of them show that there will probably be both switchers and woodwork. Tom will actually go into more detail on that. But this is such an unknown area that it's really not clear what the behavior will be. Those people are...the woodwork population is currently eligible. They're not taking advantage of their eligibility. Will their behavior change because there's a lot more

information, a lot more awareness out there? Or will their behavior not change? We just don't know. This is a major initiative and there just isn't really any kind of clear guidance on what will happen. But Tom has done a lot of work in this area and I think will go into that further. [LR546]

SENATOR CAMPBELL: Liz, my question is, at least the copy of the budget proposal or the draft or whatever that I saw earlier and began looking at what those cuts might be was before the state decision to go to a federal exchange. Was there any discussion yesterday that that budget that we all looked at prior to that decision, would that change in any respect because we are now going to a federal exchange? [LR546]

LIZ HRUSKA: We didn't ask that yesterday. As part of my written questions to the department, which I've asked for them to get back to me at a later date, I did ask about their plans as far as what they view as the relationship of eligibility to the exchanges and how their IT request relates to the exchanges. But I don't have that information and we didn't discuss that yesterday. [LR546]

SENATOR CAMPBELL: I think that could be an interesting question because some of the rather large figures that we've seen that we're saving to go to a federal exchange, I want to know that's been accounted for. So your pursuing that would help. [LR546]

LIZ HRUSKA: Right. The savings that the Governor was talking about, which this is not my area, I think that's part of the Department of Insurance request. Sandy Sostad has been tracking that. [LR546]

SENATOR CAMPBELL: Is nodding behind you. [LR546]

SANDY SOSTAD: We would have a handout if you wanted to see the Governor's numbers on that. [LR546]

SENATOR CAMPBELL: Okay. That would be great. Thank you. [LR546]

TOM BERGQUIST: This is Tom Bergquist. But that would, as I understand the exchange issue was not in HHS's budget request, that would be any part of Department of Insurance request. The only impact maybe to HHS is if any...the data processing so the Medicaid system could talk with the exchange, I think maybe the interaction there. [LR546]

LIZ HRUSKA: Right. [LR546]

SENATOR CAMPBELL: Thank you. Any other questions? Oh, Senator Mello. [LR546]

SENATOR MELLO: Thank you, Senator Campbell. Liz, this is just maybe a follow-up data question. In your conversations with Director Chaumont or the department, did they provide any hard data at all in regards to the number of...for example, the number of additional children that would be covered through their budget request through mostly the woodwork or switch insured categories or adults or any hard data they provide in regards to the number of eligible people that would be served under their budget request? [LR546]

LIZ HRUSKA: I did receive their spreadsheets late yesterday afternoon. But they are solely relying on...well, to a great extent they are relying on the Milliman report or information generated by Milliman. Beyond that, we just met with the director for an hour yesterday and there's more work to be done on this. So I can't really say I have all the answers today. [LR546]

SENATOR CAMPBELL: Okay. And we certainly understand that. Mr. Bergquist, do you want to identify yourself for the record? [LR546]

TOM BERGQUIST: Yes. [LR546]

SENATOR CAMPBELL: Are you going to change places or stay where you are? [LR546]

LIZ HRUSKA: Yeah, do you want to change? [LR546]

TOM BERGQUIST: Oh, I can sit down here. I can see over the table. [LR546]

SENATOR CAMPBELL: So for the transcriber you want to identify yourself and... [LR546]

TOM BERGQUIST: (Exhibit 5) My name is Tom Bergquist, T-o-m B-e-r-g-q-u-i-s-t. See if they get the "g" in; everybody always forgets that. Let me first start a little bit with the context in which we had done the estimate. We handed out a copy. It says "LFO Preliminary Estimate of the Affordable Care Act." And the context in which I want to present it is when we've been doing the financial status, FY '13-14 and '14-15 has always been the out years on our five-year financial status. As we now have come...and we've always acknowledged that there was going to be some costs of the Affordable Care Act, we've always put question marks every time it came up. Now those two years have now moved into a biennial budget. We can't keep putting question marks anymore. It's getting to be a point where we have to put something in there. So first of all we had to put a number in and a part of it came when we had the Tax Rate Review Committee that met a couple of weeks ago. That's the first time we revealed an updated financial status including the new out years. So to get prepared for that, we had gone through, we had different TEEOSA estimates. We used some of the agency requests and I'd say where we thought the information was better than what we had been using. And one of the issues obviously was the healthcare reform. So from the context, we started from trying to come up with an estimate that we would be able to then at least from a starting point be able to plug into our financial status as an estimated cost. So that leads me into the starting of this summary report. We spent a lot of time looking at all kinds of the

different estimates. We had the Milliman numbers, which were from 2010 that had been done for Health and Human Services. There was a lot of other estimates done. One of the problems we ran into was when you looked at like the Kaiser estimates and some of the other ones, all the numbers were totals over a seven- or eight-year period. There was never any breakdown of what it would be on an annual basis as we moved up. In other cases, we're not sure what they did or didn't include. Some would be expansion. Some would be not expansion. We come to find out that the original Milliman estimate that was one of the differences why HHS's request was higher than the Milliman estimate was the original Milliman didn't include an estimate on CHIP kids. They only talked about up to 138 percent; they didn't address the issue of woodwork or insurance shifters for those between 138 and 200 percent. So, to make a long story short, what we decided to do is, instead of trying to work with some of those numbers where we were unsure, we said, why don't we just start from scratch, just strip it down and start at the beginning and move our way up. So that's what we ended up doing. We started with going...I'll go through on the first page here. We started with total eligible population. What we did was went to the same location that most everybody had been starting with--and that was the Current Population Survey from the U.S. Census Bureau--and we started to doing queries. You can do all kinds of queries of insured, uninsured, using different income levels. So using these different calculations, you can include people that have children, don't have children. So we started with the 2010 data. It's actually collected in 2011, but it was 2010 data. At the time we started, that was the latest numbers. So we started right at that, trying to pull up the total numbers of people that we thought met all those different categories. That goes on to the table on the second page. I have to admit on that little table I started out and was calling it "Expansion, Woodwork, and Insurance Shifters," and I changed the title. But, as you'll notice down under, it says, "Currently Eligible but With Insurance." And I do have one of the expansion items on there, so that gets a little bit confusing. One of the things you'll notice is we think that some of that difference where we see the column between LFO Estimate and Milliman, I think that has to do with the CHIP kids that Milliman originally didn't use. One comment I wanted to make is again one of the reasons we wanted to

start from scratch is it's very difficult to know what the others included. But at least with this one you can know what is in there, what isn't in there, what the assumption that was used, and you have...so at least no matter what it is, if it's right or wrong, we know what was used to build it. The other comment I wanted to make is this is a starting point just like the rest of the stuff in the budget. It starts right now, and we'll be working on this between now and Memorial Day. So these numbers will probably change a lot; different things will come in. The other one I forgot to mention was because we are using this to build into a financial status, it is just the basics. We didn't get into all the other issues. A lot of times when you'll do an analysis, as Senator Nordquist was talking about, you have the costs here and there's lots of other things you could (inaudible) the savings. We recognize some of the costs, some of the savings parts, sometimes they're not quite so direct that it's something you can go into a budget bill and strike and insert a new number. We were just sitting there thinking the uncompensated care, where in our budget would we go to reduce the budget to account for the uncompensated care? I'm not sure where that is, unless it's in provider rates that they'll be able to lower their overall rates. So the analysis doesn't get into that issue, so it really is talking about the raw costs. Okay, so we started out--going back to my table--we started out with these eligibility, so these would be the total amounts of eligible. The next category would be the participation rates. And, as Liz said, that's really where the rubber meets the road. That's what causes the issue. The issue is under current law...that's the other thing we did for the most part here, and especially on our Tax Rate Review Committee, was address current law. And under current law, under the expansion, the cost would be those people who are currently eligible but aren't participating. So the question is, how many of those are going to actually participate? How many...and there's lots of different reasons. Lots of different estimates said some was more outreach, people were going to go out and tell everybody that you're eligible; others, just overall awareness; another part of it was the individual mandate, the penalty, the tax penalty if you didn't get the insurance. That created a little different dynamic because lots of these other estimates that did participation rates didn't make any separation. They didn't make any separation; they just said, our participation rate is because of these three things. Well, this is a little

bit more important in this thing because what we're trying to isolate is the cost under current law versus the cost that would be incurred because of the expansion. And therein lies the problem: If the penalty is only in effect if we'd enact expansion. And the only reason these participants are going to participate is because of the penalty, then there is no additional cost under current law, and all the woodwork and eligibility would be caused by the expansion, which kicks in the penalty, which is the reason why they're going to participate. The flip side is the penalty isn't going to cause hardly anybody to participate, and it'll be the awareness, the outreach, or what to some extent we think is an interaction with the exchanges, where you go to the exchange, you fill out your income, they tell you, oh, you're eligible for Medicaid or CHIP and send you over. What we ended up doing here, just more for illustration purposes, is what we considered as the cost of participation we're attributing not to the penalty. So we're showing it under a current law that these participations would occur whether we expand Medicaid or don't expand Medicaid. That's the way we're showing it here. That's the way we've put it in our projected financial status. There were different eligibility rates, as I noted in here. Milliman, even in their midrange their participation rates were substantially higher. They were saying woodwork individuals, anywhere from 70 to 80 percent participation. Excuse me. On insurance shifters, where we use that term, these are people that are eligible but currently have insurance; how many of those will drop the insurance and then take up Medicaid or CHIP? They were saying 50 to 75 percent. The other one which we based most of this on was on the Kaiser and the Urban Institute's study. In their case, insurance shifters, they used a flat 25 percent; that 25 percent of the people would participate. When it comes to the woodwork, they started out they had two different estimates. One was a standard, and the other was enhanced outreach. It was 10 percent; they had it raising up to 40. We kind of split the difference, and what we ended up doing is we started the first couple years at a 10 percent participation rate and had it ramp up to 40 percent by the time you got to the fourth or fifth year. The idea is it would start word of mouth once. So we...I don't want to say we cheated, but we kind of ended up having it ramp up because that just, like I say, made some sense to us. But the real key or the question then becomes is, what is the participation rate? I mean, I set

up a spreadsheet to calculate all these things. And when I plugged in the Milliman participation rates and about a $200 to $300 per year higher cost, I was basically coming up with HHS's request. So you can have that much difference in cost estimates just depending on the participation rate. I wished we knew what it was going to be. But as we looked into a lot of the different studies and different things, I could not find any real definitive study that says what is the participation rate going to be. Some had some other experiences. But it was kind of like when Mike and I were talking. We saw this last recession. Well, it wasn't like all the other recessions. So this participation is a little bit different than when other states tried to expand and do different things. So these are the participation rates that we were basing this estimate on, and that's the bulk of the difference, to a great extent, between all the different various estimates. So those are the participation rates we used. The second-biggest part was the cost per person. What we used was the 2011 average cost for ADC adults and for children. We used those as the cost per person, per year. One thing you would notice as we got into the bottom of page 3, the other thing we did is as the participation ramped up we built in a cost difference of the cost going down by 20 percent as when it was fully implemented. The concept though, when it comes to woodwork people, is there is a reason these people aren't participating. The reason they're probably not participating is they aren't sick. So the more of them that come in, the less likely you're going to have cost. The ones that are participating are probably the ones that have the highest cost. So as more people...we think as more people come in, the average cost per person is probably likely to drop. And if you ever got to 100 percent participation, the last person probably isn't going to cost anything. They could be on there for a long time but not participate. So that was the other part that we tried to build into this was a healthier...they called it...in one of the literature, a healthier cost adjustment as we pulled down. The other thing, and I just simply called it "Ramp Up." Most of what we call ramping up is...and it's basically inherent in that phasing it in from 10 to 40 percent. The other thing which is ramping up is more annualizing, as this doesn't kick in until January 1, 2014, which is only halfway through our fiscal year '13-14, so you'll find most...the first-year numbers are going to be roughly half of what the second-year numbers would be because we're

on a fiscal-year basis. The rest on page 4, the "ACA IT Implementation," what we built in, this is straight out of Department of Health and Human Services' request. I just copied the stuff off of there. The key was it was a substantial amount, but it was at a 90/10 rate. So our 10 percent matching would be $2.3 million a year for three years. So we included that in our estimates. One thing, going back, for the most part when we did this estimate for the Tax Rate Review Committee we were only looking at current law, and that's all that we put in our financial status. We do show a number here, when you get on to page 5, which has a table with some of the numbers in it, we did try to throw in some of the cost on the Medicaid expansion. Now this is really pure...it...all this really shows is the increased eligibilities, basically adults up through 138 percent of poverty. That's really all that is. It doesn't get into where we could do other statutory changes and shift people to other populations. That would require a statutory change. This is just purely the cost as that goes. What I used here was 65 percent participation...excuse me, 60 percent participation, which is what Kaiser and the Urban Institute used as their baseline and had it ramp up to 75 percent, just like I did with the woodwork. The 75 percent was their participation in their enhanced estimate. And I believe...I can't remember what Milliman had on theirs. They were using 80 percent all the way across participation. So those...come the numbers, if you go to that table, in line 6, that's the total cost under current law. And the $12.3 million and the $26.8 million, that's what we had built into our projected status when we did it for the Tax Rate Review Committee. HHS, I think they were at 46 and 98, I believe, something like that for those two. But again, other than the $200 or $300...we don't know exactly what they had as cost per person because we haven't gotten that detail back yet. But if I add $200 or $300 to my estimated cost per person and use Milliman's, their participation rates, I come pretty close to their request. I'm just kind of guessing. That kind of gives you a handle on where that sits. One last thing I want to acknowledge, and you'll see that on the bottom of page 5. We've pretty much...we did not recognize anything on a revenue side of enhanced revenue or multipliers by expanding Medicaid or anything like that. One thing that will happen under Medicaid is the Comprehensive Health Insurance Pool. Right now, health insurance premiums go to the CHIP program, and what they don't need

comes back. They've been...we've been...the last year it was about $23 million of insurance premium tax was used to handle the Comprehensive Health Insurance, the CHIP program. That's why, earlier on, you'll see I used SCHIP for the kids health insurance, and it gets confusing between the CHIP. We had talked with Department of Insurance, and one of the things on the ACA is the...you can't be denied coverage by a preexisting condition, and you can't charge excess other than for age, and I can't remember the other provision, which basically says, anybody who now is participating in the Comprehensive Health Insurance Pool is probably going to go get regular health insurance. The subsidy isn't going to come from the $23 million on the insurance premium; it'll come from being in a much larger insurance pool. So what that does is that...so without changing any law, without any statutory change, what Department of Insurance had was the first year we would gain about an additional $10 million of that $23 million. They would need to keep about $13 million to cover previous payments. The second year we would gain about $18 million to leave another $5 million for prior payments. And then, in the third year, we would pick up the whole $23 million. The insurance premium, 40 percent of all insurance premium goes straight to the General Fund. So what you'll see, down at the bottom of page 5, in line 1, that "Comp Insurance Pool - to GF," $4 million and $7.2 million, those are additional General Fund revenues we will get by the phase down of the Comprehensive Health Insurance Pool. Those numbers have already been included in the Forecast Board's forecast because this is going to happen under existing law whether we change the law or anything. It's a General Fund revenue that one can attribute to the ACA, but because it is current law, we've already acknowledged it in the forecast. The second part, which is line 2, the General Fund gets 40 percent. The Mutual Assistance Fund gets 10 percent. Of the other half, schools get 60 percent, or 40 percent of the total. What that is used for is we, in essence, certify TEEOSA aid. So when you certify TEEOSA aid, that's paid for. First we use the amount of insurance premium tax, and the rest is General Fund. So these additional revenues in line 2 that schools will get in an insurance premium, that results in a General Fund savings in terms of funding school aid. [LR546]

SENATOR FULTON: Can you say that again? [LR546]

TOM BERGQUIST: Yeah. When it comes to the insurance premium tax, 40 percent of all insurance premium tax is earmarked for schools, but we don't turn around and just...we don't give them a separate distribution. What they said was, use that to help pay for TEEOSA, which is about $15 million, which will go to $20 million. So if we certify $1 billion of state aid to TEEOSA, we basically will put them...here's $980 million General Fund; the other $20 million will be paid with the insurance premium. So there's always a difference. If you look between what certified aid is and what we appropriate in TEEOSA aid, that difference is the insurance premium. So the more money that's insurance premium, the less General Funds we need. That estimate of TEEOSA aid that was in the Tax Rate Review Committee, which brought our projected shortfall down to around $200 million, that's already assumed this higher level. So those savings in line 3 have already been acknowledged in our current financial status. Just so we wanted people to understand we've already taken...we've already utilized that money. And the only reason we did is because that was going to happen regardless of whether legislation was enacted or anything else. That was going to happen under current law. So I guess I'm kind of done. If there's questions...I kind of went on a little bit. [LR546]

SENATOR NORDQUIST: So... [LR546]

SENATOR CAMPBELL: Questions? [LR546]

SENATOR NORDQUIST: Okay. So you have $16.1 million a year. I'm confused why it's not the full $23 million. Where do you get the remainder? [LR546]

TOM BERGQUIST: Oh, I'm sorry. In terms of insurance premium, 70 percent...40 percent goes to the General Fund. Schools would get...well, the statute says 50 percent of the...60 percent of the remaining amount. So, in other words, they get 40 percent. The other amounts, counties get 15 percent; cities get 5 percent; and the Mutual

Finance Assistance,... [LR546]

SENATOR NORDQUIST: Okay. [LR546]

SENATOR HEIDEMANN: MFA. [LR546]

TOM BERGQUIST: ...MFA, which is the rural fire districts, gets 10 percent. [LR546]

SENATOR NORDQUIST: Um-hum, um-hum. Okay. [LR546]

TOM BERGQUIST: So by the time you get out there, that $16.1 million, cities would get $1.2 million; counties, $3.4 million; the MFA would get $2.3 million. And I believe the statute, the way it reads, is whatever isn't used in the MFA comes back to the General Fund anyway, so we may or may not get some of that $2.3 million. If they don't use what they already are getting, we will get all of that. But we don't know, so we didn't factor that one in. So that's what happens with the rest of it. That would then total the $23 million that we get. I have to admit, at the same time I've been working on TEEOSA school aid. And I was joking I found one thing that I found harder than the TEEOSA formula, and that's this stuff. (Laughter) Between working on both of those, my head's kind of ready to explode. (Laughter) Are there any questions? [LR546]

SENATOR NORDQUIST: Just could you prepare, when you get the data from HHS regarding their estimates for per-member cost, and just put a spreadsheet together of your woodwork estimate, their woodwork estimate, and their cost estimate for that population, yours, just something like that? [LR546]

TOM BERGQUIST: Yeah. Okay. Yeah. One of the things...the other thing that made it difficult is when I was doing the query on that data I was kind of surprised at how much the uninsured number fluctuated. I fixed the query and just kept changing the data year. And the year I was using, it was 237,000 uninsured. The year before that it was

196,000; the year before that, 196,000; the year before that, 228,000; the year before that, 213,000. And so that's what kind of...that throws another wrench into the works is the number of uninsured can fluctuate that much, so. And these numbers will float quite a bit. By the time you pick what year you want to pick and what participation rate, it can be difficult. [LR546]

SENATOR CAMPBELL: Tom, the question I have is, on that page 5, as we're looking at that,... [LR546]

TOM BERGQUIST: Yes, um-hum. [LR546]

SENATOR CAMPBELL: ...when you look at lines 7 to 10, that's the expansion, right? [LR546]

TOM BERGQUIST: Yes, um-hum. [LR546]

SENATOR CAMPBELL: So you're... [LR546]

TOM BERGQUIST: And that purely only relates to just those new eligible people, those adults,... [LR546]

SENATOR CAMPBELL: Right,... [LR546]

TOM BERGQUIST: ...uninsured adults up to 138 percent. [LR546]

SENATOR CAMPBELL: ...because we get covered for those out of the first three years at zero, so that's why you... [LR546]

TOM BERGQUIST: Right. And one point I want to make--I'm sorry--in line 9, we're on the hook for the administrative costs on all the stuff, and the administrative cost is

50/50. So what you see there in line 9 is there's nothing in lines 7 and 8 for the aid cost. But what I used for administrative cost was 3.5 percent of the total in both cases. That's why you'll see the $2.4 million and the $5.2 million is because that covers the administrative cost. We don't pay for the aid cost for the expansion, but we do pay 50/50 on administrative, as I understand. [LR546]

SENATOR CAMPBELL: Any further questions on those figures? [LR546]

TOM BERGQUIST: And, like I say, the nice thing is I tried to set it up so we can go through and adjust it, and we've got some different ideas under what different assumptions kinds of things. So, like I said, the nice part about this one is that we at least can...I can explain how we got to this number. (Laugh) [LR546]

SENATOR CAMPBELL: I'm sure all of my colleagues that are in the Appropriations have absorbed all the numbers here. [LR546]

TOM BERGQUIST: Oh, yeah. (Laugh) [LR546]

SENATOR CAMPBELL: They're used to all of these numbers, over and over. [LR546]

TOM BERGQUIST: Yeah. [LR546]

SENATOR CAMPBELL: But I have to say, I appreciate the fact that you started from the ground and worked up, because for the senators and for the Legislature, we know how you got to those figures. There's not a debate on, well, you should be taking Milliman, you should be...you know. And we've had that debate here,... [LR546]

TOM BERGQUIST: Yeah. [LR546]

SENATOR CAMPBELL: ...over the course, well, I don't think those figures are accurate,

you know, that type of thing. I appreciate the fact that you started from that,... [LR546]

TOM BERGQUIST: Yeah. [LR546]

SENATOR CAMPBELL: ...because at least all of us, as we look at these issues, have that confidence that we know how you got to that number. [LR546]

TOM BERGQUIST: And I was kind of glad when I did change some of the assumptions, that I actually got close to those originals, so at least now I kind of have a better understanding of what it takes to get to those numbers. So it was a good exercise, I think, that we went through on it. [LR546]

SENATOR CAMPBELL: And I thought you were very clear when you and I talked and you explained sort of the form or how you were going to put this whole thing. It's nice to finally see everything there. [LR546]

TOM BERGQUIST: Yep. [LR546]

SENATOR CAMPBELL: But that you said, now keep in mind that that goes back to the General Fund; the HHS Committee cannot just determine where that goes. A little joke between... [LR546]

TOM BERGQUIST: We were a little worried that...yeah, we were a little...(Laughter) [LR546]

SENATOR NORDQUIST: Well, the cap, isn't that actually in statute. [LR546]

SENATOR CAMPBELL: Senator Heidemann, did you have question? [LR546]

SENATOR FULTON: Just not...I was going to...not yet. (Laugh) [LR546]

SENATOR CAMPBELL: Not yet, that's right, not yet. (Laugh) Okay, did you have a question? [LR546]

SENATOR HEIDEMANN: Just...I think Liz mentioned it and Senator Nordquist mentioned it. If we go expanding Medicaid, our prison population would be covered? [LR546]

LIZ HRUSKA: When they are outside of the institution. So if they go to the hospital they would be covered. That also is the case for county prisoners. It's still a Medicaid program, so I think they would not be covered as long as they are incarcerated. But if they leave to get outside medical care... [LR546]

SENATOR HEIDEMANN: Because we do try to do things in-house as much as possible in the prisons for healthcare, right? Would this be then more trying to get them outside help so that we can get, if we do this...so that we can be eligible for Medicaid? [LR546]

LIZ HRUSKA: I'm not the Corrections analyst, so I don't know how that works. Doug got some information yesterday. I didn't have enough time to look at it. [LR546]

TOM BERGQUIST: I'm not sure if that's 100 percent clear or not. It's a little bit... [LR546]

SENATOR NORDQUIST: Yeah, I think we're still looking at grants or something. [LR546]

TOM BERGQUIST: We didn't factor anything in because I wasn't quite sure if they were going to allow it or not allow it. It's a possibility. [LR546]

SENATOR HEIDEMANN: I can ask questions again. [LR546]

SENATOR NORDQUIST: Yeah. [LR546]

LIZ HRUSKA: I think currently we are capturing the Medicaid match when they leave the institution. Probably not all surgeries can be performed within the confines of the correctional facilities. [LR546]

SENATOR GLOOR: Heart attack, cancer treatment. [LR546]

SENATOR NORDQUIST: Um-hum. [LR546]

SENATOR CAMPBELL: Bypass surgery. [LR546]

SENATOR GLOOR: Dialysis. [LR546]

LIZ HRUSKA: Right. [LR546]

SENATOR CAMPBELL: Thank you both very much. Our next testifier. Good afternoon. [LR546]

JIM STIMPSON: Good afternoon. [LR546]

SENATOR CAMPBELL: You can go right ahead and start. [LR546]

JIM STIMPSON: (Exhibit 6) Okay. Good afternoon, Senators. Senator Campbell, Senator Heidemann, thank you for giving me the opportunity to speak here today. I am Jim, J-i-m, Stimpson, S-t-i-m-p-s-o-n, director of the UNMC Center for Health Policy. I was invited to testify today to report on studies I have conducted relevant to today's hearing. I am not representing the University of Nebraska. There are 232,000 Nebraskans without health insurance. The Affordable Care Act has several provisions

that could reduce the number of Nebraskans without health insurance by about half, including the expansion of the Medicaid program to adults earning less than 139 percent of the federal poverty level. One of the primary concerns with the size of the uninsured population is the level of uncompensated care that is provided by hospitals and other providers. Typically, the providers and local and federal government finance these costs regardless of whether a state decides to expand Medicaid. The federal government will phase out Disproportionate Share Hospital payments beginning in 2014. Currently Nebraska receives over $28 million annually in Medicaid DSH allotments, but the ACA cuts these payments over 10 years, starting in 2014. The cost of uncompensated care is also shifted to individuals and employers in the form of higher insurance premiums, sometimes referred to as the "silent" tax. A recent report calculated that without the Medicaid expansion there would be more than $1 billion in uncompensated care provided in Nebraska from 2014 to 2019. However, if Nebraska opted for expansion of Medicaid, the amount of uncompensated care provided would be reduced to $419 million. The reduction in uncompensated care spending would aid hospitals and other care providers and also have the potential to reduce, or at least potentially hold constant, health insurance premiums. The participation rate in the current Medicaid program in Nebraska is 57 percent. However, it is reasonable to expect that the Medicaid participation rate will be higher than historical averages starting in 2014, in part because of the individual mandate for insurance coverage, but probably more because of the simplification of Medicaid eligibility and a more efficient enrollment system that will be in operation under the health insurance exchange. Therefore, regardless of whether Nebraska decides to expand Medicaid or not, there will be increased enrollment in Medicaid. According to 2011 "Nebraska Medicaid Annual Report" there were 235,000 recipients of Medicaid in Nebraska at a cost of about $1.6 billion. Even without expansion, my estimate of the current Medicaid enrollment for 2014-2015 would be about 315,000 Nebraskans based on the assumption of a 25 percent increased participation rate, sometimes referred to as the "woodwork effect." And the expenditures for that population could climb as high as $2 billion by 2014. The persons eligible for the Medicaid expansion represent a very different population and

federal match rate. This expanded population has been shown in peer-reviewed research to be healthier and, as a result, they are less expensive to cover than the currently enrolled adults. The match rate from the federal government will be 100 percent for the first three years and then gradually decline to 90 percent, compared to the 57 percent Nebraska currently receives. My analysis indicates that at least 100,000 Nebraskans would be enrolled under the expanded Medicaid program at a cost of about $158 billion, which includes administrative costs for the state and about $3.4 billion from the federal government from 2014 to 2020. Therefore, compared to the nonexpansion scenario, the expansion of Medicaid represents a 24 percent increase in enrollment, a 1.1 percent increase in state spending, and a 13.5 percent increase in federal funding. In addition to the cost it is important to factor in several potential offsets to the state budget which have been alluded to today. In this case we can expect tax revenue for the state of Nebraska to increase by more than $23 million annually due to the federal spending on the Medicaid expansion. My analysis indicates that the state of Nebraska can expect at least $168 million in new tax revenue resulting from the federal spending on Medicaid expansion as those federal dollars ripple through the state economy from 2014 to 2020. Obviously, this revenue will have a positive net impact on the state budget for the first three years of expansion, when the state is not paying anything for the expansion program. Starting in 2017, as the federal reimbursement rate begins its gradual decline to 90 percent reimbursement, there will be reduced state spending on other existing programs that may be sufficient to offset the ongoing cost of Medicaid expansion. For example, under a provision of the ACA that will be implemented in 2014, insurance companies will not be allowed to deny coverage to adults with preexisting conditions, therefore, there may be no future need for the Nebraska Comprehensive Health Insurance Pool, or at least a reduced need for that program after 2014. Depending on the benefit structure of the expansion program, another source of savings for the Medicaid budget would occur by transitioning adults from the current Medicaid program into the expansion program with the higher federal match rate, which is a 33 percent difference. Additional savings to the state's General Fund will also result from reduced payments for mental health services as more citizens gain health insurance

through the Medicaid or health insurance exchanges that cover mental health services. I want to conclude by saying that the impact on other financial and public health outcomes should be included in the discussion about whether the state should participate in the Medicaid expansion. For example, a recent study in The New England Journal of Medicine found that for every 176 adults covered under the expanded Medicaid, one death per year would be prevented. In Nebraska this could mean...translated, roughly, to about 500 deaths would be prevented. Another study found that a 10 percent expansion of Medicaid eligibility has been shown to reduce bankruptcies by 8 percent, and in Nebraska this could mean about 1,200 fewer bankruptcies per year. Finally, spending by the federal government on Medicaid expansion would generate at least $700 million in new economic activity every year in Nebraska, which could result in substantial impact on job growth in Nebraska. All of these factors should be considered as the state weighs this very important decision. Thank you for this opportunity. [LR546]

SENATOR CAMPBELL: Questions? [LR546]

SENATOR COOK: Question, Madam Chair. [LR546]

SENATOR CAMPBELL: Senator Cook. [LR546]

SENATOR COOK: Thank you. A question about the reduction in the number of bankruptcies: Is that directly related to the additional medical cost that an individual would have to take care of, that would at that point be covered under Medicaid? [LR546]

JIM STIMPSON: It... [LR546]

SENATOR COOK: What's the link? [LR546]

JIM STIMPSON: A common source of financial distress for many families nowadays is

paying medical bills, and so...and obviously this would hit people that are below the poverty level or around the poverty level, this eligibility group, and so that's what that study found. [LR546]

SENATOR COOK: Okay, thank you. [LR546]

SENATOR CAMPBELL: Senator Gloor. [LR546]

SENATOR GLOOR: Thank you, Senator Campbell. Dr. Stimpson, the comment that "A recent report calculated that without Medicaid expansion there would be more than $1 billion in noncompensated care provided in Nebraska from 2014 to 2019," do you know, when these numbers are tossed around like that, are those costs or charges? [LR546]

JIM STIMPSON: That's costs. That's from...the Urban Institute report did that analysis based on publicly available data, and it's based on estimates of costs rather than charges. [LR546]

SENATOR GLOOR: And the definition of cost versus charge, do you know whether there was a common definition used from provider to provider? [LR546]

JIM STIMPSON: Yeah. There was a common definition used in the data set that...it's a national data set in the Medical Expenditure Panel Survey that they use and...yeah. [LR546]

SENATOR GLOOR: Okay, thank you. [LR546]

JIM STIMPSON: It's standardized. [LR546]

SENATOR GLOOR: Thank you. [LR546]

SENATOR CAMPBELL: Any other questions? Senator Hansen. [LR546]

SENATOR HANSEN: Thank you. Did you say--and I think I read it, too--you predict $168 million in new tax revenues for the state of Nebraska if Medicaid is...expansion. Is that correct? [LR546]

JIM STIMPSON: Yeah. That's... [LR546]

SENATOR HANSEN: Notwithstanding the printing of money, like the federal government does, where does that $168 million come from? [LR546]

JIM STIMPSON: It's the 100...the $3.4 billion would come to the state if they chose expansion. [LR546]

SENATOR HANSEN: Um-hum. But who pays that money? It's on your federal income tax return, so we're paying it anyway. Is that correct? [LR546]

JIM STIMPSON: Right. We pay... [LR546]

SENATOR HANSEN: You...it's either printed or paid, is that correct? [LR546]

JIM STIMPSON: Printed or paid? I don't know what you mean by that. [LR546]

SENATOR HANSEN: Well, Nebraska is a very low population state. [LR546]

JIM STIMPSON: Um-hum. [LR546]

SENATOR HANSEN: And we are going to, more than likely, benefit from having a low population, a low...just gross numbers of people that need to be on Medicaid. But when you say there's going to be $168 million worth of tax revenue coming into the state of

Nebraska for expanding Medicaid, that money has to come from somewhere. [LR546]

JIM STIMPSON: It's coming from the federal dollars that you, at one point, paid, yes. Yeah. [LR546]

SENATOR HANSEN: Okay, thank you. [LR546]

SENATOR CAMPBELL: Any other questions? Thank you very much. And thank you for your two previous reports too. [LR546]

JIM STIMPSON: And I'm happy to share my spreadsheets as well. I did the (inaudible)...yeah. [LR546]

SENATOR CAMPBELL: Okay. It might be helpful if you shared them and gave them to the Fiscal Office. [LR546]

JIM STIMPSON: Yep. [LR546]

SENATOR CAMPBELL: Mr. Calvert is sitting right there. He'd be glad...so that they at least have a copy of everything. [LR546]

JIM STIMPSON: Yep. [LR546]

SENATOR CAMPBELL: Thank you. Our next testifier. [LR546]

KERRY EAGAN: (Exhibit 7) Good afternoon, Senators Heidemann and Campbell and members of the Appropriations and Health and Human Services Committee. My name is Kerry Eagan. That's K-e-r-r-y E-a-g-a-n. I'm the chief administrative officer for the Lancaster County Board of Commissioners. Thank you for the opportunity to provide information on LR546. Nebraska Revised Statutes Section 68-104 provides that the

Department of Health and Human Services is vested with the entire and exclusive superintendence of the poor in the state of Nebraska with the exception that each county board of each county shall furnish such medical service as may be required for the poor of the county who are not eligible for other medical assistance programs. This seemingly small exception to the state's exclusive duty to provide for the poor of the state is the statutory basis for general assistance, and for Lancaster County this small exception creates a large financial liability for all property taxpayers. The last fiscal year Lancaster County spent $2,114,115 on the medical needs of general assistance clients. It must be noted this figure does not include the cost of behavioral health services for general assistance clients. Those costs were absorbed within the budget of our Lancaster County Mental Health Center. We estimate those to be between $600,000 and $700,000. Of course, we expect these costs to increase next fiscal year. Expanding Medicaid eligibility under the Affordable Care Act will virtually eliminate all general assistance medical costs for Lancaster County, which is a potential savings of $2.8 million for our property taxpayers. I heard the question asked about whether jails are covered, too, and...which would be very interesting to us, too, because we spend about another $1 million on jail medical needs. And I've been researching that, and I wish I had an answer to it. But that could be an additional benefit which we have not accounted for yet. I'd be happy to answer any questions. [LR546]

SENATOR CAMPBELL: I have to say, Mr. Eagan, I was quoting Lancaster County this morning not knowing that you were coming, so I appreciate that written documentation. And it's really great to see you again. [LR546]

KERRY EAGAN: Yes. And, Senator Campbell, if you would appreciate, those are actuals from that budget, which...yeah. [LR546]

SENATOR CAMPBELL: Good. I want...you have to realize I served on the county board at Lancaster for 16 years, and I was always a stickler for what is the actual cost. (Laugh) So thanks for the testimony. [LR546]

KERRY EAGAN: You're welcome. [LR546]

SENATOR CAMPBELL: And give my best to the board. [LR546]

KERRY EAGAN: I will. Thank you. [LR546]

SENATOR CAMPBELL: Okay. Our next testifier. Good afternoon. [LR546]

BRUCE RIEKER: Good afternoon. [LR546]

SENATOR CAMPBELL: You can start whenever. [LR546]

BRUCE RIEKER: (Exhibit 8) My name is Bruce Rieker, that's B-r-u-c-e R-i-e-k-e-r. I'm vice president of advocacy for the Nebraska Hospital Association. I appreciate all of your attention and focus on putting some definition on a very fuzzy subject. Where we are at the Nebraska Hospital Association is our focus is making the best of the situation and looking for opportunities. But what I have done, my assignment, or what I was asked to talk about were the impact of uncompensated care on hospitals, the communities they serve, and those that pay for it; the potential impact of the Affordable Care Act on our hospitals and uncompensated care; and broader economic issues that impact Nebraska's hospitals and their ability to provide high-quality care. In addition to these PowerPoint slides that I've given you, made a copy, maybe you've already seen it, but the Kaiser Commission issued a report yesterday, so this is hot off their presses. It's one more analysis as to where we are. Some of their numbers are consistent with things that we've seen in the past, and some of them are in more detail. I'll try and incorporate those in my remarks and hopefully go through this, the prepared PowerPoint, fairly quickly and then entertain the questions that you have. On the top of page 2 of the slides, I want to make sure you have a frame of reference for the Nebraska hospitals. The 89 hospitals that we represent serve about 11,000 patients a

day. But financially, when we're talking about...we get a lot of questions about how our uncompensated care, charity care, and things like that are going to move with the implementation of healthcare reform. I'd like to talk about that a little bit. On an annual basis, right now we're at about $4.9 billion in net patient revenue. About $2.2 billion of that is paid in...excuse me, employee salaries and other benefits, earned income. The most recent numbers we have for our community benefits...and some describe these things differently, so I want to give you an idea of what those are. But our community benefits for 2010 exceeded $1.1 billion. So in relation to the $4.9 billion of net patient revenue, we have...and these are costs. These aren't charges, but this is all cost information. Approximately 20 percent of what we do is uncompensated. So there is part...part of that is where we see some of that cost shift or that hidden tax that you hear so much about. Some of it plays a role in there. Our charity care, we had $163 million a couple years ago. Charity care is we know going in that we are providing that care. It's already...and we're not going to be paid for it. That is something that's already been worked out with the provider or the hospital and the patient, and that's part of our public or community service mission. Unpaid costs of Medicare: about $370 million. We have a negative margin from cost of about 13 percent. And most of that negative margin, this uncompensated care, is absorbed by the 25 largest hospitals in the state because critical access hospitals are reimbursed on a different structure. So the 25 largest hospitals are eating $370 million worth of care they provide to Medicare recipients. The unpaid cost for Medicaid is about $138 million, and currently we have a negative margin of 26 percent on that from cost. So the entire cost of providing care to Medicaid recipients is about $550 million, but $138 million of that we're not reimbursed for. Bad debt is a very interesting phenomenon for us lately. Our bad debt from 2008 to 2010 went up $35 million. It was $175 million in 2008. Most of this we would attribute to the recession, but also high-deductible plans. What we're seeing is that the insurance companies are paying for their share of the care that's provided to the insured recipients. But those individuals with high-deductible plans are not paying their $4,000 and $5,000 deductibles, and so we have seen a 20 percent increase over two years in bad debt. Attribute a lot of that to the recession. But nonetheless, that is a phenomenon

or a trend that we need to somehow correct. There's a lot of external forces, going to the next slide, that are affecting reform. Some of them are the ACA and CMS, but there are many other moving parts. The one thing I want to draw to your attention on the bottom slide on page 2 is how important the exchanges will play, how significant a role they will play in the group and small-group markets. We've heard quite a bit of information shared this morning and this afternoon about part of the "pay fors" or the agreement that was negotiated on Capitol Hill about healthcare reform. And I want to point out, real quick, you know, some people choose to say that all hospital associations agreed to the deal that was cut on Capitol Hill. We did not. The Nebraska Hospital Association did not. So the American Hospital Association, which we're a part of, did. But we have shared our comments about what we think could have been corrected, both with Governor Heineman and the National Governors Association as well as our federal delegation. So we didn't endorse this, but like I said, we're trying to make the best of the situation that we have before us. The reason the exchanges are so important is because the reductions in reimbursements that we will receive or are already taking place in Medicare need to be made up somewhere else in order for us to be able to continue to provide the care, and I'll talk about those amounts in just a little bit. Joy Wilson did an excellent job talking about a lot of the federal pressures, the fiscal cliff, some of the global economic forces. I'm not going to talk about that. What we anticipate, what we see coming on a national level as well as in Nebraska is that competition in the healthcare arena is going to change dramatically. We're going to see a lot more integration. A lot of that is because of the payment methodologies and quality measures that were put into healthcare reform, such as value-based purchasing, accountable care organizations, bundled payments, all of these things trying to bring in the whole episode of care, or the continuum of care, and a payment associated with the care from, say, three days prior to admission to 30 days after discharge. So there's a lot of integration that we're still going to be going through. That will be costly. Nobody is able to put their finger on how much that will cost but, nonetheless, there are several things that will be going on in changes of the delivery market. Some of the core competencies that we're going to have to see for sustaining the provider network, on the top of page 4, core

competencies in competition, those providers who are going to be able to stay in business and provide high-quality care are going to have to have the ability to change physician and patient behavior, more personal responsibility. But also there's going to be a change from a fee-for-service payment and more of a move to a payment based upon quality outcomes. We need to be able to aggregate lives and take significant risks. Controlling the costs of healthcare: the cost containment themes, the affordable themes of healthcare reform are here to stay; integrated care through risk-based payment; employers and payers will become more aggressive in value-based design; and we will see more movement towards a defined contribution approach to healthcare than a defined benefit. Bending the cost curve, this is something...and, Senator Gloor, I know you asked about the redesigning of the delivery system. And you haven't seen that but, you know, that was the number one issue identified by our members when we surveyed them in August about what is the highest priority, redefining or redesigning the delivery system to accommodate and integrate the reforms that are coming with healthcare reform as well as the dynamics that are at play outside of reform. There needs to be transparency of all stakeholders public and private, quality improvement, comparative effectiveness research. There's been several that have talked about Disproportionate Share Hospital payments. There are Medicare Disproportionate Share cuts, and there are Medicaid. The estimated cut to our hospitals on the Medicaid Disproportionate Share payment will be in the neighborhood of $29 million. However, we don't know exactly how that's going to be laid out or implemented. And Liz Hruska had talked about that, and we're still waiting for those guidelines. But those are payments made to hospitals that provide a disproportionate share of care to Medicaid recipients. Approximately 25-30 hospitals per year in Nebraska get those payments, but it moves sometimes depending on their payer mix. On the slide on the bottom of page 5, one thing I want to talk about is the block grants may be more likely from a federal perspective. The House budget that was passed last year on Capitol Hill, they had a block grant provision in that. That block grant would have reduced Nebraska's Medicaid match by $3.2 billion over ten years. Right now we're getting approximately $1 billion per year. So, simple math, if we have $3.2 billion over 10 years it would cut our $1

billion per year down to $680 million, and it would make our negative margins somewhere in the neighborhood of 50 percent. So we would be losing 50 cents on every dollar. And what I want to share with you at this point is another thing that we are very concerned about is the stability of the provider network. Physicians, dentists, and I truly respect their decision, but financially sometimes it's very hard for them to make a financial decision that makes it worthwhile to provide care to Medicaid recipients. But then what happens as we lose those providers, then we see more patients at the emergency room. We're seeing an actual new trend. We're seeing more physicians coming to our hospitals saying, we'll still do this, but you need to make us whole. And that's why you see a lot of our hospitals putting their physicians back on as employees of the hospital rather than them having their private practices. So that's another trend that we're seeing out there, and we are very concerned about the stability of the provider network. Top of page 6, that's a slide that nobody wants this situation, but it demonstrates how upsidedown the federal government is financially. We have a debt of $16.2 trillion--that's 12 zeros behind that; income, $2.17 trillion; spending, $3.82 trillion. So we're $1.65 billion upsidedown, and we're bumping up against the debt ceiling again. If they fix just the Medicare physician payment, they would go screaming past the debt ceiling limit that we have. But that's a $346 billion problem that we're concerned about as well. The Supreme Court, a lot of folks have talked about that today. Taking numbers from the Kaiser report that I shared with you, their numbers say that if Nebraska expanded Medicaid to 133 percent of the federal poverty level, it would cost the state $250 million between 2014 and 2020. Now the federal match, from other studies and including from Kaiser and Milliman, we have seen that the minimum that anyone has estimated is somewhere between $2.3 billion and $2.4 billion. Dr. Stimpson talked about that infusion of money into our economy. So there's a wide range there, and we're not able to...I wish we were able to outsmart or outguess what human behavior is going to be as far as enrollment and participation in Medicaid expansion and the exchanges, but that is very difficult. The exchanges, they have subsidized premiums. I think that all of the testifiers, or most of them, have talked about that. When I talk about the "pay fors," and now I'm on the top of page 7, this was a $970 billion bill as it was passed on Capitol

Hill. And part of the "pay fors," I mean, there were insurance company "pay fors," pharmaceutical "pay fors." But part of the deal that was agreed to on Capitol Hill was that hospitals nationwide would take a $155 billion reduction in Medicare reimbursements. When those are fully implemented they are going to have a drastic effect on our current negative 13 percent margin on providing care to Medicare recipients. And for the sake of having the perspective of what our payer mix looks like on average, about 50 percent of our patients are Medicare recipients; about 20 percent are Medicaid recipients; and then the other 30 percent are private payer or insurance covered. So as we shift costs, and you're seeing that, we're putting more and more pressure on those that are buying their insurance and paying their bills to cover the costs that we're incurring to provide the care. Nebraska's share of that $155 billion is $854 million, what our reduction will be, which is a 6 percent reduction of our Medicare reimbursements between now and 2020. If 50 percent of our payer mix is Medicare and we're taking a 6 percent reduction, that is an automatic 3 percent reduction in our return on investment that it lowers our margin that much. We're also going to have the Medicaid DSH cuts of $29 million. Based upon the Kaiser numbers, all things being equal, if benefits are being equal and the same number or the same healthcare conditions present themselves to our hospitals for the newly eligibles if we expand Medicaid, if 57 percent, which is the national average, of Medicaid eligibles enroll and participate, it would increase our uncompensated care by about $65 million a year, or 50 percent, but $334 million over the next six years. Now, top of page 8, looking at the Kaiser numbers, the incremental impact of expansion, they estimate that the federal expenditures in Nebraska would increase by 15.2 percent, or $3.05 billion; the state expenditures would increase by $250 million over that same time period, or it would require a 1.8 percent increase in our Medicaid expenditures to accommodate that; federal and state expenditures together would be $3.3 billion, and an overall 9.6 percent increase in spending on Medicaid. Moving further, they looked at Medicaid enrollment. And these numbers vary; I think that all these numbers vary. The Department of Health and Human Services, I think that they would tell us that we have 236,000 people that are enrolled in Medicaid right now. But based upon what Kaiser said, I went and used

their numbers just for consistency in what I'm presenting to you. Current enrollment: 217,000. Even without the expansion of Medicaid because of the new provisions in the Affordable Care Act, we would experience about 20,000 more people that would enroll in Medicaid. If we expand Medicaid we would have 107,000 people that would become enrolled in Medicaid with an incremental impact of expansion of 88,000 people, or an increase of 81.6...or the percentage attributed to expansion would be 82 percent. Reduction in uninsured, Senator Hansen, I know you have some questions. Hopefully this addresses some of the movement that we may see as far as where individuals move in their various groups. Currently we have 238,000 uninsured in Nebraska. Without expansion, with the insurance mandates, Kaiser estimates that 65,000 of those would get insurance. If we expand Medicaid through the expansion, well, adding those covered under Medicaid, we would have 113,000 or an overall increase of 27.1 percent of those with coverage. Now there are also some savings, according to Kaiser. By expanding Medicaid they estimate that there would be an incremental state savings for uncompensated care of $97 million. And how they calculated that was they had made a couple assumptions there. They assumed that state and localities pay 30 percent--I don't know if that's true or not for Nebraska, but that's the assumption that they made in this analysis--and that the state and localities would only achieve 33 percent decrease in their proportionate share of paying for uncompensated care. When they factor in that $97 million savings against the $250 million that they estimate it would cost, they're saying that Nebraska's overall cost of implementing exchange...or Medicaid expansion would be $153 million, or a net increase in state expenditures of $1.1 million. Now, going back, since I was asked to talk about a few of the other factors at play that are affecting what our hospitals may or may not be doing down the road, there was discussion on Capitol Hill about increasing copays and deductibles in both Medicare as well as Medicaid. One of the areas that we need providers desperately is in the children's area, but primary care as well, and they're talking about eliminating assistance paid to hospitals to accommodate those residents and interns that are in our hospitals getting their education. The provider cuts for Medicare are already taking place, but we're very concerned about what sort of expansion of coverage there will be.

Sequestration cuts of 2 percent, this is part of the whole fiscal cliff and everything that goes with it. But if they cut Medicare reimbursements another 2 percent, that will be another $290 million that will be taken out of our hospitals, the 25 largest hospitals. Reimbursements for Medicare, I already talked about the cost of the sustainable growth rate, but right now they're facing a 27 percent reduction in physician provider rates. It would cost $18 billion to fix that for the upcoming year, to stave it off one year, but the grand fix of that is $346 billion. So I've given you a list of our federal priorities. Liz Hruska has talked about the state budget quite well, and we have listed some of those impacts that would also impact us or are of interest. And then, just on page 13, when Senator Gloor asked about where the real reform was or where it could be, and it's in redesigning the delivery system, which is outside of the Affordable Care Act and CMS, where we need to take the initiative and solve some of these situations, working in partnership with the state and other stakeholders. But we need to utilize more technology; we need to deter unnecessary care; we need to have more transparency of performance measures, healthcare teams. If anybody would like to take a look at what I would consider an incredibly successful story on medical homes, and I know that there has been some discussion of this, Oregon has done a great job. They identified the most costly patients in Medicaid. I can't remember the exact percentages, but they identified in some certain group the 16,100 people that cost the Medicaid program about 83 percent of all of their expenditures. And then they hired case managers, one case manager for each...for ten of those people, so they ended up hiring 1,610 case managers. I know that this is a bold move. But they have reduced their Medicaid expenditures on those 16,000 people by over $250 million a year because somebody is watching those patients on a daily basis--morning, afternoon, and evening--making sure that they abide by their prescription medicine regimen, doing what they're supposed to do, keeping them out of the hospital emergency room unless it's absolutely necessary. But they are saving over a quarter of a billion per year. And it was a bold move on the part of their governor--he led the charge; he's a physician; he knows what he's doing--but I think it's a very interesting model that I would...and we have information on it. I'd be happy to put together information for you if you would like to see that, but it's a

very interesting model. Let's see. I think that, yeah, that pretty much sums up what I hoped to share with you. I don't know whether I've piqued any curiosity or if you have any questions, but I would be more than happy to try and answer them if you have some. [LR546]

SENATOR CAMPBELL: Senator Cook. [LR546]

SENATOR COOK: Thank you. I would like to see that information on the Oregon program and, to save a tree or two, just e-mail it to my office. I don't know if anybody else is interested. When NHA talks about deterring unnecessary care, can you offer me one example of unnecessary care in a typical Medicaid patient? [LR546]

BRUCE RIEKER: Seeking preventative care in our emergency room. That... [LR546]

SENATOR COOK: Okay. Such as what, like an asthma inhaler? What would that look like? [LR546]

BRUCE RIEKER: One that, you know, we see a lot of is seeking an ultrasound to check the health of a baby when they claim that it is an emergency situation, but once they find out the sex of the baby everybody's healthy. [LR546]

SENATOR COOK: Oh, okay. [LR546]

BRUCE RIEKER: Yeah, so. [LR546]

SENATOR COOK: It's a miracle. [LR546]

BRUCE RIEKER: And when they present themselves to our emergency room, based upon federal law...and this is one thing that applies to our hospitals with emergency departments that doesn't apply to any other providers, when somebody presents

themselves to our emergency room we have to provide a medical screening and all care necessary to stabilize them and to make sure that if they can be discharged, they'll be discharged, or if we have to hospitalize them, we'll have to do that before we can ever ask about any ability to pay. So we have people literally coming into our emergency room to find out the sex of their baby. [LR546]

SENATOR COOK: I had one more question. "Remove legal and regulatory roadblocks"... [LR546]

BRUCE RIEKER: Okay. [LR546]

SENATOR COOK: What does that mean? []

BRUCE RIEKER: Okay, where do you want to start? But... [LR546]

SENATOR COOK: Just one example of your favorite legal and/or regulatory roadblock. [LR546]

BRUCE RIEKER: Okay. We have some at the federal level, but we also have some at the state. But the five "biggies" on the federal level now that the federal government has mandated that we bundle care and that we have bundled payments, accountable care organizations, is that we have to be "oh so careful" because there are civil money penalties for enticing physicians to refer patients to a particular hospital; there are anti-kickback penalties; there are antitrust laws; there are several federal laws that need to be changed in order so that we don't have to...right now the estimated cost by the Congressional Budget Office to form an accountable care organization is $21 million in order to set it up. So part of it is just getting through the legal hoops that exist so we make sure that the therapists, the midlevel providers, the surgeons, the primary care physicians, aren't performing any antitrust acts of price fixing or things like that. So when we put together a group of providers in what the federal government wants us to

do, we also have to have the protections that we're not going to violate these federal laws and turn around and get penalized. On a state front, and this is very encouraging to us, Dr. Joann Schaefer, the Chief Medical Officer, has approached us about what could we do if there are certain regulations that are removed, not jeopardizing the quality of care, but what regulations truly do not do anything for maintaining or providing high-quality care; which ones are simply just administrative burdens. We appreciated the fact she's come to us. We are working on putting together a short list of some of those that we will see, but...or that we would like to see. But there are things like that. [LR546]

SENATOR COOK: Can you give me an example of one administrative burden that is on a healthcare provider or entity in this state now, or you haven't seen the list? Are you... [LR546]

BRUCE RIEKER: Physician supervision. Part of that comes from the federal government. But requiring that a physicion...let's take a critical access hospital. Our critical access hospitals are 25 beds or less, okay? Some of those areas, because they're deemed to be critical to the area to make access to care available, some of our hospitals may only have three or four patients that are in the hospital at a time. I mean, and they don't all have 25 beds either. There are smaller hospitals. But they may only have one doctor, okay? But then federal and state requirements say that if they are doing therapy for cardiac rehab that a physician has to be directly present during that therapy and in observation of that therapy. It ties that physician's hands from even being able to provide care or see another patient where we have limitations of resources. And we even know the name of the person at CMS that started this. But she decided that, you know, these patients would be better served if there were direct supervision by the physician. Not being reasonably available, but direct meaning you're there, it is problematic. So there are several areas, and we are going to...we have a survey that we prepared for our members on a whole gamut of regulatory issues that they've identified. But now we're going to prioritize them, and go back to Dr. Schaefer and see what we

can do. We could have to get a waiver from CMS because some of them may...it would cause CMS a little bit of heartburn with regard to our Medicaid program, but... [LR546]

SENATOR COOK: Um-hum. [LR546]

BRUCE RIEKER: So we have some hoops to jump through. But I think that that's a great move on her part, and we're looking forward to working with her. []

SENATOR COOK: Okay, thank you. Thank you. [LR546]

SENATOR CAMPBELL: Other questions? Thank you, Mr. Rieker. [LR546]

BRUCE RIEKER: You're welcome. [LR546]

SENATOR CAMPBELL: Our next testifier. How many other people are there who wish to testify? One? Okay. Two? Sorry, didn't see the other person. Three? Okay. Go right ahead. [LR546]

MARK INTERMILL: (Exhibit 9) Okay. Thank you. Good afternoon. My name is Mark Intermill, spelled M-a-r-k I-n-t-e-r-m-i-l-l, and I'm am here today representing AARP. We appreciate the committee's consideration of this resolution. We do support responsible implementation of the Affordable Care Act. And a lot of the things, a lot of the points that I have, have already been made, so I'll go through them quickly. We have looked at this issue of what is the cost of the implementation of the Affordable Care Act. And I would say that I am pleased with what I heard from Mr. Bergquist from the Legislative Fiscal Office about the approach they are taking, kind of that ground-up approach. That's something that we also attempted to do, and it is a daunting task. We have attempted to identify some of the potential cost savings that will accompany the Affordable Care Act. Many of those have been mentioned already. The Nebraska Comprehensive Health Insurance Pool, we saw that in 2011 it was over $27 million that was provided to the

program from the CHIP Distributive Fund. The participation in any CHIP has been decreasing over the past few years, due in part to the Pre-Existing Condition Insurance Plan at the federal level, but also just the cost of any NECHIP. Inmate medical costs has been discussed. We saw that about $2.1 million in Nebraska is what is being paid for care provided outside of the correctional facilities. Nebraska has done a good job of utilizing medical assistance for those who are currently eligible. The Medicaid expansion would provide some additional opportunities to realize those costs. I think state behavioral cost, we heard Mr. Eagan talk about Lancaster County's experience. I think there are some opportunities there for savings. According to the National Association of Mental Health Program Directors Research Institute, Nebraska spent $90.54 million for state mental health agency-controlled community-based programs. And also they found that 70 percent of those SMHA-controlled revenue came from state general funds, so there may be some potential savings there as well. The cancer screening programs have been mentioned also. Every Woman Matters, Stay in the Game are services that will be covered by either coverage provided through the exchange or the Medicaid expansion. There's still cost associated with those programs, in terms of outreach, that we need to protect, but there could be some savings as well. There was some discussion about premium tax revenue that is transferred to the CHIP Distributive Fund. But we also see an opportunity for new premium tax revenue in the state. As more people are covered by health insurance we will see an increase in the amount of revenue that comes into the state from the premium tax. And, as was mentioned, 40 percent of that does go to the General Fund; and as Mr. Bergquist pointed out, 30 percent will go to schools, which will help offset the General Fund cost as well. But probably the second most compelling reason I think that I see for Nebraska to participate in the Medicaid expansion is that we will generate tax revenue. And, to address Senator Hansen's question earlier, where does the money come from? It comes from us, as Mr. Rieker said. It will come from hospitals in terms of changes in Medicare reimbursement. There are some taxes. You know, the Affordable Care Act, we had...since Congress operates under PAYGO rules, they had to find offsetting income to offset the cost. Those are either in the form of taxes, reduced reimbursement

rates. And as I tried to look at this and what does this mean for Nebraska, I tried to look at does this really amount to a fiscal impact for the state of Nebraska? What is the economic impact? And what I finally concluded is that we are already going to pay for this Medicaid expansion, whether we participate or not, through Medicare changes--the reduced reimbursement rates, in some cases, or the DSH payment changes or the tanning booth taxes or taxes on unearned income for applying that to the Medicare tax. So that money will flow out of the state regardless of whether we participate in the Medicaid expansion or not. But what the Medicaid expansion provides us is an opportunity to recoup a portion of that money that we pay out. And the amounts, I think you've heard that there's a variety of estimates of how much that money coming into the state would be. I'm erring on the conservative side, and just the lowest estimate I see is $2.3 billion over seven years. And not taking into account any multipliers, Nebraska generally recoups 4 percent of GDP, or we receive 4 percent of GDP in General Fund revenues. So just looking at that $2.3 billion, that's tax collections of $92 million over seven years. That was the second most compelling reason to participate in the Medicaid expansion. And the most compelling is the first chart that I've provided. This is...I included this for a couple of reasons. This is a summary of Census data about what sort of coverage Nebraskans have and, specifically, Nebraskans between the ages of 18 and 64 with incomes below 400 percent of poverty. The bottom block, 138-400 percent, are people who would be eligible for tax credits in the exchange. The 100-138 percent of poverty are people who could be eligible for either the Medicaid expansion or the tax credits in the exchange. Those under 100 percent of poverty would only be eligible for coverage through the Medicaid expansion. By law, they cannot participate in the tax credits through the exchange. So if we don't participate in the Medicaid expansion we will have between 45,000 and 57,000 Nebraskans, who have an income below 100 percent of poverty, who don't have any health insurance, who will still not have any health insurance. These are people 18 to 64 including, you know, the 50-64 age group is the one that AARP is most interested in. And a lot of those individuals are people who have lost their jobs, and along with that job have lost their health insurance. They need someplace to turn for some assistance, so I think that's really the reason that

AARP is supporting this issue. The last chart that I included, and I just wanted to include this to make a point that over the past several years we've had a tendency to overestimate Medicaid costs in the state. This shows what our medical assistance budget is--and this is just for Program 348; it doesn't include 344. Beginning in 2006, we overestimated Medicaid spending by about $133 million that year, what was budgeted compared to what was spent. And I just looked at 2012, and it looks like that was about $258 million that we had budgeted but won't spend. And I think this is something that...you know, for one thing, within the Medicaid program it appears that there may be some funding that could be used for this Medicaid expansion program, but also just to make the point that Medicaid has been a very cost-effective program over the last few years. And earlier this morning I heard Director Chaumont mention that 21 percent of the cost of Medicaid is spent for people over the age of 65. I'd point out that in 1985 that was 42 percent. We have reduced the percentage of Medicaid spent on people over the age of 65 from 42 to 21 through the type of noninstitutional services, replacing the institution with noninstitutional services. So much progress has been made, and I think there is more that can be realized. But part of that is to make sure we have healthy Nebraskans, and the Medicaid expansion is one way that we can do that. Appreciate your attention and be happy to try to answer questions. [LR546]

SENATOR CAMPBELL: Any questions from the senators? Seeing none, thank you very much for your testimony. [LR546]

MARK INTERMILL: Thank you. [LR546]

SENATOR CAMPBELL: Our next testifier. [LR546]

JENNIFER CARTER: (Exhibit 10) Good afternoon, Senator Campbell, Senator Heidemann, and members of the committees. [LR546]

SENATOR CAMPBELL: Good afternoon. [LR546]

JENNIFER CARTER: My name is Jennifer Carter, J-e-n-n-i-f-e-r C-a-r-t-e-r. I'm the director of the Health Care Access Program at Nebraska Appleseed. We really appreciate the opportunity to testify today on this really critical issue. As Mark said, I think a lot of the key points have been covered and the issues that need to be addressed. The one thing I thought might bear...is worth repeating is stepping back a little bit and remembering that all of this came about because there was, I think, consensus, in at least over many years that I recall previously, that a dysfunctional healthcare system is a real drain on our economy, on our work force, and aside from the human toll that it takes when people can't get the healthcare services that they need. And so that was really a point of the Affordable Care Act was increasing access to affordable healthcare coverage. And Medicaid was the foundation for that coverage. So that doesn't really...the importance of that doesn't go away with the Supreme Court decision making this functionally optional. But really it's the basis because not only has it been a successful program, but I think, as we heard this morning, it is more cost effective to cover people under Medicaid, estimated by about $3,000 per person. So if we're talking about what is most cost effective for taxpayers, covering people under Medicaid is going to be most cost effective than shifting those who are even eligible into the exchange and providing tax credits for private coverage. And then if we don't participate in this Medicaid program, you've got this huge gap, that Mark just mentioned, of people who can't get coverage at all. And then we continue to perpetuate one of the main cost drivers in the system, which is people who can't get care, can't get preventative care, don't have a doctor that they turn to or can call when they're sick. And we get really inefficient use of our healthcare system. So I think those are really important reasons for the state to consider participating and taking up this opportunity under the ACA. I also think it might be helpful to mention...oh, and I actually should mention, some of what we're passing out is a figure demonstrating the gap, a fact sheet, two fact sheets that we've created. One is more of an "ACA 101" for the general public, but I thought I would share it. What I think is not really shown here is everyone who might benefit from this program. So we've talked a lot about childless adults, and Mark

just mentioned that, which I think sometimes childless adults, people just think young people or people who haven't had kids. But we're talking about just people who don't have dependent children right now, and so it might be your 55-year-old neighbor who got hit by the recession and has lost his job and his coverage. And they can't qualify because you have to be aged, blind, disabled, or be a parent to qualify for Medicaid. And in Nebraska parents will also benefit because our eligibility level for working...for parents is about 57 percent of the federal poverty level on average. So you have to be extremely poor as a parent to qualify for Medicaid, and it sort of puts you in a Catch-22. And we've had clients that we've talked to about this where, you know, maybe they're trying to work but they've got a chronic disease they're trying to manage or that they need healthcare services for. And they don't take that quarter raise or move up in their job because they're going to lose the coverage that's so critical to them. And so I think this would really allow families to move forward a little bit, earn a little bit more money, and not lose their coverage until they got to a place where maybe they could actually afford coverage in the exchange should they earn enough to leave Medicaid eligibility at 138 percent and get tax credits to help them in the exchange. It will also help persons with disabilities. Right now our Medicaid coverage for persons with disabilities goes up to 100 percent. So there is a population that would allow persons with disabilities to also earn a little bit more and to still maintain their coverage, which I, you know, from what we've heard from talking with our partners, that's a real concern. They...you know, people want to contribute and they want to work and they might not be able to move ahead for fear of losing healthcare coverage, which is really critical to allowing people to work. So I thought those might be some points worth reiterating, but otherwise I think we've heard a lot of what's important to begin discussing about this. And I'm happy to answer any questions. [LR546]

SENATOR CAMPBELL: Questions? We actually had an interim study and good testimony from people who have a disability who want to work but they're in fear of losing the Medicaid. [LR546]

JENNIFER CARTER: Right. Thank you very much. [LR546]

SENATOR CAMPBELL: Thank you. Our next testifier. Good afternoon. [LR546]

BRADLEY BRITIGAN: (Exhibit 11) Good afternoon. Senator Campbell, Senator Heidemann, members of the committee, thank you for the opportunity to address you. I'm Dr. Bradley Britigan, B-r-a-d-l-e-y B-r-i-t-i-g-a-n. I'm dean of the UNMC College of Medicine, but I'm here today speaking for myself as a citizen. Nebraska currently has a shortage of primary care providers and specialists in many parts of the state. And even without the passage of the Affordable Care Act, the shortage was destined to worsen due to our aging population and the number of physicians in Nebraska reaching retirement age. Certainly the ACA's passage will further increase the demand for primary care providers. The College of Medicine at the University of Nebraska Medical Center is Nebraska's only public medical school and has historically been the primary source of training the Nebraska physician work force. At least 60 percent of practicing physicians in the state receive their medical school and/or residency training at UNMC. Anticipating the physician shortage even before the ACA, UNMC increased the size of its medical class by 10 percent three years ago. It's important for the Legislature to understand how the UNMC College of Medicine is funded. The budget of the College of Medicine for last year was approximately $570 million. Of that budget, 18 percent came from state funds; 24 percent from external research funding. But 58 percent came from clinical revenues generated by our clinical faculty providing patient care in conjunction with our hospital partners, particularly the Nebraska Medical Center and Children's Hospital. The UNMC College of Medicine relies heavily on revenue from clinical activities to support its educational mission. In spite of the substantial funding from the state to the UNMC College of Medicine, we have increasingly relied on revenue generated by the faculty and our hospital partners to fund the College of Medicine. Between 1998 and 2012, the amount of money transferred from the UNMC Physicians practice plan to the College of Medicine increased from $13 million to $48.5 million, allowing the size of the faculty to more than double and contributing to the nearly

threefold increase in research funding over that time. This has been a good deal for the taxpayers of Nebraska, and it's important to keep this in mind as payments for medical services and states consider whether to expand Medicaid. The ACA itself offers no special benefits to academic medical centers that provide clinical care. We will need to compete with every other healthcare provider in the state. Historically the Nebraska Medical Center has cared for a disproportionately large share of the uninsured, underinsured, and Medicaid recipients. Currently hospitals that provide a high percentage of care of these populations have received a supplemental payment from the federal government through the Disproportionate Share Hospital payment program, referred to as "dish--DSH" that you heard about from a number of individuals earlier. This offsets some of the losses these hospitals incur but certainly not all of it. In addition, hospitals that participate in the DSH program are also eligible to purchase drugs for outpatient use at a discounted rate through the federal 340B Pricing Program. The remaining unreimbursed costs are passed along to the rest of consumers in the form of higher insurance rates by those with private insurance. Last year NMC, the Nebraska Medical Center, provided $506 million in Medicaid services for which it received approximately $149 million in payment. In addition, that hospital provided $65 million in uncompensated care, while last year DSH payments to the Nebraska Medical Center were $12.5 million. And it's estimated that the 340B Pricing Program saved the hospital about $10.8 million in drug acquisition costs over that same period of time. When the ACA was enacted it was designed to reduce the number of uninsured and increase the number of persons insured through insurance exchanges and the expansion of Medicaid. With more insured persons the ACA scheduled a phaseout of the DSH payment program, as was mentioned earlier, starting with a 70 percent cut in 2014. The 340B discount pricing program was not mentioned in the ACA, but eligibility for the program is tied to eligibility for DSH payments and, thus, its future is unclear as well. When the Supreme Court ruled the Medicaid expansion was optional for states it did not alter the mandatory cuts in DSH payments. Thus, without Medicaid expansion, academic medical centers, such as the Nebraska Medical Center, as well as other community hospitals may be completely financially responsible to care for a significant

number of uninsured without the supplemental payments from DSH and the 340B Pricing Programs. If both programs disappeared, based on last year's allocation this would be an estimated $23.3 million cut to the bottom line of the Nebraska Medical Center, nearly half its operating margin last year. There is an additional threat to teaching hospitals that was alluded to or mentioned earlier that is not related to the ACA but, rather, to the federal budget deficit. Most of the medical residencies across the country are funded by the federal government. There are proposals to reduce funding to teaching hospitals that provide medical residencies to help balance that budget. If this occurs, teaching hospitals will either have to incur greater costs of residencies or reduce the number of residency positions. Keep in mind medical school graduates are not eligible to practice medicine until they complete an approved residency program. If there is not an increase or, even worse, a decrease in the number of residencies for medical school graduates, it will create a bottleneck to reducing the physician shortage regardless of whether or not medical school graduates increase in number. Given the dependence of the UNMC College of Medicine on clinical revenue generated by the faculty and our hospital partners to support the College of Medicine education mission, the uncertainty of what happens to those eligible for Medicaid expansion and the potential federal budget cuts, they are a significant threat to the college's ability to provide adequate supply of physicians for the state of Nebraska. Major decreases in support from the clinical revenue may make it impossible to sustain programs at their current levels, let alone increase the number of graduates. Raising tuition is not a good option since the average medical student currently graduates with a debt of already about $150,000. Thus, it's possible that the College of Medicine may need to look to the state of Nebraska to replace the support currently provided from our clinical operations if the cuts in Disproportionate Share payments and other threats of increased expense or decreased revenue are not replaced from Medicaid expansion or other sources and federal budget pressures come to pass, as potentially possible. So I will stop and thank you for your attention and be pleased to answer any questions. [LR546]

SENATOR CAMPBELL: Thank you, Doctor. Questions? I thought that your testimony

was very interesting with regard to how much of the revenue does come from physicians serving and how much you use that in your budget. And probably the Appropriations people know this, but we certainly didn't from the Health, so. [LR546]

BRADLEY BRITIGAN: Yeah, I mean, and this is not unique to this medical school. It's pretty much at every school, particularly the public schools across the country. We've managed to leverage our clinical income to markedly expand the types of services and the scope of education that we provide. [LR546]

SENATOR CAMPBELL: And Senator Gloor has rejoined us. But I would have to say he raised a significant question this morning in terms of with the ACA coming on, can our delivery system in the state of Nebraska handle it, or are we going to see a meltdown? I hope I'm not being too...overexaggerating what he said. Do you want to make any comments on that? [LR546]

BRADLEY BRITIGAN: Well, I mean, I think that there will certainly be a challenge in the short run as the number of providers currently available are limited. Certainly we are already preparing, and have been for a number of years, to look at modifications of delivery systems, such as increased use of nurse practitioners, physician assistants, other care providers, altering some of our care delivery systems. We will undoubtedly be relying increasingly on things such as telemedicine that is being developed to try and extend the capabilities of the current providers. But there is no question that the work force needs to increase. As I already mentioned, the College of Medicine has expanded its class size; the College of Nursing has expanded its class size. We recently are in the process of expanding our Allied Health school to the Kearney campus and expanding that. But that will take time to occur. But certainly, through utilization of technology and a (inaudible) expansion of the work force and in changes of some of the work style that we will do, you know, the hope is there that, you know, things will not get too overwhelmed. But certainly, as has already been mentioned, a lot of those patients are already receiving their care in the emergency room, and it can certainly be done in a

much more cost-efficient and thoughtful and effective manner if they're actually linked up with primary care providers rather than seeking episodic care. [LR546]

SENATOR CAMPBELL: The work force issue has been discussed at great length by the Health and Human Services Committee because of the number of hearings. And at some point it seemed to me we need to bring together a lot of the professionals and talk about how do we begin looking at scope of practice issues, which is always... [LR546]

BRADLEY BRITIGAN: Um-hum. [LR546]

SENATOR CAMPBELL: Yes, all my colleagues smile at that. But at some point I think we're going to have to have those discussions in order to ensure the delivery with or without the ACA. [LR546]

BRADLEY BRITIGAN: No, and I...certainly the trend and the discussion nationwide across the health profession schools is that in order to meet this challenge and the increased number of patients that we'll be taking care of and to limit costs, it is clearly going to be a, you know, strategy of each individual care provider being able to practice to their maximum skill set in order to make this work and be as cost-effective as possible. [LR546]

SENATOR CAMPBELL: Thank you, Doctor, and thanks for your testimony today. [LR546]

BRADLEY BRITIGAN: Thank you. [LR546]

SENATOR CAMPBELL: If the counting was right there is another testifier. [LR546]

_____: There's (inaudible). [LR546]

SENATOR CAMPBELL: Thank you for catching that. A page will pick that up for you. Good afternoon. [LR546]

DON HORTON: Good afternoon. I'm sorry, I have nothing prepared. My name is Don Horton, D-o-n H-o-r-t-o-n. I'm a concerned citizen and just thought it would be important to let you folks know I'm currently paying about 50 percent of my income to insurance, to the tune of $15,115 per year. And according to this piece of paper from my provider, it's jumping to about 70 percent, at $18,208. That's about 70 percent of my income. So do I work to pay for insurance, or do I just go on, you know, welfare or what have you? Which is isn't going to happen, but I just thought it would be important to put a face to some of the issues that are actually here. [LR546]

SENATOR CAMPBELL: Absolutely. We always appreciate, and you should never apologize and say, I don't have testimony or I'm just a citizen. [LR546]

DON HORTON: Sorry I'm so nervous. [LR546]

SENATOR CAMPBELL: Your testimony is extremely important. Are there any questions from the senators? Well, thank you for... [LR546]

DON HORTON: Yes, ma'am. [LR546]

SENATOR COOK: I have a question. [LR546]

SENATOR CAMPBELL: Oh, I'm sorry, Senator Cook. [LR546]

SENATOR COOK: Thank you, Madam Chair. Mr. Horton, is that for you as an individual, or are you paying to cover a family? [LR546]

DON HORTON: No, that's a family of four. [LR546]

SENATOR COOK: Okay. [LR546]

DON HORTON: I don't know why the 20 percent increase. I've paid out of pocket, over and above my premiums, about $680 thus far. [LR546]

SENATOR COOK: Um-hum. [LR546]

DON HORTON: The provider has paid about $1,333, which really would be one premium for next year's rate, so I don't understand why the 20 percent. They said it's the pool that I'm in. [LR546]

SENATOR COOK: Hmm. Okay. [LR546]

DON HORTON: So if I don't make a decision on what I'm going to do, you know, in the next 30 days, this is going to become a reality. Their answer, if you want me to embellish a little, is to get a lower premium with a higher deductible. Well, if one of us happened to get sick, I still have to pay the deductible; it's still going to be...the best rates can...I've got four quotes. The best-case scenario is going to be $18,600. If I do I have to pay all of the deductibles. [LR546]

SENATOR COOK: Um-hum. [LR546]

DON HORTON: So there's no savings; there's none. It's a math game and, quite frankly, I just don't know what to do. [LR546]

SENATOR COOK: Thank you very much. [LR546]

DON HORTON: Yes, ma'am. [LR546]

SENATOR NORDQUIST: Just real quick. [LR546]

SENATOR CAMPBELL: Senator Nordquist. [LR546]

SENATOR NORDQUIST: So you're a family of...family in a...is it in a large-group or small-group plan or individual family policy? [LR546]

DON HORTON: It's an individual, yes sir. [LR546]

SENATOR NORDQUIST: Individual family policy. Okay. [LR546]

DON HORTON: Unfortunately, leaving Virginia I was on the COBRA program. [LR546]

SENATOR NORDQUIST: Um-hum. [LR546]

DON HORTON: I had to come off of the COBRA program. Went out and got the coverage that we have. It's a great plan, don't get me wrong. [LR546]

SENATOR NORDQUIST: Yeah. Um-hum. [LR546]

DON HORTON: I've enjoyed a lot of good coverage from these folks. But it's just unaffordable. [LR546]

SENATOR NORDQUIST: Sure. [LR546]

DON HORTON: You know, moving from a job that was relatively well-paying to an industry in, you know, the Midwest,... [LR546]

SENATOR NORDQUIST: Um-hum. That's right. [LR546]

DON HORTON: ...my salary was reduced by almost $100,000, you know. [LR546]

SENATOR NORDQUIST: Um-hum. Yeah. [LR546]

DON HORTON: At those numbers it's just unaffordable. We can't make it happen. [LR546]

SENATOR NORDQUIST: Um-hum. Hmm. I know your story certainly rings true. And it's what I get from a lot of my constituents, too, about how it limits what they can do as far as jobs. I mean, a lot of people stay in employment solely because of the access to healthcare, and it limits their ability to achieve what they want to for their families. So we appreciate your testimony today. [LR546]

DON HORTON: Absolutely. My pleasure. [LR546]

SENATOR CAMPBELL: Thank you, Mr. Horton, and for your patience and waiting. [LR546]

DON HORTON: Thank you. Absolutely. Thank you. [LR546]

SENATOR CAMPBELL: Any other testifiers this afternoon? Senator Nordquist, did you wish to make any closing? [LR546]

SENATOR NORDQUIST: No, I think we'll wrap up for the day. [LR546]

SENATOR CAMPBELL: All right. And with that, we will close the interim hearing, and thank you all for coming this afternoon. [LR546]