[LB577 LB578]

The Committee on Health and Human Services met at 1:30 p.m. on Thursday, February 28, 2013, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB577 and LB578. Senators present: Kathy Campbell, Chairperson; Bob Krist, Vice Chairperson; Tanya Cook; Sue Crawford; Mike Gloor; Sara Howard; and Dan Watermeier. Senators absent: None.

SENATOR CAMPBELL: Good afternoon. I want to welcome you to the hearings of the Health and Human Services Committee. I'm Kathy Campbell, and I serve District 25 in east Lincoln. I'm going to go through the procedures for the committee, and then we will have introductions. And then Senator Krist will be handling the hearing on LB577 as I open and listen for the testimony. If you plan to testify today, you need one of the bright orange sheets that are located on either side of the room. Diane Johnson is the clerk and she'd appreciate it if they were printed legibly. When you come forward to testify, you can give your orange sheet to Diane and any handouts that you have. If you need additional copies of handouts, the pages will be glad to help you do that. As you sit down, we will ask that you identify yourself once again and spell your name. The spelling is for the transcribers as they listen so that they can recognize your voice and know the exact spelling of your name. We do use the lights in the Health and Human Services Committee. You will start with five minutes. It will be green for what seems like a long time, four minutes. And then it will go to yellow and you have one minute, and then you will look up and somebody will be trying to get your attention to wrap (laughter) up your testimony. If you do not wish to testify today but you would like to leave a comment about how feel, you can do that on the white sheets. Our two pages today are Kaitlyn and Deven and they'll be glad to help you in any way. So with that, we will start with introductions. And, Senator, would you do that? [LB577]

SENATOR WATERMEIER: Dan Watermeier from Syracuse, District 1. [LB577]

SENATOR COOK: I'm Tanya Cook from Omaha. I represent District 13. [LB577]

SENATOR KRIST: Bob Krist, District 10, Omaha and Bennington. [LB577]

MICHELLE CHAFFEE: I'm Michelle Chaffee. I serve as the legal counsel to the committee. [LB577]

SENATOR GLOOR: Mike Gloor, District 35, Grand Island. [LB577]

SENATOR CRAWFORD: Good afternoon. Sue Crawford, District 45, that's eastern Sarpy County, Bellevue, Offutt. [LB577]

DIANE JOHNSON: And I'm Diane Johnson, the committee clerk. [LB577]

SENATOR KRIST: And before we start just to reemphasis, I don't like to cut people off but in the interest of fairness, five minutes is what's afforded to everyone. A few minutes here or there if absolutely necessary, but I will try to hold you all to five. So thank you. Senator Campbell please, LB577 if you will, please. [LB577]

SENATOR CAMPBELL: (Exhibits 1 and 2) I will. Thank you, Senator Krist, and good afternoon, colleagues. I'm Kathy Campbell, K-a-t-h-y C-a-m-p-b-e-l-l, and I am the senator representing the 25th Legislative District. The intent of LB577 is to require Nebraska Medicaid to add the newly eligible adult population under the Patient Protection and Affordable Care Act to the Nebraska Medicaid state plan amendment and outlines the health coverage provided under the program. Now before I proceed to explain that to you, I want to do a little bit of history. And the history entails what is Medicaid. Congress passed Medicaid in July of 1965 and it was optional to all of the states. The Nebraska Legislature adopted Medicaid in late August of 1965, and no doubt was probably one of the first sets of states that did that. Medicaid is health insurance for low-income children, the elderly, and people with disabilities, also a small number of very poor parents at 54 percent or lower of the federal poverty level. It is a shared partnership with the feds matching 55.7 percent of the funds to our state funds of 44.3 percent. And each state has a state plan within the federal guidelines. We are now at a new healthcare structure with the ACA which affords new opportunities and, admittedly, new challenges. Old assumptions give way to new realities for healthcare. No matter what you think of the ACA, it is the law of the land upheld by the United States Supreme Court. Today, we are not focusing specifically on the totality of the ACA, but we are focusing on Medicaid expansion. Under the Supreme Court's ruling this past summer, a major question was left to the states: Should we adopt the Medicaid option to expand our eligibility to include more Nebraskans, uninsured, low-income adults? Discussion and debate are essential in determining public policy. Just as in 1965, the Nebraska Legislature should undertake this discussion and determination. A more thorough review of the bill's content can be ascertained by reading the bill's statement of intent and explanation I am providing. And I think that the pages handed that out to you. I'm also providing you with a chart which lays out the fiscal note from the legislative budget and Fiscal Office. I am most grateful for the extraordinary amount of time that office, in particular Liz Hruska, spent on this issue. We know we have more work to do in clarifying what savings we might achieve. For now, I think the office has taken a very conservative approach and given you a good fiscal note. Please note an overall savings for the upcoming biennium. Senator Nordquist will go through the charts in detail in his opening on LB578. Let's now turn to LB577. LB577 provides for expanded eligibility to low-income adults age 19 through 64 with incomes of zero to 133 percent of the federal poverty level. And with the income disregard, that threshold effectively sets at 138 percent of the federal poverty level. LB577 stipulates the use of Secretary-approved coverage benchmark, one of four options that any state can choose. This coverage will use the current Medicaid state plan benefit package. If a

problem ensues with the Secretary-approved coverage, an alternative benchmark must be submitted by Nebraska. Choosing the state's current Medicaid benefit package as the benchmark allows for several things. It allows for the continuity of coverage for individuals currently enrolled. It provides equity of coverage between current Medicaid enrollees and new eligibles, and assures the healthcare needs of this population are met in a way that provides appropriate, preventative care for health cost savings. Additionally, it has the advantage of administrative simplicity in determining eligibility and administering benefits and making the program easier for enrollees to explain and certainly for consumers to understand. LB577 specifies that the expansion will include benefits required by the ACA and will comply with the Mental Health Parity and Addiction and Equity Act. LB577 reiterates the newly eligible low-income adult population will qualify for the enhanced federal assistance package as outlined in the ACA. The federal match for the first three years is at 100 percent with step-down increments over the years to 2020 when the rate is finally set and continues at 90 percent for the federal government. LB577 provides for the essential health benefits described in the ACA and includes a definition of habilitative services. It is left to each of the states to provide that definition. One of the main points I want to make regarding LB577 is that we are already--we are already--paying for the expenses related to not covering healthcare for low-income adults. All of us--all of us--are paying the cost. Some of these costs are financial, some of these costs are as a society, and some of the highest costs are borne by the individuals themselves. Let me share with you a brief list of what costs we are currently incurring. We are incurring the costs for expensive emergency room care for unaddressed medical needs; the cost in uncompensated care provided by our hospitals and healthcare providers; the cost in increases to each of us through our medical bills and our health insurance premiums estimated to be over $1,000 per family per year; the cost borne by our employers in lost productivity through employee illness. We are talking about hardworking, low-income Nebraskans. The cost by our counties in general assistance funds to pay for medical expenses paid with our property taxes; the cost by our public agencies for mental health and substance abuse services; the cost in foreclosures and bankruptcies as a result of uninsured individuals who cannot pay for their medical bills. If we don't adopt this option, we will incur the following additional costs. The cost of the federal taxes we pay that will not come back to benefit Nebraska. We will pay for other states. We will pay for their low-income uninsured population while our citizens remain uninsured. No federal tax dollar is free. It is paid by the citizens of Nebraska and every state across this land. We will pay for the costs in loss of healthcare dollars estimated for federal dollars that would come into the state at $2.3 billion. And the greatest, most graphic costs, are in deaths, the avoidable loss of life to individuals who often wait too long to get care. Research studies have indicated an estimated 500 lost lives in Nebraska annually with a disproportionate numbers of people of color and residence of low-income counties. In addition, LB577 will address an inequity regarding subsidies within the ACA. Under the ACA, childless adults with incomes below 100 percent of the federal poverty level are not eligible for subsidies to purchase insurance in the health insurance exchanges. Without the

Medicaid benefits provided by this bill, these adults will not qualify for any assistance, leaving them uninsured. LB577 is a smart investment. It is a way to stop writing a blank check for the ever-increasing costs that all of us pay. It is a way to invest a portion of what we already are spending into funding healthcare access for the last group--the last group--left uninsured and those least able to pay for coverage. It is estimated in the state that we have 12 percent of our population that is uninsured. Do we say to this last group, we the 88 percent have insurance. We are so sorry we cannot insure you even though we have the federal match paying 100 percent of the cost for the first three years. To me, this is the human cost. I would respectfully ask of my colleagues to hold their questions to hear all testimony, and I certainly will close and respond to questions. Finally, I have requested that Dr. Jim Stimpson, director of the Center for Health Policy at the College of Public Health at UNMC, provide information to the committee on research he has completed on this topic. With your permission, and I did talk to the Vice Chair prior to the meeting, I would ask that he be allowed to provide his briefing prior to the beginning of the testimony on this bill. I specifically wrote to the college, to UNMC, asking him to testify. And that would conclude my opening, Mr. Vice Chair. [LB577]

SENATOR KRIST: Thank you, Senator Campbell. While the Doctor is making his way to the chair, can I see a show of hands of everyone who's going to testify in support of LB577? About 16 people. Thank you very much. Those in opposition? I think I see three. Okay. Thank you very much. And neutral? Great. Doctor, welcome. [LB577]

JIM STIMPSON: (Exhibit 3) Good afternoon. Thank you, Senator Krist, Senator Campbell, committee members for allowing me to testify today. I am Jim Stimpson, J-i-m S-t-i-m-p-s-o-n, director of the UNMC Center for Health Policy. I was invited to provide revised estimates for the number of potential enrollees for Nebraska, including those who are currently eligible but not enrolled in the Medicaid program, and the potential impact on individual and family private insurance premiums should Medicaid be expanded. I am speaking here for myself in a neutral position. I am not representing the University of Nebraska. Regardless of whether Nebraska decides to expand Medicaid or not, there will be increased enrollment in Medicaid starting in 2014. There are now several estimates of the expected number and costs of new enrollees expected in Medicaid from 2014 to 2020. I revised the estimates from my previous report published August 2012 using the most recent data available. The UNMC Center for Health Policy estimate is nearly identical to the revised estimate produced by Milliman in a January 8, 2013, report to DHHS. Starting in 2014, there will be nearly 55,000 newly eligible new enrollees in Medicaid, and approximately 21,000 new enrollees in Medicaid that are currently eligible to enroll, but are not currently participating. I provided an exhibit, Exhibit 1, in my written testimony outlining the figures starting in 2014 and ending in 2020 after...over those seven years. For our estimate, we have about nearly 55,000 starting in 2014, and by 2020 there would be nearly 80,000 enrollees in the expanded Medicaid program. In the current Medicaid program, there would be new enrollees of approximately 21,000 starting in 2014 and by 2020 there would be nearly

42,000 new enrollees in that current Medicaid program. The next piece is to talk about the impact of Medicaid expansion on private insurance premiums. 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, these costs are financed by the providers and by state and federal government. Eventually, this cost is shifted to individuals and employers in the form of higher insurance premiums, sometimes referred to as a silent tax or a hidden tax. Increased numbers of persons participating in the health insurance market could have a significant impact on individual and group insurance premiums. As requested, we estimated the impact of Medicaid expansion on private health insurance premiums based on the expected decrease in uncompensated care. The impact of providing healthcare to the uninsured has been estimated to increase or markup private health insurance premiums by an average of 8 percent for state residents based on prior research by health economists. This markup was applied to the most current data available on private insurance premiums paid in Nebraska and the expected decrease in the uninsured population attributable to Medicaid expansion. Overall, the cumulative savings to a typical private insurance policy premium over seven years, 2014 to 2020, is estimated to be on average $757 for individuals and nearly $2,100 for families. The following exhibits in my written testimony present the results of this analysis for the expected markup on annual and individual family insurance premiums and the net savings. So Exhibit 2 presents the individual annual premium markup, and Exhibit 3 presents the family premiums. The white bar is the markup in premiums without Medicaid expansion, and the black bar is the markup in premiums with Medicaid expansion. And to try to make it easier, Exhibit 4 simply subtracts the difference to simplify the presentation of the results and shows the net savings over 2014 to 2020. So starting in 2014, the average individual will save $81 per year and the average family would save $225 per year, and that would gradually ramp up by 2020 to be $120 for an individual and $335 for a family. Thank you for this opportunity. [LB577]

SENATOR KRIST: Doctor, it should be noted that when I look at Exhibit 1, your numbers are remarkably close to the Milliman study. Do you see the same statistical variances in the other data that you've provided to us? Are you right there with the Milliman study as well? [LB577]

JIM STIMPSON: You mean for cost or... [LB577]

SENATOR KRIST: Costs, yes. [LB577]

JIM STIMPSON: Yeah, yeah. [LB577]

SENATOR KRIST: Okay. [LB577]

JIM STIMPSON: We are very, very similar on cost as well. [LB577]

SENATOR KRIST: And you didn't cheat? You didn't look at their numbers first? (Laughter) [LB577]

JIM STIMPSON: For the... [LB577]

SENATOR KRIST: That's a joke. Don't answer it. Any other questions for the Doctor? Got to get some levity in here. [LB577]

SENATOR HOWARD: Thank you, Senator Krist. Thank you for your testimony. I had a question. You list currently eligible yet unenrolled individuals. As we are planning or thinking about this bill, should we be planning for the 54,000 or should we anticipate that there's a portion of them that will continue to remain eligible but be unenrolled? [LB577]

JIM STIMPSON: The currently eligible? [LB577]

SENATOR HOWARD: No, the newly eligibles. Should we plan for 55,000 coming on board January 1, 2014, or is there a portion that you think will remain unenrolled? [LB577]

JIM STIMPSON: I think that is the portion. That's the estimate after assuming how many will participate. And we estimated about a 65 percent participation rate starting in 2014, and then it would gradually ramp up to about 75 percent participation by 2016. [LB577]

SENATOR HOWARD: Thank you. [LB577]

JIM STIMPSON: Yeah. [LB577]

SENATOR KRIST: Thank you, Senator Howard. Any other questions? Senator Gloor. [LB577]

SENATOR GLOOR: Thank you, Senator Krist. And thank you, Dr. Stimpson. I think that answers one of my questions. So if we look at the payback in terms of the cost shift offset, for want of a better term, on here we're starting with a 55 percent participation rate of those that would be eligible and then moving up... [LB577]

JIM STIMPSON: 65. [LB577]

SENATOR GLOOR: We start with 65? [LB577]

JIM STIMPSON: 65. [LB577]

SENATOR GLOOR: And then ramp that up to? [LB577]

JIM STIMPSON: To 75. [LB577]

SENATOR GLOOR: Up to 75. Okay. Do you know, has there been any commitment? I mean, this assumes that we'll automatically see the insurers roll back their premiums because there will be this savings, but we don't know that the insurers will necessarily do that. Is that a fair representation? [LB577]

JIM STIMPSON: Yeah. This is based on a simulation of other analysis done by economists at Emory University based on how much uncompensated care is shifted on. But, absolutely, we'd never know 100 percent what...how human behavior will function. [LB577]

SENATOR GLOOR: Let me ask you along a little different vein, and you may not be the right person to ask, but is there a direct relationship between increased utilization of health services and improvement in health status? [LB577]

JIM STIMPSON: Well, it's a complicated relationship. There's a lot of places across the country that are overutilizing and having bad outcomes, but those are usually high-insurance markets. And then there are places that don't get enough care, preventive care and primary care, and have negative outcomes. [LB577]

SENATOR GLOOR: Yeah. I mean, part of my challenge as we think through this is the automatic assumption that an increase in utilization results in improvement in health status. Not talking about cost here. I'm just talking about interactions. And I know most of what you've given us are numbers that relate to dollars and cents. But appreciate your perspective. Thank you. [LB577]

JIM STIMPSON: Yeah. [LB577]

SENATOR KRIST: Any other questions? Senator Crawford. [LB577]

SENATOR CRAWFORD: Thank you, Senator Krist, and thank you, Dr. Stimpson. I'm just following up on Senator Gloor's question about whether or not you would expect these savings to show up in actual premiums. Now there are medical loss ratio provisions in the larger act that would appear to address that because it would...if the cost of providing care goes down, then that 80 percent that's going to...or 85 percent that's going to care would seem to go down. So it seemed there are some provisions in the larger act that would try to make sure that some of that savings comes through. Do you agree? [LB577]

JIM STIMPSON: That's not really clear. [LB577]

SENATOR CRAWFORD: Okay. [LB577]

JIM STIMPSON: I think it's too early to tell. [LB577]

SENATOR CRAWFORD: Okay. [LB577]

JIM STIMPSON: Especially because those provisions are trying to bring down the administrative cost of, you know, down to 20 percent, whereas, you know, for example, Medicaid administrative costs are 3.5 percent. So it's such a wide gulf it's...and I don't think that we have information to know for sure. We know that this study was based...that we based our estimate on had shown that there are demonstrated cost-shifting whenever there was increases in Medicaid expansion or other kinds of insurance coverage in a market. [LB577]

SENATOR CRAWFORD: Thank you. [LB577]

JIM STIMPSON: And we might presume, reasonably presume, it may continue. [LB577]

SENATOR KRIST: Thank you, Senator Crawford. Any other questions? Senator Howard. [LB577]

SENATOR HOWARD: Just a piggyback off Senator Gloor. He asked does increased utilization show improvements in health status, and you said that in certain areas it does and in certain areas it doesn't. Could you say Nebraska is one of those areas where it does or it doesn't, or is it more based on urban versus rural? [LB577]

JIM STIMPSON: I think it's based even more specifically where you live, your neighborhood that you live in. I don't think it's even as gross as state or urban/rural. There's been a lot more detailed analysis by the Dartmouth group showing certain neighborhoods, you know, zip codes specifically that have far overutilization, too many tests, too many procedures and, therefore, a lot of negative outcomes. And then certainly there's some very impoverished areas, some very poor areas, neighborhoods and zip codes that aren't receiving the level of preventive care or primary care and having negative outcomes from that. [LB577]

SENATOR HOWARD: Did the Dartmouth study look at Nebraska? [LB577]

JIM STIMPSON: It looks across the country. [LB577]

SENATOR HOWARD: And then...no. Thank you. Thank you. [LB577]

SENATOR KRIST: Thank you, Senator Howard. Senator Crawford. [LB577]

SENATOR CRAWFORD: Thank you, Senator Krist. What about a more basic

relationship between coverage and health outcomes? Are there general patterns in that relationship that you could discuss? [LB577]

JIM STIMPSON: Yeah, absolutely. Coverage was associated with better health on average. And specifically New England Journal Medicine article last year showed...specifically looked at Medicaid expansion. Some states that had expanded Medicaid early, and found that for every 176 people that were covered, 1 death was prevented. And so applying that, extrapolating that grossly would roughly estimate 500 deaths potentially saved here. There was a previous report that was very influential that looked at insurance coverage and deaths across the country specifically for...and looked at each state. They found that lack of health insurance was resulted in over 25...or about 25,000 deaths across the country. Specifically that was at least 100 deaths in Nebraska in a given year. [LB577]

SENATOR CRAWFORD: So just to follow up, so while there may not be an overall empirical relationship, just dollars to health outcomes, there is a relationship between health coverage and health outcomes, a positive relationship between health coverage and health outcomes. And also demonstrated positive relationship between Medicaid coverage expansion and improved health outcomes. [LB577]

JIM STIMPSON: Right. Correct. [LB577]

SENATOR CRAWFORD: Thank you. [LB577]

SENATOR KRIST: Anybody else? Thank you. Thank you, Doctor. Thank you for your information. [LB577]

JIM STIMPSON: Yep. [LB577]

SENATOR KRIST: Okay. Could we have the first proponent for LB577. Welcome. [LB577]

JENNIFER CARTER: (Exhibits 4, 5, 6, 7, and 8) Good afternoon. My name is Jennifer Carter, J-e-n-n-i-f-e-r C-a-r-t-e-r. I'm the director of public policy at Nebraska Appleseed. First, we'd like to thank Senator Campbell and the all the cosponsors for introducing this very important bill and really for all of the work that this committee and others have done to ensure that the implementation of the Affordable Care Act in Nebraska is smart and deliberate and productive for all Nebraskans. Appleseed believes that the Medicaid option under the Affordable Care Act presents us with a great opportunity to provide healthcare access to thousands of Nebraskans, keeping our families strong and secure and ensuring that Nebraskans have affordable healthcare options. LB577, which would implement this new option, we believe is good because it is a good deal for our state. It will grow the economy, it utilizes current healthcare resources in a more efficient and

productive way, and it simply is the right thing to do. Senator Campbell did a little bit of this, but I thought it might be helpful since we work on Medicaid so much to give sort of a little bit of a review of what current Medicaid does so that we can see how LB577 would benefit. And as Senator Campbell said, Medicaid eligibility is based on federal poverty level and family size, but income doesn't determine coverage alone. Only certain groups of people are eligible. And, as she mentioned, for adults you have to be over 65, aged, blind, or a very poor parent. So what LB577 does that would be so helpful is that it makes coverage available to Nebraskans in minimum and low-wage jobs who are not currently eligible for Medicaid and there's no way they're going to afford coverage in the private market. And specifically just to give you a sense of the eligibility level, it would...138 percent of the federal poverty level is about $15,856 a year for an individual, and it's about a little under $27,000 a year for a family of three. So still not, you know, making a ton of money and not at a position where you can afford private insurance. So in general, the LB577 would provide healthcare coverage to three new main groups. One is adults earning low wages who do not have dependent children, because again if you're not a parent and you're not aged or blind or disabled you can't qualify. So that would be a really helpful category. Second, working parents who can now earn more of the...what we believe is about the top level is about 54 percent of poverty for parents right now who can be eligible for Medicaid. So this would allow parents to work, really work more, earn more. Parents who are doing that already, but who are not eligible for Medicaid coverage, could now get coverage up to the higher level of 138 percent. It would also have a similar benefit for persons with disabilities who are able to lose a little bit...earn a little bit more without fear of losing their critical coverage, because right now their eligibility ends at 100 percent of poverty. So it would bump that up a little bit. And it also benefits Nebraska. This a good deal for our state as many states have recognized recently. Between 2014 and 2016, the federal government will pay 100 percent of the cost of services for those who are eligible. That's estimated, the most conservative estimate we have found is estimated to return $2.3 billion back into Nebraska's economy. It is...one important thing to note, though, those...that 100 percent federal funding is statutorily tied to those years. So if we're going to get the full benefit of these dollars, that's why we have to do this now, because it's not like any time you join you get the 100 percent. You'll only get them in those years. Second, it will grow the economy, and some of this is based on the work of Dr. Stimpson who put out...had a report that estimated about $700 million in new activity as a result of all of those dollars being returned to Nebraska. Separately, studies have shown that a 10 percent expansion in Medicaid has been shown to reduce bankruptcies by about 8 percent. And we hear a lot about medical costs driving bankruptcies. So if you extrapolate that in Nebraska, that would be about 1,200 bankruptcies prevented. Finally, it's the right thing to do. This program would provide healthcare access to an estimated 54,000 Nebraskans. And we have also cited the study that Medicaid saves lives, that they found that in other places. What will happen if we don't pursue it, and I've passed this around, both the Medicaid 101 sheet and...is that we will create a significant gap in coverage. The ACA, when it was structured, anticipated Medicaid would be the

foundation of coverage in part because it is much more cost-effective to cover people under Medicaid than it is to provide a tax credit to buy private insurance. So it wasn't until the Supreme Court decision when this became effectively voluntary that we didn't...wouldn't know...automatically have a Medicaid coverage for those folks. And so what happens now, what the law anticipated, was that coverage would be there. So they started the tax credits at 100 percent of poverty. That means now you've got this gap, as demonstrated there, where some people are eligible for Medicaid...I can stop unless you want me to just finish the thought. [LB577]

SENATOR KRIST: Wrap it up. That's fine. [LB577]

JENNIFER CARTER: Okay. So those who are not eligible for Medicaid, those childless adults that we've talked about and the parents over 54 percent of poverty, they're going to fall into that gap with no access to coverage because they're not even going to be able to access the tax subsidies to try to provide...to purchase private insurance. So I can...we have more in our testimony and I'm happy to answer any of the more kind of policy or technical questions if possible. And I'm also handing in two letters for people who couldn't be here from the Nebraska AIDS Project and the Family Planning Council of Nebraska. [LB577]

SENATOR KRIST: As a frequent testifier now, you always submit it next time you come back. [LB577]

JENNIFER CARTER: I know. [LB577]

SENATOR KRIST: So you'll start four instead of five. [LB577]

JENNIFER CARTER: Absolutely. I'll be very short. [LB577]

SENATOR KRIST: Let me just get this straight for the record, and I just want to put it out there. We're about to start a ball game and in inning 1, 2, and 3, we're at 100 percent payback. If we don't get in this ball game at inning 1 with the first pitch, we can't participate at all in those first three innings or first three years? [LB577]

JENNIFER CARTER: I think my understanding of it is that if we started and want to start it in 2015, we would get 100 percent for that year but then we'd only get 100 percent for two years. So we would have missed out on that first year of 100 percent and it'd be a lot less than the $2.3 billion that would be returned. I don't actually know what the figure would be, but. So it's more that as we delay, we're sort of missing out on that benefit. [LB577]

SENATOR KRIST: So you're going to make me play left field if I come in late. [LB577]

JENNIFER CARTER: Right. Exactly. [LB577]

SENATOR KRIST: All right. Thank you, Jennifer. Any other questions? Senator Gloor. [LB577]

SENATOR GLOOR: Thank you, Senator Krist. Jennifer, do you think current Medicaid rates make it difficult for Medicaid participants to see physicians? [LB577]

JENNIFER CARTER: I have not heard. We don't get a ton of calls about not being able to get in to see a doctor from clients that we know are on Medicaid. I would say that we do pay attention and are supportive of the idea that the rates have to really be enough to pay the cost for those doctors because we want to make sure there's meaningful access, and there's a meaningful access provision in the law in fact so that people really can see the doctors when they're on Medicaid. But we have not...it's not our experience that it's really difficult to get in to see a doctor. [LB577]

SENATOR GLOOR: Elaborate on the meaningful access issue if you would, please? [LB577]

JENNIFER CARTER: So my understanding of current federal Medicaid law is that you can't create barriers that would...Medicaid clients need to have meaningful access to care. So if you...I'm trying to think of a good example of what might get in the way of that. I mean, to some extent if you...if the state reduced Medicaid rates so far that everyone dropped out of Medicaid, there would be no meaningful access for people on Medicaid. Sometimes it's just a matter of creating barriers once you're on, maybe making a client jump through so many hoops that they never actually get in to see the doctor even if there were tons of doctors, that might affect meaningful access. So it really just bottom line means we're giving you the coverage, so you should be able to go see the doctor, and the state can't create barriers to that. [LB577]

SENATOR GLOOR: You don't think a look back saying that current rates of reimbursement are so low that that in and of itself presents a meaningful access. Maybe there's no way we know until somebody contests that component. [LB577]

JENNIFER CARTER: Right. And I think they have in other states, and this is where actually probably James in my office would have been the better testifier for this question, so we can absolutely follow up. But I think it is sort of determined by the courts to some extent. I don't think there's a set...and it's going to depend on the area as well, just geographically how many Medicaid providers do you have in that area. So, for example, if you wouldn't allow...maybe another example is if you wouldn't allow transportation, if somebody can't actually get to the doctor and you're not allowing them any transportation, you'd be interrupting their meaningful access to care, so. [LB577]

SENATOR GLOOR: Sure. [LB577]

JENNIFER CARTER: So sometimes it's been around issues like that. [LB577]

SENATOR GLOOR: Yeah. If you could check with James, I'd appreciate any information. [LB577]

JENNIFER CARTER: Sure. Yeah. Absolutely. [LB577]

SENATOR GLOOR: Thank you. [LB577]

SENATOR KRIST: Any other questions? Senator Howard. [LB577]

SENATOR HOWARD: Thank you. Thank you for your testimony. You passed out a letter from the Family Planning Council of Nebraska. [LB577]

JENNIFER CARTER: Yes. [LB577]

SENATOR HOWARD: And they talk about how Medicaid expansion could replace or support other programs. Can you speak to what programs Medicaid expansion would sort of supplant in this state? [LB577]

JENNIFER CARTER: I think, my understanding is to some extent there would be...because there's mental health parity, there would be greater coverage would be our hope for behavioral health. So that would cover a population that's not getting coverage for that right now. I do think to some extent there would be...right now we have coverage, for example, for pregnant women, and so it might be that now at least women up to 138 percent would be getting that. They don't get full Medicaid coverage now; they could under this program. So those are some of the things that I can think of. I think on one of the charts I think that you may have gotten may have also have some of the...I think the...I don't know if it's in...I didn't actually read Nebraska AIDS Project's letter, but I think there may be some savings there as well because there's a specific program to cover just drugs for that is my understanding, and I think that now people would get them, you know, more holistic care as a result. [LB577]

SENATOR HOWARD: Thank you. [LB577]

SENATOR KRIST: Thank you, Senator Howard. Senator Crawford. [LB577]

SENATOR CRAWFORD: Thank you, Senator Krist. And thank you, Jennifer, for you testimony. I just want to clarify two points. So one point that you're making is that the exchange and subsidies just simply don't apply for people who are under 100 percent of poverty. Correct? [LB577]

JENNIFER CARTER: Exactly. Right. [LB577]

SENATOR CRAWFORD: Now so we...then we do have people who are between 100 percent and 138 percent of poverty. [LB577]

JENNIFER CARTER: Correct. [LB577]

SENATOR CRAWFORD: And if we expand Medicaid, the people who fall in that window, that category, could either choose to be covered under Medicaid or choose to be on the exchange with subsidies. Is that true? [LB577]

JENNIFER CARTER: I will have to confirm this, but my understanding is that if you're eligible for Medicaid, I don't think you would get the tax subsidy, in part because of cost factors, so. [LB577]

SENATOR CRAWFORD: Okay. Okay. And...okay, good. So... [LB577]

JENNIFER CARTER: I wouldn't...sorry. [LB577]

SENATOR CRAWFORD: That's fine. So the law is saying that it is much cheaper for you to be on Medicaid than to get the subsidies, so we're going to make you pick that cheaper choice. [LB577]

JENNIFER CARTER: Right, exactly. [LB577]

SENATOR CRAWFORD: So we are Nebraska taxpayers, but we're also federal taxpayers. [LB577]

JENNIFER CARTER: Absolutely. [LB577]

SENATOR CRAWFORD: So is it fair to say that should we not choose to expand Medicaid, then we would be asking the federal government to pay a much higher price... [LB577]

JENNIFER CARTER: Right. [LB577]

SENATOR CRAWFORD: ...for those who are between 100 percent and 138 percent of poverty? I think I saw something that's maybe four times as much. Would you comment on that? [LB577]

JENNIFER CARTER: Yep. That's my understanding that it's about $3,000 more per person. [LB577]

SENATOR CRAWFORD: Per person in that 100 percent, 138 percent of poverty. [LB577]

JENNIFER CARTER: Yeah. And just generally to give a tax credit rather than covering people in Medicaid. And the other point is that realistically somebody at a 102 percent of poverty under the law still has to pay about 2 percent of their annual income to premiums. So you're going to...that's the population that will remain uninsured and really without access to care is going to be even, you know, above the 100 percent of poverty line, because they may be able to go into the exchange and make something work, but... [LB577]

SENATOR CRAWFORD: Right. So you're worried they wouldn't take advantage of the exchange. [LB577]

JENNIFER CARTER: Right. So you have... [LB577]

SENATOR CRAWFORD: But if they did... [LB577]

JENNIFER CARTER: Either it'd be more expensive for them to take advantage of it or we sort of have the expense keep driving the costs up in the way the uninsured and uncompensated care population does now. [LB577]

SENATOR CRAWFORD: Correct. But if they did, if they were covered, it would cost us more as federal taxpayers... [LB577]

JENNIFER CARTER: Right. [LB577]

SENATOR CRAWFORD: ...than if they were...if Nebraska expanded and we were paying instead that money into Medicaid expansion. [LB577]

JENNIFER CARTER: Absolutely. [LB577]

SENATOR CRAWFORD: Thank you. [LB577]

SENATOR KRIST: Thank you, Senator Crawford. Any other questions? Thank you, Jennifer. [LB577]

JENNIFER CARTER: Thank you very much. [LB577]

SENATOR KRIST: Next proponent for LB577. Welcome. [LB577]

ROWEN ZETTERMAN: (Exhibits 9, 10, and 11) Thank you very much. I'm Rowen

Zetterman, R-o-w-e-n Z-e-t-t-e-r-m-a-n, and I'm representing the Nebraska Medical Association. I also brought letters of support today from the Nebraska Academy of Physician Assistants, from the Friends of Public Health in Nebraska, and from the Cancer Action Network of the American Cancer Society. Nebraska Medical Association is the unifying physician organization for the state of Nebraska. And in 2007, the association developed a proposal to ensure that all Nebraskans had adequate healthcare coverage. The preamble of that proposal stated that all Nebraskans should have good access to timely and needed healthcare which emphasized good health habits, wellness and prevention, and that access to needed healthcare are social goods that contribute to the well-being of the state and all of its residents. At its 2012 annual meeting, the Nebraska Medical Association reaffirmed its support for Medicaid expansion as an important facet for ensuring that all Nebraskans have adequate coverage. So why is the association so interested in ensuring that all Nebraskans have adequate healthcare? It's because they know that patients without healthcare coverage have a 25 percent higher mortality than patients with insurance, are three to five times more likely to delay needed care for themselves and their children, and are more likely to skip preventive care, such as mammograms and pap smears for women and rectal examinations for men, or colonoscopy for both. They know that diabetics without healthcare coverage are 11 times more likely to have unexpected hospitalizations than those with adequate coverage, and that expectant mothers without healthcare coverage are more likely to delay routine prenatal care resulting in a three times greater likelihood of an adverse pregnancy outcome and a 30 percent greater risk that they'll have an infant that dies following delivery. We must ensure that all Nebraskans have access to healthcare coverage. In states where Medicaid coverage is similar to that of the proposed Medicaid expansion for Nebraska, patient mortality of those in the ages 34 to 64 years is reduced. And you've heard today that a similar reduction of mortality for Nebraska would mean that more than 500 Nebraskans annually would not die needlessly simply because they didn't have healthcare coverage. The distribution of the uninsured in Nebraska is split pretty much between the rural and the urban counties. And while Medicaid expansion will provide health coverage for an additional 50,000 to 80,000 Nebraskans, it will also produce an economic return of more than $700 million annually to the state, including 10,000 jobs. That also means that Medicaid expansion will allow medical offices to hire additional team members to supplement our healthcare practitioners in providing primary care needs for these patients. In summary, Medicaid expansion will provide routine and preventive care to more Nebraskans, will reduce costly hospitalizations and deaths of Nebraskans, will have a positive economic advantage for the state of Nebraska, and allow our practitioners to provide enhanced, team-based care for their patients. Why would we consider turning down such an important opportunity for the health of Nebraska? We should do what is best for Nebraskans. Thank you very much for the opportunity to speak on behalf of the physicians of the state and of the other healthcare providers in Nebraska. [LB577]

SENATOR KRIST: Thank you. Any questions? Senator Gloor. [LB577]

SENATOR GLOOR: Thank you, Senator Krist. And thank you, Dr. Zetterman. Can any physician practice you know or survive on 100 percent Medicaid reimbursement? [LB577]

ROWEN ZETTERMAN: They would have to do it very carefully. There's no question about it. We all...that's part of where the cost shifting occurs, of course, with healthcare revenues. [LB577]

SENATOR GLOOR: Sure. [LB577]

ROWEN ZETTERMAN: That doesn't mean we shouldn't do this because they still, if they provide the care with no money coming into those offices, the ultimate cost overall for their patients goes up and they have no reimbursement in which to provide that. So the additional revenue actually should benefit them. We need better team care in most primary care offices, and so any way that we can enhance revenues in those offices, even with Medicaid dollars, they'll be better off. [LB577]

SENATOR GLOOR: Well, and I agree with components of that. I'm your patient-centered medical home advocate in the Legislature. So I do think changes in the way we provide care, a system where we provide care can make a difference. But, yeah, there is cost shifting. My concern is...and you don't want to talk yourself out of helping the lobby for higher reimbursement rates here. So I'm just...be careful. (Laughter) [LB577]

ROWEN ZETTERMAN: I guarantee you we'll all speak on behalf of that, even for commercial insurance, if you really want to know. [LB577]

SENATOR GLOOR: Yeah. Here's my concern. At the current reimbursement rates Medicaid provides, and most physician practices I know of are doing the best job they can as you point out trying to take Medicaid patients, are we giving people an access card to health services that's difficult to redeem? [LB577]

ROWEN ZETTERMAN: You know, I think, first of all, I'd need to know more particulars about what you're proposing. I think the problem of my concern for tax credits, as an example, is it now requires additional money often for those people and an extra activity, whereas Medicaid expansion actually allows them to have access fairly easily in filling out the forms and getting it done. So that...I'd have to know more about what you're proposing really to answer your question. [LB577]

SENATOR GLOOR: Well, it's a pretty straightforward formula. It's current reimbursement rates plus an increased population seeking using Medicaid services doesn't necessarily equal those folks being able to get in and see providers. That's my

concern. [LB577]

ROWEN ZETTERMAN: Well, you know, I think if you look at it on what the absolute need is, the 50,000 new patients, it would take about 25 providers in the state of Nebraska to take care of those 50,000 people. The typical family physician generally cares for about 2,000 people in their practice. That's really not very many when you think about it just on a straight individual basis, and then think about spreading that out across to several thousand physicians of the state in order to take care of those 50,000. I believe that it's imminently doable. [LB577]

SENATOR GLOOR: So we have 50 new slots for family practice that you know of in the state of Nebraska that have opened up all of a sudden? [LB577]

ROWEN ZETTERMAN: If we can (inaudible) reimbursement, which you're now proposing, and (laughter) we'll do that. We clearly have to do that. You know, it's interesting. There is an expansion of GNO (phonetic) for primary care reimbursement in the bill. At this point today, I don't believe any state has yet taken advantage of it--including Nebraska--to increase payment to the physicians even though the money is actually there and in the bill. [LB577]

SENATOR GLOOR: Good point. Thank you. [LB577]

SENATOR KRIST: Thank you, Doctor. Any other questions? Okay. I'm sorry. Senator Howard. [LB577]

SENATOR HOWARD: Just to piggyback on what Senator Gloor because he always gives me good ideas. Are we doing this in the wrong order? Should we be talking about provider rates before we talk about Medicaid expansion? [LB577]

ROWEN ZETTERMAN: You know, I truly believe that when you look at the overall issues of costs and other things within the healthcare system, we'll never be able to solve the issues of cost and how to control cost until every patient is actually covered under some sort of mechanism within the system. So my personal belief is let's get everybody into the system, and then let's begin to look at the issues of cost and how we're going to take care of those issues. [LB577]

SENATOR HOWARD: Thank you. [LB577]

SENATOR KRIST: Senator Crawford. [LB577]

SENATOR CRAWFORD: Thank you, Senator Krist. I wondered if for the record and for the people watching and listening if you could just clarify the last point that you had made about resources available for improving reimbursement that we're not taking

advantage of. [LB577]

ROWEN ZETTERMAN: It's an area in which I have limited knowledge. But as I understand the current bill, it is a 10 percent increase for the first two years for primary care physicians, family physicians. I think that's family physicians, pediatricians, general internist, obstetricians in providing care. We have to apply for the federal money that comes along with that as I understand. And I think that's in Medicare, in Medicare and Medicaid both. [LB577]

SENATOR CRAWFORD: So it's money that we would need to apply for to receive. [LB577]

ROWEN ZETTERMAN: For Medicaid. That's correct. [LB577]

SENATOR CRAWFORD: If we receive it, we would be able to provide those higher reimbursement rates. [LB577]

ROWEN ZETTERMAN: That's my understanding. But I have to be honest and tell you that I need more information to really give you the perfect answer. But I do know the latter is true. No one's applied for it yet. [LB577]

SENATOR CRAWFORD: Thank you. [LB577]

SENATOR KRIST: Anybody else? Thank you. Thank you, Doctor, for your testimony. [LB577]

ROWEN ZETTERMAN: Thank you. [LB577]

SENATOR KRIST: Next proponent. Welcome. [LB577]

SHARON LIND: (Exhibit 12) Thank you. Thank you, Senator Campbell and Senator Krist for the opportunity to be here today. My name is Sharon Lind, S-h-a-r-o-n L-i-n-d. I am the chief executive officer of Ogallala Community Hospital testifying on behalf of the Nebraska Hospital Association and its 89-member hospitals in support of LB577. Implementation of the Affordable Care Act will cost our nations's hospitals $155 billion over the next ten years in reduced Medicare reimbursements. Nebraska's share of those reductions is an estimated $856 million. In 2012, the United States Supreme Court changed the rule when it decided that the federal government should not force states to expand Medicaid eligibility, making an expansion in each state optional. Some opponents are concerned that the federal government will not live up to its financial obligation. Current Medicaid eligibility is a means-tested program that provides health coverage for low-income individuals. Expanding Medicaid would encourage the newly eligibles to see a doctor and receive more appropriate care at a more appropriate time,

care that is less expensive than being treated in the emergency room. Furthermore, expansion will lead to a stronger economy where more Nebraskans will be able to work and more children will be ready to learn. Excuse me. If Nebraska fails to expand Medicaid, it will leave billions of dollars on the table, billions of tax dollars paid by Nebraskans that will go to other states. Nebraska hospitals lost millions...hundreds of millions of dollars each year because of bad debt, charity care, and uncompensated care for Medicare and Medicaid. In 2010, Nebraska hospitals absorbed more than $209 million of bad debt. On top of bad debt, Nebraska hospitals provided charity care in excess of $162 million. Public programs like Medicare and Medicaid reimburse hospitals less than the cost of providing care. This means that for every dollar it costs a hospital to provide Medicaid services, they are reimbursed at 74 cents. Bad debt and charity care coupled with less-than-adequate compensation for Medicare and Medicaid affect the cost of private health insurance. As the Legislature provides Medicaid expansion...considers, excuse me, Medicaid expansion, the Nebraska Hospital Association urges the Unicameral to take into consideration the additional federal cuts that have already been imposed on hospitals since the ACA was signed into law, together with more cuts currently under consideration by Congress. In addition to the $856 million cut in Medicare reimbursements imposed by the Affordable Care Act, Nebraska hospitals will incur sequestration costs of $275 million, bad debt payment reductions of $30 million, and coding adjustment losses of $114 million through 2022. Collectively, those represent lost revenues of more than $1.25 billion. Additional Medicare cuts currently under congressional consideration would reduce hospital reimbursements by another $672 million. Medicaid expansion will improve the public health and make fiscal sense for Nebraska. This is...that has been determined by other states where some of the most vocal critics of the Affordable Care Act and Medicaid expansion have reversed their stances, justifying the position change because the expansion will not only save lives, but also creates jobs and stimulates the economy. Nebraska Hospital Association and its member hospitals support Medicaid expansion. Failure to do so will come at a high price. Healthcare providers will be forced to continue to absorb more bad debt and charity care. Without expansion, the provider network will become more fragmented. More importantly, if the state decides not to expand Medicaid, it will turn its back on billions of dollars of federal assistance, depriving many individuals of the opportunity to improve their health and preventing them from being able to work and learn. Thank you for the opportunity to comment on this important matter. [LB577]

SENATOR KRIST: Thank you for your testimony. Is there a relationship between the Medicaid expansion and patient-center medical homes in our population health? [LB577]

SHARON LIND: There is. Our providers, we believe in that if we get more folks on a plan, we can influence how they access care and we can influence the minimizing of delay in care and impact their health in a positive way, getting them a line through a

primary care provider, managing their chronic diseases differently, looking at patient-centered medical homes. If we have folks that can't get to our clinics or hospitals, how do we find a way to get there and monitor their health, make sure they're on their medications, make sure they're on their treatment plan? So providing an opportunity to be, for us as providers, more engaged in that patient care, patient-centered medical homes, and population health management provides the mechanism to do that. It helps us by getting folks on Medicaid. The mechanism exists. Allowing folks to get on a plan allows us to transform that delivery of care and influence how they access it. Reducing our ER...currently it's episodic. When it's a crisis, they access care through the ER, end up with an inpatient stay. It allows us to manage that in a very different way through our primary care providers. It stabilizes the network, helps us influence that delivery model, transform it in a different way, because the current model is not sustainable. And so allowing us the opportunity to do that will contribute to how we influence that population health management and the health of our communities. [LB577]

SENATOR KRIST: Thank you. Any other questions? Senator Gloor. [LB577]

SENATOR GLOOR: Thank you, Senator Krist. Probably just one line of questions for you, Sharon. By the way, you have a tough job, and the smaller the hospital, the tougher the job as far as I'm concerned. So thanks for the work you do. [LB577]

SHARON LIND: You're welcome. [LB577]

SENATOR GLOOR: But you talked about emergency rooms. So if we expand Medicaid coverage, are you going to close down your emergency room? [LB577]

SHARON LIND: Not at all. Our emergency room exists to take care of emergent cases. And oftentimes what we're seeing is nonemergent cases coming into the ER, folks who are not aligned with a physician or a clinic, and that's how they access care. And often we're seeing delays in that care. We're proponents for expanding the eligibility because it allows us to have more insured, covered lives. And when we have more covered lives, we can manage their care very differently. [LB577]

SENATOR GLOOR: I have two biases, and so let me put them out there for you and have you shoot them full of holes if you want to. A lot of the folks who access primary care through the emergency room do it for a number of reasons. And quite frequently it has to do with both mom and dad or mom or dad can't get off work to take themselves or their kids in to emergency rooms (sic). So mom comes home from a busy day, hasn't had time to make your traditional appointments between 8:00 and 5:00 and uses the emergency room. I don't know that that's going to change at all when somebody has Medicaid coverage. So that's one of my biases is that there is an issue of access that has something to do with coverage, but it also has an awful lot to do with how difficult it

is for people to make the time in a busy working life. And we're talking about a population here who usually gets paid by the hour, and leaving work usually means taking money out of their paycheck. And now armed with Medicaid, they at least don't have to worry about having a bill when they go to an emergency room. So that's one issue that has me concerned that we may not see much of a change in those numbers. That's number one. Number two is, as you've said, emergency rooms are there for emergency services. And if we were to wipe the slate clean of all the inappropriate usage of emergency rooms, we still have to have an emergency room, and we still have to have staff to provide some care. We still have to have equipment to take care of the car accidents and the heart attacks. And I think some of the savings that are tossed out there about emergency room use and savings as a result of that don't take into consideration the fact that emergency rooms still have to be built on hospitals. It's a requirement you have by way of licensure. And those dollars, although it's not appropriate to use emergency rooms, it's not the best way to provide care, as you've already pointed out. It's still likely to be the most convenient access point for most people to use. Any comments you want to make about that? And I know I've...two not too simple points that I've made there and I haven't done it concisely either, but that's me. I'm kind of that way. Sorry. [LB577]

SHARON LIND: And that's all right. I understood. First off, you're talking about the human behavior and that component of taking responsibility for healthcare and folks being accountable to that. And as providers, our member hospitals, we understand that until they get on a plan, the plan requires them to do certain things like be aligned with a primary care doctor, participate in their healthcare. So until we provide a mechanism for the working poor to have the ability to be on an affordable plan and participate in that, not a lot is going to change in that circle of care, in that environment. So it provides us a mechanism, a built-in mechanism for that human behavior and that accountability. As providers, we have to be accountable to be having access to those Medicaid patients. There is a requirement that there's not a delay in having care. It is part of participating in the program. So we need to make sure we have the providers, that we have block schedules. We run some of our clinics after hours. We have urgent care settings. We have Saturday morning clinics. We do that for a reason, to provide additional hours of access to care. So as we look at the model, at transforming that model, the focus really needs to be on how are they accessing care. And if we can get it aligned with a clinic and a provider and manage preventive health, chronic diseases, everything that drives our high cost in the ER in our inpatient stays, we can have the efficiencies built in. We're still going to need the ERs for that urgent care, but we can have some of the built-in efficiencies and the cost savings relative to how we manage that care. And that produces lower costs for us as providers. But we have to have the opportunity to transform that model, and the way to do it is to get more insured lives aligned with the physicians. [LB577]

SENATOR GLOOR: So you think the reimbursement rates right now would give you

enough oomph, enough dollars to be able to undergo that transformation. [LB577]

SHARON LIND: I think if we...our member hospitals would find it reasonable if we stabilize the rates but had more insurers, because currently those uninsureds are receiving charity care. It's 100 percent uncompensated care to us. So having them on Medicaid and getting some payment, that would otherwise be charity care, is a benefit to us. [LB577]

SENATOR GLOOR: So here's a case where you think you could make it up on volume. I mean, not to be... [LB577]

SHARON LIND: No, not necessarily. [LB577]

SENATOR GLOOR: Okay. [LB577]

SHARON LIND: Not necessarily. But we'd be getting reimbursement for insured lives that are otherwise charity care that we get no reimbursement for. So if we want to maintain a level of access and services, the additional reimbursement will be a positive thing. There should be a correlation between as we see folks on Medicaid and an increase in insured lives or Medicaid, we should see a correlation of our charity care and bad debt decreasing. [LB577]

SENATOR GLOOR: Okay. [LB577]

SHARON LIND: That should come. [LB577]

SENATOR GLOOR: We'll be watching closely, I'm sure, if we make the move. I mean, it...you're right. [LB577]

SHARON LIND: That should come. [LB577]

SENATOR GLOOR: That almost has to be there for the financial models we've given to work, it has to be. It has to be. Thanks. [LB577]

SHARON LIND: And during that time line, we have to be committed and courageous to redesign and transform the model so that it's very efficient and very low cost and very high quality. [LB577]

SENATOR KRIST: We had a discussion like this not just too long ago, in fact, yesterday. (Laughter) And my point was it's going to be up to very creative and very courageous CEOs like you just described. So bravo. Senator Crawford. [LB577]

SENATOR CRAWFORD: Thank you, Senator Krist. And I echo Senator Krist's

comments. And so my question to you, it will take CEOs like you being willing to do the planning and the effort to make that transition. So I would ask, is it the case, is your hospital right now preparing plans for how you're going to transition the care out of emergency room and into urgent clinics and Saturday morning clinics? Are you meeting together and do you...have you been doing strategic planning on how to make this transition work? [LB577]

SHARON LIND: Indeed we have. And I can speak specifically to our rural health environment, and we are part of Banner Health. And we understand the current model is not sustainable. We're working with our medical staff. We have after-hours clinic. We have Saturday morning clinic. We have a medical staff who understands the future is patient-centered medical homes and population health management. Our physicians do nursing...rounds in the nursing home as well as our ER physicians on the weekends if our family practice are unavailable. Oftentimes residents have difficulty getting to the clinic or the hospital until there's been a delay which lands them in the ER in an inpatient stay. So our medical staff, inclusive of ER physicians, are doing rounds in the nursing homes. We are working on in western Nebraska, I would share with you, a collaborative model with our assisted living, nursing home, home health, and public health districts to really partner on a provider that can serve the community needs, setting up that population health management model. And our medical staff is very much on board with that because they understand the future needs to change. [LB577]

SENATOR CRAWFORD: Excellent. I appreciate your hard work in that area. [LB577]

SHARON LIND: Thank you. [LB577]

SENATOR CRAWFORD: Thank you. [LB577]

SENATOR KRIST: Thank you, Senator Crawford. Any questions? Senator Howard. [LB577]

SENATOR HOWARD: Thank you. Thank you for your testimony. You mentioned that Ogallala was...had extended hours and urgent care. Is that something that your hospital is the only one who's doing that or is that a movement across the state? [LB577]

SHARON LIND: That is a movement across the state and our member hospitals do the same thing. We've got urgent care centers where folks can have access. We utilize our PAs, our midlevels in those clinic environments, but we are not alone in that. And it's across the state in all rural and urban markets. The after-hours clinic, early morning, or later in the evening, that provides the access to care and minimizes the overutilization of the ER, if you will. [LB577]

SENATOR HOWARD: Thank you. [LB577]

SENATOR KRIST: Thank you, Senator Howard. Senator Gloor. [LB577]

SENATOR GLOOR: Thank you, Senator Krist. Just one quick question. Is your urgent center a proprietary or a not-for-profit venture? [LB577]

SHARON LIND: Not-for-profit. [LB577]

SENATOR GLOOR: Okay. [LB577]

SHARON LIND: And we're not an urgent center, but we have after-hours clinic. So we're not a "urgent care center," but we have after-hours clinic. [LB577]

SENATOR GLOOR: Is there an urgent care center in Ogallala? [LB577]

SHARON LIND: There is not. [LB577]

SENATOR GLOOR: Okay. Thank you. [LB577]

SENATOR KRIST: Any other questions? Thank you for driving in. [LB577]

SHARON LIND: Thank you. [LB577]

SENATOR KRIST: Next proponent. Welcome. [LB577]

MARY ANN BORGESON: (Exhibits 13, 14, and 15) Hello. Good afternoon, Senators. Thank you for having me today. Mary Ann Borgeson, M-a-r-y A-n-n B-o-r-g-e-s-o-n. I am here wearing multiple hats today. I'm here as the chair of the Douglas County Board of Commissioners. I'm also here to speak on behalf of NACO, the Nebraska Association of County Officials, which wants to make the statement that they're in support of LB577. While all counties may benefit differently, we are in support and see a benefit of the Medicaid expansion program. I will read to you, not the whole thing since you have it, but Lancaster County has asked me to read into the record part of their letter. The expansion of Medicaid under LB577 will result in tremendous savings to the property taxpayers of Lancaster County. For this reason, the Lancaster County Board of Commissioners supports this legislation. Last fiscal year, Lancaster County spent $2,114,115 on medical needs of general assistant clients. It must be noted this figure does not include the cost of behavioral health services for general assistant clients, which is absorbed in the budget of the Lancaster County Community Mental Health Center. Conservative estimates place this cost between $600,000 and $700,000. We expect this cost to increase this fiscal year. Expanding Medicaid eligibility under the Affordable Care Act will provide medical coverage for virtually all of Lancaster County's general assistant clients, with potential annual savings of $2.8 million to our property

taxpayers. As far as Douglas County goes and as far as you all know, we're a creature of the state. We do what the state administers and tells us...or we administer what the state tells us to do. Many of those come down as unfunded mandates. Where we see potential savings for the taxpayers of not only the state of Nebraska, but Douglas County specifically, is in our general assistance primary healthcare clinic. Right now, we would be able to say that we would have about a $2.1 million savings in serving those clients in our primary healthcare clinic that would be covered by the Medicaid expansion. Through our Douglas County Health Center and the ancillary services that we provide to our primary healthcare clinic, which include the pharmaceutical cost, would be a savings of about $1.3 million. The Community Mental Health Center, which is...there are many of the clients that we serve already covered by Medicaid, but their pharmaceutical costs are not, they hence would be covered at about a $300,000 savings, which would be a grand total for Douglas County of about $3.8...nearly $4 million. There is also in our Department of Corrections, we are responsible also to provide the medical care to the inmates. One potential thing we're working with the federal government through our national association is that...to eliminate the inmate exception rule. As you well know, when someone enters a correctional facility, if they're covered by Medicaid, that's either terminated or suspended for the time that they're incarcerated. What we're trying to see is if the federal government would release that exception to say until sentencing, so that they step foot in a facility, they would still be covered which we provide right now at 100 percent through property tax dollars, the cost from the time they step foot in to the time that they're...continuing on. So we're still looking at what benefits this would be for our health department. And across the state, if a county has a county hospital, we--through the Affordable Care Act--are going to be losing our DSH payments. That equates to about a $300,000 loss for Douglas County. The Medicaid expansion program would, again, be an area which would benefit to us for another source of revenue. [LB577]

SENATOR KRIST: Excellent. You're the first that's mentioned DSH, so I'm going to pick on you. When you look at the ACA and you look at the many-legged stool, they took from here and they gave to here and they took from here and they gave to there. So essentially DSH was something that you depended upon and now it's gone. So if you don't take advantage of all the legs of the stool, you're going to be knocked off of it. Could you...do you want to talk about that for just a second? [LB577]

MARY ANN BORGESON: That, again, is at that $300,000 right now. Through our long-term care...our health center, Douglas County Health Center, has three very distinct services in which is provided out of that center. It's not a hospital. We provide assisted living, long-term care. We provide our Community Mental Health Center, which provides outpatient, partial day, and inpatient, and then we have our primary healthcare clinic. The DSH payment is for and through our long-term care component that we are able to get reimbursed for that because of the disproportionate share of indigent people that we serve. So, yes, we would lose that $300,000 no matter what. [LB577]

SENATOR KRIST: In your other efforts you mentioned in terms of providing medical treatment until sentencing gives new meaning to innocent until proven guilty I think... [LB577]

MARY ANN BORGESON: That's right. [LB577]

SENATOR KRIST: ...which is probably a good question to ask. [LB577]

MARY ANN BORGESON: Yes. [LB577]

SENATOR KRIST: Any other questions for Commissioner Borgeson? Senator Howard. [LB577]

SENATOR HOWARD: Thank you. Thank you. In the last sentence on the Lancaster County Board of Commissioners, you mention that expanding Medicaid eligibility could see a potential annual savings of $2.8 million for property taxes. Are you suggesting that Medicaid could...that Medicaid expansion could lower property taxes? [LB577]

MARY ANN BORGESON: Yeah. We were actually asked when we met with the Governor on this if we would be willing to put on the table a dollar-for-dollar savings in property tax dollars through this. And I answered no (laughter), and the reason is is because if you look back historically, even the last three to five years, the state aid to counties has been cut. We've been able, I think, across the state to show that we've been very frugal with our dollars and able to not raise taxes willy-nilly in order to make up those shortfalls. This could potentially be freed up dollars that we would be able to move to areas that, again, we're currently mandated to do and not receive any funding from the state for. [LB577]

SENATOR HOWARD: And then you work a lot with Region 6 as well. [LB577]

MARY ANN BORGESON: Yes. [LB577]

SENATOR HOWARD: Do you see any potential savings through the region's system as well? [LB577]

MARY ANN BORGESON: There potentially could be. And, again, it all depends on how many sign up and as quickly as they get signed up. But through Region 6, the counties are mandated to match what the state provides. If those dollars of match are now covered by Medicaid expansion, the counties would see potential savings there as well. [LB577]

SENATOR HOWARD: Thank you. [LB577]

SENATOR KRIST: Thank you, Senator Howard. Any other questions? Thank you, Commissioner. [LB577]

MARY ANN BORGESON: Thank you. [LB577]

SENATOR KRIST: I learned another technical term--willy-nilly. (Laughter) That's good. Next proponent. [LB577]

NANCY FULTON: (Exhibit 16) Good afternoon, Senator Krist, Senator Campbell, and members of the committee. I'm Nancy Fulton, N-a-n-c-y F-u-l-t-o-n, and I'm a 34-year classroom teacher, but now I am serving as president of the Nebraska State Education Association. I'm here today on behalf of our 28,000 members. Those include teachers, support staff, faculty, and retirees in support of LB577, which would expand Medicaid coverage to low-income, working people. I taught third grade in Wilber-Clatonia. I know firsthand that the key component to a successful classroom environment is healthy children and healthy staff members. They can then focus on the physical, intellectual, and emotional energy for learning. A child, a parent, a para-educator, or a secretary that does not receive the preventative care and comes to school sick jeopardizes the whole learning environment. There are those that would pit healthcare against education. I would propose that they work hand in hand. At NSEA, we believe that healthy children, parents, and staff are the essential components to our ability to provide students with a quality education. So on behalf of the students, the parents, and staff of Nebraska, I respectfully ask that you do advance LB577. As you've heard earlier today, it's the right thing to do. Thank you for your time and for your support of children and education. [LB577]

SENATOR KRIST: Thank you, Nancy. I would just like to say I've read several op eds and editorial pieces lately that would say we are doing this and taking money away from the kids and away from education. And my question would be either to you or any other part of your staff at NSEA, how do we take this money and use it for education? And think the answer is it can't be done, it's different color money. But what you're telling us today is it's a component of education to have a healthy kid in the classroom. And you feel free to comment on that if you'd like to. [LB577]

NANCY FULTON: And I think that's absolutely right. If a child comes to school with an earache and their parent says, I don't have money to take you to the doctor, go to school. That child is not going to be learning that day. I mean, they're going to be sitting there, you know, holding their head and crying and...I mean, because if anybody is ever suffered from an earache, of which I can sympathize with, that's very painful. [LB577]

SENATOR KRIST: Thank you so much for your testimony. Any other questions for Nancy? Thank you. [LB577]

NANCY FULTON: Thank you. [LB577]

SENATOR KRIST: Next proponent. Hi. Welcome. [LB577]

BEATTY BRASCH: (Exhibit 17) Thank you very much. My name is Beatty Brasch, B-e-a-t-t-y B-r-a-s-c-h. As executive director for the Center for People in Need in Lincoln, Nebraska, LB577 expanding Medicaid is a win-win situation for our state's economy and the needs of our most vulnerable citizens. LB77 (sic LB577) would extend Medicaid eligibility to more than 54,000 Nebraskans currently without health insurance. We see these individuals on a daily basis at the Center for People in Need. They are trying to do right by working hard and providing for their families. These working poor make too much to qualify for Medicaid, yet too little to afford health insurance premiums. When they need medical services, they go to the emergency room for treatment, the most expensive source of medical care, and we wind up paying for uncompensated care. The Affordable Health Care Act gives Nebraskans a chance to rectify this problem by expanding...paying for expanded Medicaid eligibility. This is important because poverty is a tremendous problem in our state. In Lincoln alone the numbers tell a sobering story. According to the 2011 Census Bureau survey, 16 percent of Lincoln's population lives in poverty. That is more than 30,000 people. Of those, 45 percent live in extreme poverty. By expanding Medicaid, we can take advantage of federal resources to better serve those living in poverty. Medicaid expansion would be paid for by the federal government through 2016. After that, the federal government would pay 90 percent of the costs. Current programs provide for care for cancer patients, people with disabilities, pregnant women, and so others. So Nebraska is already paying for any increased costs that later would be associated with Medicaid expansion. Further, property taxes in the three largest counties also fund healthcare services for the uninsured at a cost (inaudible) of nearly $8 million a year. Expanding Medicaid will result in significant savings for state and county programs. In addition, Medicaid expansion would pay...add $700 million to Nebraska's economy over the next six years sustaining nearly 10,000 jobs. So the question before you today is really whether you accept federal resources to take care of legitimate state needs or whether you will leave those dollars with the federal government. Governors and state legislators around the country, regardless of political party, are concluding the same thing--Medicaid expansion is the right thing to do. It comes down to the best interests of the state. The decision to expand Medicaid should be an easy one. At the Center for People in Need, we ask you to do the right thing--move LB577 out of committee. [LB577]

SENATOR KRIST: Thank you, Ms. Brasch. Any questions? Senator Crawford. [LB577]

SENATOR CRAWFORD: Thank you, Senator Krist. And thank you for your work and for being here to testify today. Could you see any way that the Center for People in Need would be involved in helping to educate families, educate parents to help them be able

to better use newer models of care that we just heard about? One of the issues is if we expand access, will we really get care in more appropriate places or not. Could you...I don't know what all services you provide or what you do. [LB577]

BEATTY BRASCH: Yeah. [LB577]

SENATOR CRAWFORD: Do you see that as some piece of that puzzle that we need to solve in Nebraska that your organization could play a role in? [LB577]

BEATTY BRASCH: Absolutely. We already run the health hub through the Community Health Endowment, and there we help people navigate the healthcare system right now which is very complicated. We also, we see 30 percent of the low-income families in Lincoln, I think 70 percent of the low-income individuals. And we would absolutely be handing out materials consistently and encouraging people to take advantage of it. And we have access to a lot of people. And also through the other human service agencies we'd be a very active role in doing that. [LB577]

SENATOR CRAWFORD: We count on that. [LB577]

BEATTY BRASCH: Okay. I promise. (laughter) [LB577]

SENATOR KRIST: Thank you, Senator Crawford. I'm aware that you're instrumental in trying to navigate and trying to help people with ACESSNebraska, which is much appreciated. [LB577]

BEATTY BRASCH: Yeah. [LB577]

SENATOR KRIST: Thank you very much. [LB577]

BEATTY BRASCH: We're delighted to do it because it's a huge problem for people and if we can make it a little bit easier for them, we're very happy. And we appreciate your support and hope that this bill goes through. We're excited about the potential. Thank you. [LB577]

SENATOR KRIST: Next proponent. [LB577]

RUSSELL GRONEWOLD: (Exhibit 18) Good afternoon, Senators. My name is Russ Gronewold, R-u-s-s G-r-o-n-e-w-o-l-d, and I'm the chief financial officer for Bryan Health. I'm speaking today on behalf of Bryan Health and Alegent Creighton Health. I read with great interest this past Sunday of the expose in the Lincoln Journal Star about the effort to feed the poor and most vulnerable residents in Lincoln. Due to the incredible amount of donations and volunteerism, the community is able to provide a minimum amount of sustenance necessary for at least most of those families. These

same families require healthcare. And while we rely on donations and volunteerism, they're not enough to take care of the high levels of training and technology that today's health system requires. Larger hospitals, such as Bryan Health and Alegent Creighton Health, have long served that safety-net role. And, in fact, one of four patients at Bryan Health is either Medicaid or uninsured; at Alegent Creighton Health, it's one in five patients. Now hospitals of all sizes across the state in all communities provide that safety-net role. I just want to give you four reasons why larger hospitals in particular are interested in the Medicaid expansion. The first is a loss of disproportionate share of dollars that was mentioned just a moment ago. The idea of having additional funding through the Medicaid program would be funded by cutting those disproportionate share dollars. At Bryan Health, that's as much as $25 million over the next five years; at Alegent Creighton Health, that's $36 million. Without the expansion of Medicaid, the worst of both worlds materializes; that meaning, we will still continue to provide those services to those in need, but with much fewer resources to do so. At $5 million roughly a year at Bryan Health, that's equivalent to the salaries of roughly 100 caregivers in a year. The second reason is more appropriate access. Today when the uninsured come to seek care at one of our facilities, 86 percent of the time they come through the most expensive door in the hospital, and that's the emergency room. That compares with about 36 percent of the commercial market; 62 percent of the Medicaid market. By getting those uninsured folks linked up with primary care providers, we believe that we can expect more appropriate utilization, lower overall healthcare costs, and reduced crowding in our emergency departments. A third reason in the unique services and service areas tertiary hospitals like ours provide. We serve patients way outside of our immediate communities, from literally from one end of the state to the other. And, in fact, charity care at Bryan Health, a full one-third of it is provided to folks outside of the Lincoln-Lancaster area. Part of that is because we have services that demand greater or that cover greater geographic areas. Behavioral health, for example, at both Alegent and at Bryan Health, we are the sole provider of those inpatient services for surrounding regions. And, in fact, 43 percent of our patients are either Medicaid or uninsured in that service area, and at Alegent Creighton Health it's 50 percent. Similarly when we look at tertiary services like trauma, like oncology which cover large geographic regions, very large portions of charity care are written off to those areas as well. Finally, the whole area of the changing insurance and economic landscape is an important reason for us. Seventy-four percent of our charity care comes from the uninsured area. From 2010 to 2011, charity care write-offs grew by 50 percent for those folks who make under 200 percent of the poverty level. That's where we provide a complete write-off of a person's bill at 200 percent of the poverty level. It grew for 25 percent for those folks in bankruptcy. But the interesting part is the fastest growing sector of charity care write-offs is in fact those folks with insurance. While the dollars aren't as big, the percentage growth is much faster. Those folks who now have high-deductible plans with deductibles of $1,000 to $10,000. Under the health exchange portion of the ACA, we will...we expect a large number of folks to convert from traditional insurance to high-deductible plans and, therefore, we'll see a very large explosion in those write-offs,

which is in fact those deductibles where most of healthcare occurs. As mission-driven hospitals, not-for-profit hospitals, we have always taken care of the vulnerable and we see firsthand not just the amount of the folks coming in, the large unmet need, but also the cost associated with it. The passage of LB577 will assist Nebraska and our hospitals in continuing to provide the best and most appropriate care to not just the most vulnerable, but to all who require it. Thanks for your consideration. I'd be willing to take any questions. [LB577]

SENATOR KRIST: Senator Crawford. [LB577]

SENATOR CRAWFORD: Thank you, Senator Krist. And thank you for your testimony. We've heard some people discuss how they think it takes getting more people in the model before you see changes. I wanted to...I think you said there's somewhere around 60-something percent of Medicaid patients currently are still using emergency room access. [LB577]

RUSSELL GRONEWOLD: Um-hum. [LB577]

SENATOR CRAWFORD: And so if we expand Medicaid, how confident are you that we'll get the emergency room use of this expanded pool to now, to come below that 60 percent? [LB577]

RUSSELL GRONEWOLD: Yeah. The 86 percent is the number the uninsured today. And so, you know, we... [LB577]

SENATOR CRAWFORD: Sure. Right, right, right. And they could become then... [LB577]

RUSSELL GRONEWOLD: We do believe that we could bring that down from the 86 percent to the 62 percent. We're continuing to get creative with how we go about bringing that 62 percent down further. For example, we have a program called E.D. Connections where we see those sort of, you know, frequent fliers in the emergency room where we try to hook them up with primary care physicians. And we've been able to do that. We found primary care physicians who are willing to do that. And when we've been able to do that, we have reduced dramatically the amount of times those individuals come into the emergency room. But it really is, then, at that point, a one-on-one, you know, working with individuals to get it down and trying to develop programs that we can really work with people one on one. [LB577]

SENATOR CRAWFORD: And do you have a plan in place, strategic planning, in place for how you're going to change the interaction of people coming into the emergency room should Medicaid expansion happen? [LB577]

RUSSELL GRONEWOLD: Well, the answer is yeah, that planning is going on all the time; and not just with Bryan Health, but with community resources. I'm sure the same is probably the case with Alegent Creighton Health as well. We work with the local residency program. We work with People's Health here in town. And together we're completing those kinds of assessment. We are looking at new ways to get folks hooked up with those resources. You know, again, I think it was mentioned before, a number of folks are eligible for Medicaid that don't avail themselves of it. And so we have plans in place, actually I have been doing this now for a couple of years, where we are identifying those individuals, helping them get enrolled and get to those benefits; and then, again, getting them hooked up with the appropriate resources, in this case hopefully a primary care physician. [LB577]

SENATOR CRAWFORD: Do you feel you have...how many primary care physicians do you have access to for new patients coming in to get...that you would be able to try to hook these new patients into to allow the new patients to have access to a primary care physician? Do you feel there are existing, is there existing space, existing capacity to link new patients into those relationships? [LB577]

RUSSELL GRONEWOLD: Well, when it comes to the primary care physicians, we haven't had a problem thus far. I mean, we have found that generally as we've worked hand in hand with the physicians, they've been willing to take sort of their fair share. Where their concern is where they're getting dumped on. And so they don't want to be the one or two or handful of doctors that have to take all of them by being generous. And so it really does kind of mean that we have to work together with a large number of them. So far we've been able to do that. [LB577]

SENATOR CRAWFORD: Thank you. [LB577]

SENATOR KRIST: Senator Gloor. [LB577]

SENATOR GLOOR: Thank you, Senator Krist. Russ, thank you for taking the time. And I've been out to Bryan and been tutored in E.D. Connections. Am I saying it right? [LB577]

RUSSELL GRONEWOLD: Yes. [LB577]

SENATOR GLOOR: I think it's a good business model as well as a humane model. So I applaud Bryan, and I believe that's in conjunction with St. E's ER also if I'm correct. [LB577]

RUSSELL GRONEWOLD: Yes, it is. [LB577]

SENATOR GLOOR: So as a community initiative, it's a smart thing to do. But I think if

we're going to wrestle with this larger issue of Medicaid expansion, we have to grab the bull by the horns when it comes to submits. And one of the things that continues to bother me--and it's come up several times today--and you being a CEO are the right person to help with this, is the fact that ER care is so incredibly expensive. Yeah, but if a huge chunk of it is charity care, as has been pointed out already, Bryan could charge a million dollars a visit... [LB577]

RUSSELL GRONEWOLD: Right. [LB577]

SENATOR GLOOR: ...and we could say, gee, every time we direct somebody (inaudible) someplace else, we save a million dollars. If you're not going to collect the money, if you're not going to collect the money, it's not a cost savings specifically. And you understand the direct and indirect expense. Every hospital has to have an emergency room. And I'm not saying ERs are the best place to provide care. [LB577]

RUSSELL GRONEWOLD: Right. [LB577]

SENATOR GLOOR: It's certainly pretty high tech. But Bryan is going to continue to have to have an emergency room with physicians and nurses and equipment and the depreciation expense associated with the building and the equipment regardless of whether all the inappropriate patients go away or whether a certain number of those inappropriate patients continue to come in. And my point is you can't take every one of those patients and say this is a savings to the system. And I'm trying to figure out, when I look through numbers, how often we make that huge, simple calculation that's not correct and not an actual savings. You understand my argument there. [LB577]

RUSSELL GRONEWOLD: Absolutely. Right. And I think the thing that all of us are continuing to do is, we happen because of the explosion in emergency care, not just among uninsured but the general population, we're redesigning and expanding our emergency room on our east campus as we speak. We did that recently on our west campus. What we're trying to do in those cases is to try and recognize that all E.D. care does not need to be provided in the exact same way. So we are creating fast track E.D. care so we can hopefully lower the costs for some of those visits. Federal regulation creates quite a bit of a problem in terms of us being able to truly create the differentiation in care that would be necessary to truly lower the cost all the way. So looking at different ways to do urgent care so that we can actually bill it differently, all of those are regulatory issues as much as anything. But I do think it will continue to be upon us to get creative with our design and still comply with those regulations. [LB577]

SENATOR GLOOR: Okay. And by the way, somebody in my apartment tripped not that long ago and caught themselves and tore their hand badly. It was a hand that looks very much like this. (Laughter) They got great care and the bill, I thought, was relatively reasonable. (Laughter) [LB577]

RUSSELL GRONEWOLD: Thank you. [LB577]

SENATOR KRIST: Good ad. (Laughter) Any other questions? Thanks for coming, Russ. [LB577]

RUSSELL GRONEWOLD: Thank you. [LB577]

SENATOR KRIST: Next proponent. Welcome. [LB577]

STACIE BLEICHER: Senator Krist, Senator Campbell, and committee members, my name is Stacie Bleicher; it's S-t-a-c-i-e, the last name is B-l-e-i-c-h-e-r, and I'm here today representing the Nebraska Chapter of the American Academy of Pediatrics in support of LB577. And I apologize, I'll have to submit some written testimony at a later time. But, as a group, the pediatricians feel very strongly that this expansion is useful. It brings funds to the state that we need to be able to...hopefully, be able to expand care somewhat. I have great fears as a practicing pediatrician when I look at my 19-year-old diabetics that are going to be going off of Medicaid, have families that don't have private health insurance that can put him on his plan until...on their plan till he's 26, about what's going to happen with that kid when they have no source of coverage for his medical needs. And we see, you know, a huge population of kids that come out of poverty that don't have parents that can provide that kind of coverage, even though, you know, it's through the ACA. And I think that's an ever-increasing group of kids. This committee, I think, has looked at foster care kids being provided additional funding so that their medical costs are taken care of instead of just being cut off short. And we see that with our general population of kids that are on Medicaid. Their potential resources for health insurance, even if they're able to go on to school and be able to afford a student health insurance plan, is very difficult. Sometimes they have difficulty even being able to afford schooling itself. So we would very much support this expansion and would hope to see this move to the floor for General File. [LB577]

SENATOR KRIST: Thank you, Doctor. It should be noted, I guess, it's all about information and foster kids are continued to age 26 in January of 2014. So it's going to be, I think, a wonderful thing for the foster kids. But again, that's just one category, so. [LB577]

STACIE BLEICHER: Sure. [LB577]

SENATOR KRIST: But thank you. Any questions for the doctor? Senator Crawford. [LB577]

SENATOR CRAWFORD: Thank you, Senator Krist. And thank you for your testimony and your work with our kids. One of the issues that keeps coming up again and again is

whether providers will step up and provide care at Medicaid reimbursement rates. Can you speak to the commitment among pediatric providers or other doctors that you're familiar with? [LB577]

STACIE BLEICHER: I think I can pretty well, for the pediatricians, and I think, you know, for the most part, as long as it's not a practice that's isolated to Medicaid only, that most practices are willing to accept and continue to work with Medicaid. We do anticipate seeing an increase in rates, and my understanding is that things are kind of in process with CMS and that at some point when they accept our plan then those rates will be increased effective the first of this year and that we'll be reimbursed at a higher rate once all of that comes through the CMS process. And I don't have a very good feel yet for what those numbers are going to look like, but I think will be very welcome for primary care providers. I do think that the Legislature is looking at some additional legislation that may help encourage more providers to be sure they're participating at some level or another in Medicaid. I don't think we have a big absence of participation in pediatrics. I think there are some other primary care specialities that are a little leery to be involved with Medicaid because of reimbursement rates. And the practices that deal with a high proportion of Medicare are getting hit with huge cuts in reimbursement right now. So it will be a little bit of a challenging time, and yet I think as communities, if we feel, yes, we're going to be the best for the people in our community and offer them services, that again, the decrease in uncompensated care, being able to get people, you know, on a better track with good health can only benefit the whole community. [LB577]

SENATOR CRAWFORD: Well, I imagine for...in your...for your practice, for pediatricians, we already expanded Medicaid several years ago. [LB577]

STACIE BLEICHER: That's correct. [LB577]

SENATOR CRAWFORD: And so I don't know if you recall any lessons from that expansion in terms of access or changes that you had to make in terms of practice, because we already expanded it to kids several years ago. So you already experienced a Medicaid expansion in terms of your health profession. [LB577]

STACIE BLEICHER: We have. Within Lancaster County we did have to work with our Medical Society for a while to work on setting up a rotational basis so the practices were sharing more evenly in accepting new Medicaid patients. I think that has been largely phased out. And although there are many practices that are supposedly, quote, closed to Medicaid, it's not that they don't accept new patients, but if you're open it's that phenomena of, oh, you get everybody; and most practices can't afford to do that. So we all basically are accepting, whether we're listed as closed or not, but need to have some control in terms of numbers we accept at a time. [LB577]

SENATOR CRAWFORD: So how did that coordination work? [LB577]

STACIE BLEICHER: Well, through our Medical Society they actually kept just a list of the physicians that just rotated. So as families called in to find physicians, they would move through the list one at a time instead of, you know, just saying, oh, well those two practices are open so everybody calls there. But they would just make sure that there was some even distribution of the patients, and it was actually divided up by physicians not by a group. So if a group had 14 people, you know, each of those docs would be in line for patients. And the ones that had three or two or one, would be in line, but wouldn't be getting asked to take new patients every fourth family, for example, so. [LB577]

SENATOR CRAWFORD: Okay, excellent. Thank you. [LB577]

SENATOR KRIST: Thank you, Senator Crawford. Senator Gloor. [LB577]

SENATOR GLOOR: Thank you, Senator Krist. Dr. Bleicher, thank you for the work you do with kids. [LB577]

STACIE BLEICHER: You're welcome. [LB577]

SENATOR GLOOR: It's my understanding that it's not unusual for a pediatric practice, a general pediatric practice to have upwards of 50 percent of the patient load, Medicaid patients. Is that fair? [LB577]

STACIE BLEICHER: I think that's especially true in our rural communities that have limited...especially, in the pediatric practices, because those oftentimes are the special needs kids, and so they're going to go more towards pediatric care than family practice care if a pediatrician is available, and then probably also in the inner city and the impoverished neighborhoods in Omaha. Some of the others are probably more in the range of 15-25 percent. It's not all of them that are up at a 50 percent level, but my guess would be that those situations, UNMC, Creighton, I know in Grand Island they are probably about at that level that they struggle a little bit to make ends meet with reimbursement; but also with how people utilize the healthcare system. So again that's...we have to work on that concept of medical home and working on case management and family education to make it affordable. [LB577]

SENATOR GLOOR: Okay. Thank you. [LB577]

STACIE BLEICHER: Thanks. [LB577]

SENATOR KRIST: Thank you, Doctor. Any other questions? Senator Howard. [LB577]

SENATOR HOWARD: Thank you for your testimony today. I did have a question. Since Medicaid expansion is really not so much about pediatric patients, but really about either childless adults or parents who are working who are just working poor, in your opinion, when parents have health insurance, do their children also have health insurance? Is there a correlation? [LB577]

STACIE BLEICHER: Actually not always because going to the family plans in the people that have more marginal incomes can be so expensive that the families just can't afford to put the children on the plan, and so they'll have living income to work with after the fact. But I also find if the families...for example, the other day I had a couple of kids in, one of the children had pneumonia. The mother was in the room just hacking up a storm and had been sick longer than the two children had been. And I said, so when are you going to go the doctor, because, you know, if I get your children well you're going to give this right back to them, because I suspect you have the same problem. "Oh, my deductible is too high. I can't afford to do that," you know. And it's kind of like, you know, that's not good either. We need...the parents need to be healthy and covered, and I think then it's more reasonable that, you know, if they're in a hourly-pay job time where they are taking some time off, they can better afford to get in and get the kids healthcare. And you know, especially if we're planning health maintenance visits where we can do a lot of counseling and get them engaged in an office where they can call in with health problems, sometimes we can help them over the phone and they don't have to miss work. Many offices do have, you know, later in the afternoon or early evening hours, Saturday or Sunday hours, to try and accommodate working parents, so. But they have to understand and know the practice well enough to be able to know those resources are available. [LB577]

SENATOR HOWARD: Thank you. [LB577]

STACIE BLEICHER: You're welcome. [LB577]

SENATOR KRIST: Thank you, Senator Howard. Any other questions? Thank you, Doctor. [LB577]

STACIE BLEICHER: Thank you. [LB577]

SENATOR KRIST: Next proponent. Welcome. [LB577]

JESSICA MEESKE: Thank you. Good afternoon. My name is Jessica Meeske and I'm a pediatric dentist. I live in Hastings. I'm also a local school board member. [LB577]

SENATOR KRIST: Can I ask you to spell your last name. [LB577]

JESSICA MEESKE: Yes, I'm sorry. Jessica Meeske, J-e-s-s-i-c-a M-e-e-s-k-e. [LB577]

SENATOR KRIST: Thank you. [LB577]

JESSICA MEESKE: Sorry about that. [LB577]

SENATOR KRIST: It's all right. It's more for the transcribers, but thank you very much. [LB577]

JESSICA MEESKE: Okay. I understand. So I'm a pediatric dentist in Hastings. I'm also a local school board member; I chair the Medicaid committee for the Nebraska Dental Association; I'm on the Governor's Medicaid Reform Council; and I'm also a trustee of a small liberal arts college in Hastings. And I'm testifying today in support of LB577, and I do so on behalf of my patients and the children in my school district, their parents, my developmentally disabled adult patients I see, and the young adults that are at my college--so many who lack affordable health insurance. As a children's dentist whose practice sees a large percent of Medicaid, uninsured, and developmentally disabled adults, there are just too many adults I'm seeing that are falling through the cracks. And when I see a patient that lacks medical or dental insurance, I see families put off care, and they leave kids and the parents to suffer from dental pain and the medical complications that arise from those dental infections. Something that is a simple cavity that needs a simple filling gets put off for many months. Then a worried parent who hasn't been able to seek dental care now has a swollen cheek from the untreated cavity, has to miss work, can't get their kid to school, and now has a dental emergency. As a school board member, I have great concerns about the kids in my community whose parents lack insurance. In Hastings, about 55 percent of our kids are on free and reduced lunch; and when parents are sick, when they're not engaged in their kids' education and their kids' healthcare, they can't get their kids to school. We know that when we had snow days last week. We had 70 percent of our kids make it when Hastings Public did have school. Of the 30 percent who didn't, 85 percent of those kids were from families on free and reduced lunch. And when kids miss school and paras miss school, kids can't learn. And when they can't learn, they can't graduate; and when they can't graduate, they can't go on to get productive jobs and become productive citizens--and jobs usually that have employee-sponsored health insurance. And so the cycle continues, and I have a front-row seat every day. My concern doesn't stop with kids and their working parents. I worry about the disabled adults that need our help, especially the ones that lack insurance. They're just one bad accident or illness away from losing their job or their home. We've seen this firsthand with friends of one of our own kids. You know, I wonder why these parents can't make Johnny's dental visit, can't make the parent-teacher conference? Well, oftentimes, they're working two or three jobs just trying to make ends meet as the working poor, or they're not healthy themselves to get their kids where they need to go. I worry about our college kids, our college kids who need to go purchase medication for a chronic illness, but instead they need to use it to purchase books, and so they forgo that medication. Okay. So if I forget about my

most important role today as a child advocate, and I wear my small business hat--because I'm not a big CEO, but I'm a little CEO of a dental practice--as a small business owner I share concerns that I think some of the opponents today will probably articulate. Will we have an adequate infrastructure? How am I going to see more patients on Medicaid? How am I going to find ways to take care of this population when they bring about so many challenges in a private practice? What if my colleagues don't take their fair share and I become a dumping ground? And what if the Medicaid fees decrease because we're trying to cover more people? The honest answer is, I don't know exactly how I'm going to do this. But I know this: For 35 years, our practice has survived fee decreases, managed care, adding Kids Connection, red tape administrative barriers, and adult caps on adult dental care, and we're going to find a way to make this work, because (1) we're here to serve the vulnerable populations of Nebraska, and (2) I would like to make a profit. But (1) we're here to serve people. Not every kid who qualifies for Head Start do we have a seat for in all of our preschools, and I imagine it's going to be similar with Medicaid as well. But what it's going to do is give these adults and these working parents a fighting chance. And I just ask you, as well, not to pit healthcare and education; the two go together, just like parents and kids go together. Thanks. [LB577]

SENATOR KRIST: Thank you, Doctor. Any questions? Did you have one other thing you wanted to say? I know we ran you out of time pretty quickly. But is that it? [LB577]

JESSICA MEESKE: That's going to do just fine. [LB577]

SENATOR KRIST: That's great. Thank you. Thanks for coming in. [LB577]

JESSICA MEESKE: Thanks. [LB577]

SENATOR KRIST: Next proponent. Welcome. [LB577]

LAILA GHARZAI: (Exhibit 19) Hi. My name is Laila Gharzai, L-a-i-l-a G-h-a-r-z-a-i. I'm a second-year medical student at the University of Nebraska Medical Center. I am a member of a group called student delegates. We've organized just to follow legislative items of interest to us as students and as future healthcare professionals. I'm here as a member of student delegates and I'm speaking for myself in support of LB577, the legislation to expand Medicaid in Nebraska. I do not speak for the University of Nebraska. When I look back at my reasons for entering healthcare, I imagined being a doctor, and I imagined in an environment with the best technology, with the best people around me, and I imagined that I would be surrounded by patients who had never had to deal with complications from illnesses. I quickly learned that's not the case at all. That's, in fact, what we deal with every single day. I volunteer at a student clinic, and I see the same patient every month. His biggest problem is getting ahold of his insulin. I worked in McCook, Nebraska, for three weeks this past summer, and I saw my first

patient die. He died of chronic liver disease, a perfectly preventable illness. Unfortunately, this is true for many, many Nebraskans. This happens every day all across the state. There are patients arriving in emergency rooms due to complications from chronic illnesses, things like diabetes, liver disease. And a lot of times it's just because they didn't have access to primary care. I want to help patients like this. I think they deserve the care that they need. I think that they deserve it before it's too late for them. This is only going to happen if these people are able to gain access to primary care well before they need the emergency room. Right now, it's not possible for a lot of Nebraskans. And when I graduate from medical school, I'm going to be entering a broken healthcare system. From healthcare costs, from lack of access to care, we have so many daunting problems that we need to deal with. But although there's no easy way to fix this, Medicaid expansion is an indispensible step towards correcting our healthcare system. We would start by covering Nebraskans that are currently without healthcare coverage, like the patient that I described earlier. These are patients that are forced to use emergency services. This uncompensated cost, as you've heard a lot about today, imposes costs onto local hospitals, communities, and by extension, each and every single one of us. We are covering these expenses in the form of higher tax rates. Private insurers do this by a silent tax on premiums on their policyholders. These costs could be reduced if those patients that can't afford private insurance right now would be eligible for Medicaid, and therefore, would be able to access primary healthcare services. We'd be able to start practicing preventative medicine, which is what I'm learning about every day in the classroom. We'd make it easier to prevent the complications that arise from untreated chronic illnesses. Chronic diseases are the most common, most costly, and most preventable problems in the U.S. today. If we were able to prevent small health problems from turning into costly complications, our patients would benefit, our communities, and Nebraska taxpayers. If I'm the only doctor in a small town in rural Nebraska, I don't want a patient coming into the emergency room for costly interventions that are going to go unpaid for. I'd much rather have them come in on a regular basis and pay for cheaper, regular, primary care visits. The people that benefit from Medicaid expansion are just the people that we need to start gearing our preventative medicine efforts toward. Fifty percent of Nebraskans who are eligible for Medicaid live in rural areas, and 70 percent of the health professionals working in rural areas are UNMC graduates. By expanding healthcare coverage, we'd greatly impact rural providers and the large rural communities they serve. Places like McCook, where I was this summer, would directly benefit. We'd get more jobs, we'd get the benefit of reducing uncompensated care, and we'd get the indirect benefit of adding productivity for all of those people. So I really encourage you to support LB577. I'm really looking forward to a healthcare and medicine where we don't need to use the emergency rooms as a place of last resort. Instead, it's just going to be for emergencies. Thank you. [LB577]

SENATOR KRIST: Any questions? Senator Gloor. [LB577]

SENATOR GLOOR: Thank you, Senator Krist. Thank you, Laila, for your testimony. I'm going to read a sentence back to you: According to the CDC, chronic diseases are among the most common, costly, and preventable of all health problems in the United States. [LB577]

LAILA GHARZAI: That's correct. [LB577]

SENATOR GLOOR: During your experience in Omaha and McCook, did you see a lot of tobacco-related illnesses? [LB577]

LAILA GHARZAI: I did. [LB577]

SENATOR GLOOR: Would you say a lot of people...I mean, what percentage of your patients would you say suffered from tobacco-related illness? [LB577]

LAILA GHARZAI: Well, when I was in McCook, I was doing a surgery rotation, so I would not say that high of a percentage, I mean. [LB577]

SENATOR GLOOR: Yeah. But overall you see this as one of those significant chronic diseases that's a problem. [LB577]

LAILA GHARZAI: Actually, no. I think diabetes; I think hypertension; I think atherosclerosis; problems from high cholesterol; high fat diets; obesity. These I think are the problems. I do not deny that smoking is a huge problem and that lung diseases are a huge problem, but that's not what I see. [LB577]

SENATOR GLOOR: Okay. Thank you. [LB577]

SENATOR KRIST: Any other questions? Thank you, future Dr. Laila. [LB577]

LAILA GHARZAI: Thank you. [LB577]

SENATOR KRIST: Welcome. [LB577]

JONAH DEPPE: Good afternoon. [LB577]

SENATOR KRIST: How are you? [LB577]

JONAH DEPPE: (Exhibit 20) I'm fine. I'm speaking today for NAMI Nebraska. My name is Jonah Deppe, J-o-n-a-h D-e-p-p-e. NAMI Nebraska supports LB577, which will provide access to mental health services and physical health services for individuals with a mental illness who presently do not meet the current Medicaid requirements and are uninsured. Access to health services would assist these individuals and would

prevent increased mortality and morbidity. Those suffering from serious mental disorders are dying from similar causes, heart disease and diabetes, chronic illnesses, as seen in the general population, but they are dying at rates of two to three times the general population. These are preventable conditions with access to general healthcare. Without the access to health services, these diseases are life-threatening, and I think we've heard about them several times today already. Many individuals with a mental illness are able to work with the proper care and treatment. Their jobs often are not full time or are low paying and do not provide health insurance. Medicaid expansion would provide access to the healthcare they need, both physical and mental health. Parity is important to their well-being. Presently, to receive needed services, it is necessary to access them through the emergency rooms at hospitals. And when hospitalization is needed, the cost of these services are then passed on to others in higher charges and insurance costs, which you've again heard of several times today. The Affordable Care Act provides the option of Medicaid expansion to provide health services to Nebraskans making less than 138 percent of the federal poverty level. The new program is for working Nebraskans in minimum and low-wage jobs who don't qualify now for public healthcare programs, who can't afford coverage on their own, and who won't be eligible for tax credits in the exchange. NAMI Nebraska supports Nebraska's choice to provide Medicaid expansion to help bridge the gap for primary care. Thank you. [LB577]

SENATOR KRIST: Thank you, Ms. Deppe. Any questions? Seeing none, thank you so much for coming down. [LB577]

JONAH DEPPE: Um-hum. [LB577]

SENATOR KRIST: The next proponent. About two weeks ago, in another committee, I saw somebody do that and someone stepped on their phone before they could get that. [LB577]

JAMIE PETERS: So it might not be a good idea? [LB577]

SENATOR KRIST: Yeah. He... [LB577]

JAMIE PETERS: Maybe I should back it up. [LB577]

SENATOR KRIST: Yeah, that would be good. Just saving you a little trouble. [LB577]

JAMIE PETERS: (Exhibits 21, 22, 23) If it rings, I won't...it's not mine. My name is Jamie Peters, spelled J-a-m-i-e, Peters, P-e-t-e-r-s. I am here today to testify on behalf of the Nebraska Nurse Practitioner Association and our 500-plus members in support of the LB577. NNP supports greater access to quality healthcare for all Nebraskans and contend that expanding our Medicaid program to offer healthcare insurance for an additional 20,000 Nebraskans is one way to accomplish this. We thank Senator

Campbell for introducing this important legislation. Nurse practitioners across the state offer services to meet the healthcare needs of our citizens, and we continue to look for ways to increase the opportunity to offer our care. We contend that the sustainability of our current provider network, as it relates to Medicaid expansion, as well as newly insured under federal healthcare exchange and increasing numbers of baby boomers moving into Medicare, is an important consideration for the committee. There are numerous barriers to care for providers across the state, and as a primary care nurse practitioner, I am confident that these barriers will present increasing difficulty for the state's newly insured to receive timely access to high quality care. I am an adult nurse practitioner, certified through the American Academy of Nurse Practitioners, and I am licensed as a primary care provider. I would like to take a couple moments to tell you a little bit about my practice. Health at Home Consultants is an independently owned nurse practitioner practice. We go into...we specialize in bringing high quality, cost-effective care to the vulnerable population in their home setting. Our goal is to provide home care medicine in one of the most rapidly expanding areas of healthcare. Our coordinated care and considerate attention prevents unnecessary hospitalizations. Often our patients have limited mobility, failing minds, chronic illness, psychiatric conditions. They're not able to see their doctor unless they're taken by ambulance to the ERs. We have set our sights on what is best for this vulnerable population. Medicare and Medicaid have many barriers that have made it difficult to provide efficient care. For example, durable medical equipment. It's a term that's used for medical equipment that's in the home. It aids to the better quality of living. As a nurse practitioner, we must obtain a physician's signature in order to...prior to the delivery of the item that's been ordered. We are affected by this in our practice approximately six times a month per provider. Again, examples of DME: wheelchairs, nebulizers, blood glucose monitors. We are taking this indigent population, asking them to wait, often, for this signature. Sometimes it's taking up to two weeks to get these signatures in order to provide a wheelchair to this person that may be homebound. Removing these barriers prevents nurse practitioners from practicing to their full scope. It's crucial due to the implementation of the Affordable Care Act. I am one example of a nurse practitioner who owns her own practice. I serve a vulnerable population that may otherwise face difficulties accessing services, but unfortunately, there are not many stories like mine. But why shouldn't there be? Evidence supports that nurse practitioners provide high quality, cost-effective care. Eighteen states, including Iowa, Colorado, Wyoming, they do not have a requirement for the integrated practice agreement like we have in Nebraska. The Rural Health Research Center has encouraged states to consider the removal of the IPA to address the rural provider shortages, and they also identify that in states that do not have an IPA, nurse practitioners gravitate towards those communities. Currently, there are 1,080 nurse practitioners in Nebraska, which is exciting, because 20 years ago there were less than 50 in our state. As a member of the healthcare provider network, we contend that it is important to keep NPs on the forefront, along with other primary care providers, of any discussion concerning healthcare costs, quality, and accessibility to care issues. I have submitted two articles outlining solutions

to this problem with my testimony. There are many unknowns to the total impact of Medicaid expansion. But one thing we know for sure: that there are many people who do not...who are not able to receive medical attention they need; and many times, because of this, they end up costing the state more. We also know that with the increases in numbers there will be a shortage of healthcare providers. We see this as an opportunity for change to remove barriers and force the healthcare community to work more closely together than ever before on behalf of patients that we serve. Madam Chair and members of the committee, I thank you for the opportunity to testify in support of LB577 and would be happy to answer questions. [LB577]

SENATOR KRIST: Any questions for Ms. Peters? Thank you so much for coming. [LB577]

JAMIE PETERS: Thank you. [LB577]

SENATOR KRIST: The next proponent. Welcome. [LB577]

KATHY HOELL: (Exhibit 24) Thank you. Thank you very much for having this hearing. Thank you, Senator Campbell, for introducing this very important piece of legislation. My name is Kathy Hoell, K-a-t-h-y H-o-e-l-l. I do work for a statewide disability organization; however, at this time, my testimony is my own. I'm doing it on my own time, and I'm taking...I'm here as what is known as an anecdotal advocate. As a person with a disability, I am also requesting reasonable accommodations under the Americans with Disabilities because of my speech issues. I...(inaudible) time. [LB577]

SENATOR KRIST: No problem. Take your time. [LB577]

KATHY HOELL: Anyway, I am here in favor of LB577 and I want to make it really clear that as a person with a disability, I empathize with the plight of Nebraskans with disabilities who are my friends, loved ones, acquaintances, and faces on the street in our state that can't be here because of their life circumstances. Recently, I received the 2011 Disability Status Report for Nebraska from Cornell University. It is stated in this report that there are 16,300 people with disabilities without insurance in Nebraska. It is estimated that about 14,000 of these would qualify for Medicaid if it was expanded to the 138 percent. These people that I'm talking about are currently working enough and barely making over the threshold so they can't receive Medicaid and they won't..., and they will not qualify for the healthcare exchange because their incomes are so low. There is a stigma over Medicaid, and recipients of Medicaid are...feel ashamed. And I know it's been mentioned earlier that there are people that are eligible that have not signed up, and there are people with disabilities that I know are in that same boat, and that's because of the stigma that is associated with it. But sometimes you just have to make a choice. Every one of these individuals is one incident away from a major life catastrophe. An individual that I know who has a severe and persistent mental illness as

part of her recovery plan does work, but usually, maybe, if she's lucky, 15-20 hours a week. But it...and she does not qualify for Social Security because one of her previous employers, unbeknownst to her at the time, did not pay into the system and so she does not qualify for Social Security, thus does not qualify for Medicaid. A few years ago she was diagnosed with cancer. She went through the treatment (inaudible) and they were able to treat the cancer and she had surgery, she had chemo, the whole bit. But now she is not pursuing getting any follow-up care because she can't afford it. She's totally letting her health go. She's also, because she has no way to pay for her medication for severe mental illness, she is choosing which medication she purchases per month. So she's not taking the medications properly. Another individual I know was diagnosed with a life-threatening infectious disease as a young adult prior to the passage of the Affordable Care Act. He was under his parents' insurance until he aged out. When the recession hit, he never found a full-time job that provided healthcare benefits. He is under a limited Medicaid program related to his disability, but it does not cover any other medical issues that may arise for him. He has two part-time jobs, but he still cannot afford private health insurance. And so he's just another one of the incidents just waiting to happen. LB577 would enable him to have more coverage and have control over his healthcare needs and would allow him to have a less stressful life. I'm sharing these stories with you because they are just a couple voices of the 16,000-plus Nebraskans with disabilities who are uninsured, marginalized, dismissed, and voiceless. Medicaid expansion is not a partisan issue. It's a moral issue. Republicans, Democrats, and Independents nationwide recognize the benefits to their states and to their citizens from expanding Medicaid up through 138 percent of poverty. Therefore, I hope the Health and Human Services Committee will vote to advance this bill to the floor of the Legislature. And if there's any questions, I would be glad to answer them. [LB577]

SENATOR KRIST: Any questions for Kathy? Senator Crawford. [LB577]

SENATOR CRAWFORD: Thank you, Senator Krist. And thank you, Kathy, for coming in today. It's great to see you. You're an advocate for so many in Sarpy County, and I appreciate seeing you here, and I appreciate your testimony as well. It's very helpful to hear these stories because I think often we talk about Medicaid and people are assuming that people who are disabled don't have these kinds of gaps. So I appreciate you taking time to come in and talk about these stories to help us to see what that looks like for your friends. [LB577]

KATHY HOELL: Yes. Recently, I heard somebody make a comment that they assumed that all people with disabilities were under medical coverage by Medicaid, and that is not the case. [LB577]

SENATOR CRAWFORD: Thank you for coming to clarify for that. I appreciate it very much. Thank you. [LB577]

SENATOR KRIST: You're one of our frequent flyers. Keep coming back. Take your time. [LB577]

KATHY HOELL: I will. [LB577]

SENATOR KRIST: I know you will. [LB577]

KATHY HOELL: Otherwise you may end up with this table in your lap. [LB577]

SENATOR KRIST: Please, no. Hi. [LB577]

REBECCA RAYMAN: Hi. My name is Rebecca Rayman, R-e-b-e-c-c-a R-a-y-m-a-n, and I am here today representing the 63,532 patients served by Nebraska's six quality health centers. I myself am the executive director of one of these health centers located in Columbus, Nebraska, and our health center serves 60 percent uninsured. Overall, in Nebraska, health centers serve...53 percent of the patients that we serve are uninsured. This is 33,674 patients. Many of our patients will be in the gap that has been discussed today. And I want to just talk a little bit about our patients and who they are. I've gotten to know a lot of our patients, being the director of a health center for ten years, and I will tell you that most of our patients do not want to use the emergency room for care. They really prefer to have a primary care provider. They really want good medical care. I know that in our local area our local hospital will tell you that our federally qualified health center saves them between $200,000 and $250,000 a year. Our local ER director just told me recently that he believes that our community health center cuts off about 14,000 visits a year from the ER that are unnecessary. So I think when patients are offered an alternative, they will take the alternative. They really do want quality care. In rural areas like where I'm from, there are a lot of small employers and so there are a lot of employers with under 50 employees. We have a lot of part-time workers. A lot of the people that we see who will fall into the gap maybe string together two or three part-time jobs. I have a family in mind that is in the gap right now. This was a family that was fairly middle class. There are three children in the family. The mother and the youngest child were traveling on a rural road one day and were T-boned from the side by a trucker, and the youngest child ended up pretty disabled. The mother is no longer able to work so she needs to stay home. The child has many, many needs. That has thrown them into the gap. And so sometimes you're...you...we can't predict who's going to end up in the gap. It could be any of our children or our grandchildren in the future. But...and that's the story of our a lot of our patients, I guess. I have another patient that comes to mind that's a behavioral health patient. This patient had three DUIs, driving under the influence; has been with our behavioral health clinic; is now in college and is falling into that gap. This is a person who has really turned their life around and who I believe is really going to do great things in the future. It's...we just really need to see that these individuals are insured. Medicaid expansion is critical to keeping healthcare costs down for the state of Nebraska and for the state's hospitals due to the overuse of the

emergency room for noncritical care. Without expansion, it would potentially leave some 33,000 eligible low-income people with no affordable coverage alternative, and it possibly denies many of these hardworking Nebraskans the security of having insurance for their healthcare needs, no matter how complex or how serious they might be. I would just really strongly encourage you, I think, and especially for patients with chronic care conditions, having regular, comprehensive, quality care makes a huge difference. For every 1 percent that you reduce a diabetic's hemoglobin A1C levels, we save thousands of dollars and we help to keep that person working far into the future. So the health centers of Nebraska strongly support Medicaid expansion, and we look for your favorable consideration. Thank you. [LB577]

SENATOR KRIST: Thank you. Thanks for what you do. Any questions for Ms. Rayman? Senator Gloor. [LB577]

SENATOR GLOOR: Thank you, Senator Krist. Thank you. Thanks for making the drive down. Does Columbus have enough primary care providers right now? [LB577]

REBECCA RAYMAN: For Medicaid expansion? [LB577]

SENATOR GLOOR: Well, right now, I guess I would say, but obviously it leads to the issue of, and then what, with Medicaid expansion. [LB577]

REBECCA RAYMAN: You know, I can't answer for the entire community of Columbus. But I really believe that with more preventative care we can have less care on the other end. And I think it'll take awhile. It'll be kind of a steep climb. I think at first we won't have enough services, but I think in...over the years, it will even out and we will. I don't know if I'm making sense to you or not. [LB577]

SENATOR GLOOR: Well, yeah, and I don't disagree with you. But there's a...how do we get more preventative care? Who pays for the preventative care? We don't pay for the preventative care to a large extent anymore, and how many years will we have to wait? I mean, those are all...I mean, there are an awful lot of questions about this. But my guess is central Nebraska, probably like a lot of outstate communities, regardless of the size, could use a few more primary care providers. I just don't know whether it's a crisis in central Nebraska, or in Columbus anyway, or not. [LB577]

REBECCA RAYMAN: It's not a crisis in our area. Within the private medical community I think we have capacity at this time. I know I sit on the board of the hospital, and we're no longer looking for primary care physicians or our family practice physicians. We are looking more to our shortages in specialties. So I think right now...right now, in our area, I think we're ready. [LB577]

SENATOR GLOOR: Okay. Thank you. [LB577]

REBECCA RAYMAN: You're welcome. [LB577]

SENATOR KRIST: Senator Howard. [LB577]

SENATOR HOWARD: Thank you. Thank you for your testimony. And this is just out of curiosity. I work in an FQHC as well, and we have sort of been ramping up our services and expanding capacity and having new access points. Has Columbus been doing something similar? [LB577]

REBECCA RAYMAN: You bet. We're in the process of building a new facility. It'll have double the number of exam rooms. We've just hired an additional family practice provider last summer. So we are looking at what this change will mean. We still...I will still tell you that we have more demand for our services than we can meet. Even though we've been ramping up, there are a lot of people out there who need affordable healthcare. We have a lot of people who have high deductibles. In the rural area we have a lot of people who work for small ag operations. They can't afford insurance. So we do have more patients than...in the FQHC side, than we have capacity, but we are working very hard to get there. [LB577]

SENATOR HOWARD: Thank you. [LB577]

SENATOR KRIST: Thank you, Senator Howard. Thanks for working towards a solution. Thank you very much. [LB577]

REBECCA RAYMAN: Thank you. [LB577]

SENATOR KRIST: Next proponent. Welcome. [LB577]

JON BAILEY: (Exhibit 25, 26, 27) Good afternoon. Members of the committee, my name is Jon Bailey, that's J-o-n B-a-i-l-e-y, and I'm the director of research and analysis at the Center for Rural Affairs in Lyons, Nebraska. And I come before you today to offer testimony in support of LB577. Medicaid is the critical part of access to health insurance and access to healthcare in rural Nebraska. Nebraska's rural communities have lower health insurance coverage rates than more urban counties for residents under 65. The most recent Census Bureau data show that Nebraska's rural counties have a 15.5 percent uninsured rate, higher than any other county type in the state. As county population decreases, uninsured rates increase. Counties with high uninsured rates, with 21 percent or greater, exist only in nonmetropolitan Nebraska. As a state, we need to adopt public policy that reduces the rural uninsured rate and provides more rural people better access to healthcare. Medicaid can be an important policy response to the health insurance disparity found in rural areas. Nationally, it is estimated that 20 percent of Medicaid recipients reside in rural areas. However, in Nebraska, that rate may be

higher. In the most recent data available from the Nebraska Department of Health and Human Services, Medicaid average monthly eligibility is split almost evenly between urban and rural counties. Presumably, expanding Medicaid as called for in LB577 would have the same result in rural Nebraska. Overall, we have found that the new Medicaid initiative in the Affordable Care Act as contained in LB577 would provide health insurance coverage to a significant number of rural Nebraskans and could potentially reduce the rural uninsured rate nearly in half. We also conservatively estimate that nearly one in five households under the age of 65 in rural legislative districts would qualify for Medicaid under LB577. Lower incomes in rural Nebraska, especially among working age adults, result in a significant population that is uninsured and in need of health insurance coverage. We heard Ms. Rayman talk about the number of small businesses in rural communities. We found that three-quarters of rural Nebraska small businesses do not provide or offer health insurance to their employees. Based on the average wage paid these employees, many would qualify for Medicaid health insurance coverage under LB577. This bill would relieve small businesses of any obligation to offer or provide health insurance to their employees while also providing health insurance coverage to those employees. We can tell you from personal experience with our small business development program at the Center for Rural Affairs that expanding Medicaid as in LB577 is an intriguing prospect for rural small businesses to be able to hire and retain employees. You've heard a lot of testimony today from the provider network. I won't repeat that. I agree with almost everything that's been said. We think this bill will help stabilize the rural healthcare infrastructure and would help all of the rural providers with the challenges they are facing in providing access to their patients. One thing that hasn't been mentioned today and I think is important, especially for rural communities, is long-term care. Medicaid is vital for long-term care, the type of healthcare services that exist in rural areas in large numbers. The most recent data shows that Medicaid was responsible for 43 percent spent nationally in long-term care, making Medicaid the primary payer for long-term care services. For the group receiving old age--that's 65 plus--long-term care, Medicaid spends more per recipient than any other group. Nursing facility beds are more plentiful in rural areas, and a higher percentage of rural elderly are eventually admitted to long-term care facilities. With the high costs of long-term elderly care, many elderly eventually have no choice but to enroll in Medicaid. Reducing the amount of uncompensated care borne by rural healthcare providers is critical to providing long-term care services to the rural elderly and in keeping rural healthcare facilities viable. We think that because of the importance of long-term care in rural areas, if the uncompensated care issue continues, many of these facilities will eventually close, leaving many of our rural elderly with no facilities to attend. We thank Senator Campbell and Senator Krist for bringing it, and the other sponsors of this legislation, for bringing this important issue to the Legislature. And for the financial and economic benefits we've heard today to the state, we urge the committee to advance LB577. But, most importantly, for the health and well-being of Nebraska's people, we urge the advancement of this bill. I also have written testimony from Mr. Al Guenther of Dunbar, Nebraska, and Dr. Amanda McKinney of Beatrice,

Nebraska, that I would like to introduce. Thank you for your attention today. I'd be happy to answer any questions. [LB577]

SENATOR KRIST: Thank you, Jon. Thanks for coming. [LB577]

JON BAILEY: Thank you. [LB577]

SENATOR KRIST: Senator Crawford. [LB577]

SENATOR CRAWFORD: Thank you, Senator Krist. And thank you for coming, Jon. I appreciate this very much. [LB577]

JON BAILEY: Thank you. [LB577]

SENATOR CRAWFORD: And I really appreciate you mentioning the small business angle. I think that's an important element to consider is how this would allow entrepreneurs or people even starting their own businesses or small businesses to have that safety net, that cushion, as they begin. I was wondering if you could put a face on that point by telling us about perhaps one of the small businesses that you've worked with at your center or somebody who has talked about this that can see the potential for this for their small business development. [LB577]

JON BAILEY: Well, I'm not sure I can pull one off the top of my head without leaving the thousands of other businesses. [LB577]

SENATOR CRAWFORD: Well, we don't have time for thousands today, so maybe pick one. [LB577]

JON BAILEY: I would pull out a business that actually is just down the street from our office in Lyons. She produces health food and, primarily, gluten-free mixes for soups and breads and other types of items, and sells...and makes them and sells them out of a little storefront just down the street from us in Lyons. She...her story is that she started this business because of her own health problems, and found that making her own food this way alleviated a lot of her health issues. So she started this business, and she got a loan from our small business program and started the storefront in Lyons, but because of her health problems is not able to obtain insurance for herself and her family. And right now, because of the start up of the business, is still not making a lot of money and probably would qualify for Medicaid coverage under this program. So that's an example. A lot of startup entrepreneurs which our rural economies are built on, to a large extent, don't make a lot of money. Even when they're established they don't make a lot of money. And they would be able to qualify for this program and have health insurance that they can't afford now. And as I mentioned, their employees, who aren't paid a lot of money, generally, would also qualify. And they don't...these businesses don't make

enough to provide, as I said, provide insurance to their employees. And so we see that's one of the reasons for the high uninsured rate in rural Nebraska. We just have an economy that doesn't provide health insurance like the urban economy does. [LB577]

SENATOR CRAWFORD: Thank you. I appreciate that very much. [LB577]

SENATOR KRIST: Any other questions? Thank you, Jon. Thanks for your testimony. [LB577]

JON BAILEY: Thank you. [LB577]

SENATOR KRIST: Hi. [LB577]

TOPHER HANSEN: (Exhibit 28) Good afternoon, Senator Krist, members of the committee. Senator Campbell, thank you for introducing the bill. My name is Topher Hansen; that's T-o-p-h-e-r, Hansen, H-a-n-s-e-n. I am here today on behalf of the Nebraska Association of Behavioral Health Organizations. We're about 48 organizations across the state consisting of consumer groups, provider groups, and the regions are also members, so we have quite a unique organization. Across the country there are no organizations like NABHO that combine those groups. And I am here as president to represent that group. I also am the president and CEO of CenterPointe here in Lincoln. Quality, consistency, and continuity are the adjectives I think of when I think of why to do this. They really describe what is needed in this bill and LB577. For individuals with behavioral health disorders, getting access to quality care makes all the difference on whether they will have a short-lived problem or one that will last a lifetime. Quality and comprehensive, and I underline comprehensive, care means having professionals available to deal with mental health problems, substance use problems, and physical health problems. These things are a three-legged stool. They all live in the body. They all...all these systems interact with each other, and it's important that we have the systems, the payment structure, and the delivery systems that approach these problems together so we can get people better sooner and for longer. So leaving one undone extends the duration of all the problems. It makes for an unhappy life for the consumer, and for costly care, to keep repeating the kinds of solutions that people need. Medicaid provides the funding avenue for individuals to receive care in all three of these areas. Currently, without Medicaid, consumers don't know how to cover the cost of care. So people come in that don't have private insurance and they don't have Medicaid, for one reason or another, and they don't have an idea of, so then what. Nobody says, oh, I can get the Nebraska behavioral health system to pay. They don't know that. and they feel without resource on those things. Sometimes they do qualify for Medicaid, as was stated earlier, and don't know that. And if we are able to identify that and we do--in fact, we operate one of the leading programs called SOAR across the country in helping people to qualify for Medicaid--then we can access that system. But they are unaware of how the system pays when they don't have money. So the consumer who does not

know how to access care waits for an emergency and seeks help for an emergency department in a local hospital. That is very common. And without Medicaid, the ongoing physical healthcare is left unattended. I should say the group that we're describing tends to be the group with multiple disorders and who is in the public sector for the most part. A fraction of them work, but most are fairly devastated and in our system. The result of...well, so the ongoing physical healthcare then is left unattended if there's no Medicaid to cover that person. So the result is the daunting statistic that persons with serious mental illness die 25 years sooner than the average person--25 years. So if you're 52 and you're in this room, you're not here because you have passed away from physical health issues that are oftentimes preventable, but left unattended because people don't know how to access the system. Access to quality healthcare allows people to live longer with greater satisfaction and at less cost. Consistency of care is critical also. Not getting care because of lack of funds for the care, or even the copay, ends up in poor health outcomes. Having Medicaid be a consumer's regular source of payment for healthcare services allows them to establish a medical home and a behavioral health home. Sometimes these homes may be in the same place, places will collaborate or coordinate, but they remain the same place for the consumer over time. That's important. That consistency in providers is important to long-term health and wellness. Consistency also factors into the funding for providers. Having a consistent payer source for an individual decreases the time and money spent dealing with consumers moving on and off of the eligibility list for Medicaid. Providers are not reimbursed for their cost of care for these services; that is, the Medicaid rates are less than the cost for the care. So minimizing eligibility confusion is important in reducing costs for quality care. And providers will tell you, across the board, that we all lose money on rate reimbursement for these services. So, if we can't break even on the proposition, we sure would like business efficiencies to help us lose less money. Continuity of care for consumers is also critical. To have the same provider who knows what you're doing and is familiar with your case and has a great deal of knowledge, helps provide a better quality care. And providers will continue to provide these treatment services. We are dedicated to this. It is in our mission. But this switch to a consistent payer source, a continuity of care for the consumer, is going to be important to better health outcomes in our communities and a savings to the overall society. So the equation is: access, plus quality, plus consistency, and continuity equals more effective and more efficient care--which translates to mean healthier people and savings in public dollars. NABHO supports LB577. Thank you for your time. [LB577]

SENATOR KRIST: Thanks, Topher. Any questions? Thank you for your testimony. Next proponent. [LB577]

BRAD MEURRENS: (Exhibits 29-34) Good afternoon, Senator Krist, Senator Campbell, members of the committee. For the record, my name is Brad, B-r-a-d, Meurrens, M-e-u-r-r-e-n-s, and I'm the public policy specialist at Disability Rights Nebraska, the designated protection and advocacy system for persons with disabilities in Nebraska.

As an organization premised on advancing public policy and protecting the rights of Nebraskans with disabilities, we fully support the effort to extend Medicaid coverage per the federal Affordable Care Act as proposed in LB577. Such a Medicaid extension would increase access to needed healthcare for many Nebraskans with disabilities. The overlap between poverty and disability, as well as uninsured status and disability, is significant. Thousands of Nebraskans with disabilities live in poverty and lack health insurance. According to the American Community Survey, 16.8 percent of Nebraskans with disabilities, age 21-64, were uninsured in 2011; 24 percent of Nebraskans with disabilities, ages 21-64, were living below the poverty line in 2011. It is false to assume that all Nebraskans with disabilities are currently utilizing and using Medicaid-funded services or would be covered under traditional Medicaid. Not all people with disabilities meet the financial, family, or disability-specific eligibility limits; thus, many people with disabilities would be left in the gap between current Medicaid eligibility and the insurance exchanges under the ACA. The National Association of State Mental Health Program Directors notes that, quote, many people recognize Medicaid as a program that provides coverage to the poor, but few know that millions of working adults, mainly childless, do not currently qualify for Medicaid even if they have little income, and about 25 percent of this population has serious and moderate behavioral health conditions. Simply put, LB577 would provide affordable coverage for a wide range of people with disabilities: people with disabilities who are ineligible for traditional Medicaid due to excess income or assets; people with disabilities who are in the two-year waiting period for Medicare; people with disabilities who are eligible for traditional Medicaid with a spend-down; people with disabilities who are not considered severe enough for Medicaid; people whose disabilities are not diagnosed; people with disabilities who do not know or do not admit that they have a disability--I'm counting those as two; people with disabilities who churn off and on traditional Medicaid--that means low-wage workers who become ineligible for Medicaid when they are employed and people whose disabilities improve when they have a consistent source of healthcare and/or treatment. Ten. Without LB577, they would have nowhere to turn for affordable healthcare and would face unaffordable insurance premiums. The National Health Law Program states, quote, states that refusal to implement the Medicaid expansion would generate a, quote, coverage gap for the lowest income adults. Lower income adults earning at least 100 percent federal poverty would qualify for subsidized coverage, but many childless adults and parents earning less would be left with no viable coverage option. For lower-income adults between 100 percent and 133 percent of federal poverty, private insurance premiums through the exchange will likely be unaffordable. Failure to extend Medicaid would harm families and individuals with disabilities below the federal poverty line because the ACA does not provide for individuals earning below the federal poverty line to receive any federal subsidies to help them purchase insurance through the exchanges. Individuals earning less than 100 percent of federal poverty must purchase insurance without any federal assistance, while individuals earning 100 percent to 400 percent above the federal poverty line will qualify to receive federal subsidies to help pay for coverage. Medicaid is designed to provide a more robust package of services

that are not typically found in private insurance. Benefit packages in the private market are often tailored to healthier populations who are less likely to have disabilities or chronic health conditions. Even if Nebraska chooses not to extend Medicaid coverage, Nebraska will still have to serve uninsured people with disabilities in situations such as hospital emergency rooms which tend to be at a much higher cost and provides very little opportunity to recoup those expenses. For those reasons, we recommend that this committee advance LB577. And I would also like to state that I handed, along with my handouts, which is where these quotes in my testimony come from, we've also included a letter of support from The ARC of Nebraska, as well. [LB577]

SENATOR KRIST: Brad, you're always so thorough and give us the information, and we appreciate that. [LB577]

BRAD MEURRENS: I'm very happy to hear that. [LB577]

SENATOR KRIST: I ran out of fingers. I was going to loan you one. [LB577]

BRAD MEURRENS: I know. I was thinking about the toes, but I would definitely have run out of time, so. [LB577]

SENATOR KRIST: Thanks, Brad. [LB577]

BRAD MEURRENS: You're welcome. [LB577]

SENATOR KRIST: Any questions? Seeing none, great. Thank you. Next proponent. Welcome, Jim. [LB577]

JIM CUNNINGHAM: (Exhibit 35) Thank you. Senator Krist and members of the committee, good afternoon. My name is Jim Cunningham, J-i-m C-u-n-n-i-n-g-h-a-m. I want to start by apologizing to Senator Krist for the incorrect introduction in my written testimony. I've been around long enough that I should have anticipated that situation. [LB577]

SENATOR KRIST: That's all right. [LB577]

JIM CUNNINGHAM: I'm the executive director of the Nebraska Catholic Conference which represents the mutual interests and concerns of the Archdiocese of Omaha and the Dioceses of Lincoln and Grand Island on matters involving public policy under the direction of the diocesan bishops. I'd also like to take this opportunity to thank Senator Campbell and her colleagues who introduced this important bill. The tradition and approach of Catholic social teaching regarding healthcare are shaped by a fundamental principle: that every person has a right to adequate healthcare, a right that flows from the sanctity of human life and the inherent dignity of human beings, each one being

made in the image of God. Consistent with this principle, our view is that the healthcare system should be measured against how it affects the vulnerable and disadvantaged. The Bishops' Conference has concluded that the Medicaid expansion option advances this important principle and promotes the common good; and therefore, we are in support of LB577 and urge your favorable consideration of it. Expanding Medicaid eligibility will improve access and equity for many of those otherwise excluded, especially very low income adults. There is clearly a life-improving, and in cases, lifesaving benefit to Medicaid coverage. Moreover, this expansion will mitigate other financial pressures throughout the healthcare system. We understand and appreciate that there are concerns about cost. As everyone recognizes, action to control overall healthcare spending in Nebraska and throughout the nation is necessary. The robust public policy discussion about cost control and improving outcomes throughout the delivery system has been ongoing and must continue. And I have to tell you, as a person not specifically close to these issues, I find the discussion that's occurred already here this afternoon to be very enlightening and encouraging. Nevertheless, cost concerns alone cannot justify continuing to exclude so many vulnerable Nebraskans from access to healthcare, particularly in light of the available Medicaid coverage option. You face serious challenges addressing a variety of issues relating to healthcare affordability and access and implementation of the Affordable Care Act. The Bishops' Conference sincerely thanks you for your service and wishes you well in this important endeavor. Thank you for your time and attention. Please advance LB577 for consideration by the full Legislature. Thank you. [LB577]

SENATOR KRIST: Thanks for coming down, Jim. Any questions for Jim? Senator Gloor. [LB577]

SENATOR GLOOR: Jim, this is as much a statement as anything, but you and I know each other well enough for you to know that I certainly have embraced a ministry for a large portion of my life to the underserved and uninsured and whatnot. But I just have to say, part of my concern here is that we have underpaid providers. We don't have enough providers. And we're talking about expanding supposed access by way of giving people access to insurance, to tens of thousands of Nebraskans. And this is a setup for major misery and it's not for want of people wanting to do the right thing. I think it's a problem of people not understanding the complexity of the healthcare system and how perhaps being miserly at the state level of how we fund scholarships, how we fund appropriately for training primary care practitioners, may well come back to haunt us in ways we can't yet perceive. I am excited about the opportunity to provide coverage for people and am scared to death, both ways. And I think people who leave this hearing, and I'm glad to hear so many people, like you, saying that they've learned from it, but who leave with smiles on their faces thinking that this is going to take care of all of our problems, are looking at this incredibly simplistically. These are difficult decisions and the ramifications can be extremely positive or it can be extremely negative. And we do ourselves a disservice if we don't walk very slowly down this path as we make

decisions. [LB577]

JIM CUNNINGHAM: And I don't want to give any impression that we are underestimating the complexity of this, and I take your admonishment in good stead for consideration. I would have to say that based on the dialogue that has occurred here today, a lot of it inspired or initiated by your questions, I think is encouraging that these issues can be adequately addressed, and I believe that the essence of increasing access to healthcare for people who have a right to that healthcare will ultimately be the prevailing result of all this. I'm confident that with the people who have testified here today and people like you and the other senators, that these issues can be adequately addressed. [LB577]

SENATOR GLOOR: Well, I say that as a bad Catholic, because as you know I'm Protestant; but as somebody who has an incredible amount of admiration for the church's commitment to serving... [LB577]

JIM CUNNINGHAM: Thank you. [LB577]

SENATOR GLOOR: ...as a ministry and a deeper understanding of this difficulty, as a result of a variety of tough decisions that the church has made when it comes to providing these scope of services. So this is both a chance to run up a flag. There's no admonishment here. It's just...I'm glad to hear that letter, and I know within that letter there is an understanding that this is a difficult issue. So thank you. [LB577]

JIM CUNNINGHAM: Thank you. [LB577]

SENATOR KRIST: I guess that makes me a bad Protestant. (Laughter) [LB577]

JIM CUNNINGHAM: I would like just to add one thing to Senator Gloor's comment. I do have a comment in my written testimony about the importance of Catholic healthcare ministry. In the interest of time, I left that out, but I appreciate very much you alluding to that. Thank you. [LB577]

SENATOR KRIST: Thanks, Jim. [LB577]

JIM CUNNINGHAM: Thank you. [LB577]

SENATOR KRIST: Next proponent. And just a show of hands for the proponents that remain. One, two, three, four, five, six. Not to interrupt and I don't want to do this, but by popular consensus it's time to take a break. So let's take a ten-minute break and come back. Okay. [LB577]

MONICA MARTZ: Okay, my name is Monica Sheehan Martz, it's M-o-n-i-c-a

S-h-e-e-h-a-n M-a-r-t-z. And I am in favor of expanding the Medicaid eligibility because in 2000 I was diagnosed with an illness and then in 2008 I decided to open my first small business, and I was not able to get covered for health insurance from...three different insurance companies denied me and then two of them said that they wouldn't even put my application in because they knew it would be denied. So I did not have health insurance, and still do not have health insurance; but I am a hair stylist and there's millions of us. Everybody has one. And there's a lot of us that have our own suites, our own businesses now, and so there's no pool that exists for people in the hair industry or the beauty industry as far as I know; but it is definitely an issue that many, many of us face. So yeah, now I have a daughter, she's eight months, and she's covered under Medicaid, but I am not. And so it would be really nice to be able to know that I have healthcare coverage in the event that anything should happen. I am her provider, her sole provider, so yeah, it's pretty important. But yeah, so that's my stance. I'm a single mom and I need healthcare coverage so I can take care of my daughter. It has forced me to be very health conscious and take care of myself and eat well and all of that, which is great. But in the event that any catastrophic event should happen, I need coverage, and so I'm in favor of this. So thanks very much. [LB577]

SENATOR KRIST: You're one of those people that's just one accident away, basically. [LB577]

MONICA MARTZ: Um-hum. Yeah. [LB577]

SENATOR KRIST: Any questions for Monica? Senator Campbell. [LB577]

SENATOR CAMPBELL: I just want to ask this question for the record, because a person who has been helping today watch her child, said be sure this question is asked. You were not eligible at 100 percent of the federal poverty level, is that correct, Monica? [LB577]

MONICA MARTZ: Right. Um-hum. [LB577]

SENATOR CAMPBELL: At 138 percent, you would qualify. [LB577]

MONICA MARTZ: Um-hum. That is true. [LB577]

SENATOR KRIST: An important definition. Thank you, Senator Campbell. [LB577]

SENATOR CAMPBELL: Thank you. [LB577]

SENATOR KRIST: Monica, thanks for sticking around. [LB577]

MONICA MARTZ: Thank you. [LB577]

SENATOR CAMPBELL: Thank you, Monica. [LB577]

SENATOR KRIST: Next proponent. Welcome. [LB577]

JOHN CAVANAUGH: (Exhibits 36-39) Senator Krist, Senator Campbell, thank you and members of the Health and Human Services Committee. I am John Cavanaugh, J-o-h-n C-a-v-a-n-a-u-g-h, and I'm here today to testify in support of LB577 on behalf of the Nebraska Child Healthcare Alliance, a coalition of child healthcare advocates, including Building Bright Futures, Boys Town, University Hospital, Nebraska Medical Association, Creighton University. I'm also submitting written testimony supporting LB577 from Building Bright Futures and Voices for Children and March of Dimes Foundation, and that's being distributed to you. Participation in the Medicaid expansion to enable working, uninsured Nebraskans access to healthcare makes sense from a wide variety of perspectives. And I think that the hearing today has highlighted just how many lives and in how many different ways this legislation touches Nebraskans. As advocates for children and improving educational outcomes, we know that if parents have access to healthcare they make sure that their children are also covered while also promoting preventative care and lowering costs in the healthcare system by reducing the use of more expensive treatments and services, like the use of emergency rooms into the healthcare system. This legislation allows uninsured parents with incomes between 62 percent and 133 percent of the federal poverty level to access health insurance. Healthy parents are better able to take care of their children in promoting good habits. The true choice here is not between quality education and access to healthcare, as you've heard from earlier testimony from educators as well as healthcare providers. We know that children in healthy families learn better. It's why we initiated school-based health centers in Building Bright Futures and Building Healthy Futures, with the help of the Legislature. LB577 actually saves money in our healthcare system and makes sure our minimum wage and part-time workers and parents have access to healthcare. The education community understands this and so does the health community. Medicaid expansion is an opportunity to improve the lives of every Nebraskan, and we should seize it with enthusiasm. I thank this committee for really, I think, a terrific hearing here this afternoon where you have gotten the picture of just how comprehensive this legislation is in terms of its impact on the quality of lives in our state. And I salute Senator Campbell and her cosponsors for the leadership and this committee for the diligence that you've obviously put forth in this committee. Thank you. [LB577]

SENATOR KRIST: Your observation is mine, John, and you're the number 21 guy in line and usually you have to remind people if the testimony has been given before skip over it. The diverse testimony that we have had has been enjoyable to hear and it will continue I'm sure. Thank you. [LB577]

JOHN CAVANAUGH: Thank you very much. Thanks. [LB577]

SENATOR KRIST: Next proponent. Welcome. [LB577]

LOWEN KRUSE: Thank you. Senator Krist, Senator Campbell, and hello to all. I am Lowen Kruse, L-o-w-e-n K-r-u-s-e, and I'm here to testify for LB577. And I would just underline what John said and what some of you have said and what we were saying during the break. I used to think set hearings were a little bit of a pain, especially when I had to be in them all the time, but I am impressed. And I'm more impressed as years go by with the importance of this institution and, again, the quality today. Having spent eight years on Appropriations, I hear the dollar signs question floating around in the room and would speak to it very briefly. You have spoken to it a lot yourselves already. The question kind of floating is: If we avoid paying costs of low income, would that be kind of an economical way to go? Some of them will die so they won't cost anything, you know. I'm just talking as the mathematics teacher here or something. Well, the answer clearly is no. We will pay for those costs; guaranteed we will pay for those costs plus penalties. Now that's been set forth a number of ways today so I'm not going to pursue that. I'd rather go a different direction and follow the question why. As you say, let's get a little different angle on it. Why would we pay for these persons that we don't know, these strangers out here? Is it because they're so deserving? I did a lot of research on this and some of it's in my book, and I know you've memorized my book so I'm not going to have to repeat it (laughter). But is it because they're deserving? No. Is it because they are hardworking citizens? We love to put those two words together. It's kind of humorous, isn't it? You know, what about the citizens that aren't hardworking? Well, neither one of them push the needle over on this. Is it because they paid taxes or, you know, whatever else that we want to put into it? No. We...I live in a neighborhood where Mrs. Jones is down the street and if she falls and breaks her hip, are we going to let her die in the middle of that room? She doesn't have insurance. She doesn't have family. She doesn't have friend. Nobody is going to come in. Do we let her die? We all know the answer. No. No, we will not allow that. So the question isn't about all of these people, who's deserving and so on. It's about us. It's who we are. We are not going to let Mrs. Jones die, even though it would be of an economic benefit to us to do so. And I would then quickly respond to the things I also hear in the air is, well, this is because we've just suddenly gotten so compassionate, conservative, or whatever term you want to use for it. And that's kind of a recent thing and we suddenly care about all these people, and...no, I couldn't find any evidence of that. And I pushed back on it and I'm going to save you all the details, but I'll go back to my grandmother, Petrea Frimann in Howard County in the '30s, before there was any of this stuff. She was deserving, in my mind, she paid taxes and she ran a farm as a widow for ten years trying to keep things together, and her...and she'd been robbed of the pension from her husband who worked for 20 years for the federal government. You know, is she deserving, all that? It was because she was Petrea Frimann in Dannebrog, Nebraska. When she was in her own home before she became senile, Dad and I would come in and cut wood in the neighboring woods and stuff so she had fuel for a fire, and we'd bring milk in and cream

and so on, and eggs, and you know. But when she had to get out on her own, the Howard County commissioners who were just as generous and liberal-minded as they are today (laugh), paid her bills, 100 percent of them for the rest of her life. This is not a new thing among us. So I would also...as I tried to think about it, turned it upside down and say, if we were just starting with Medicaid, what would we learn by sweeping all that stuff away? Well, you have that type of answer. My time is up. I'll just let your minds fill in that answer. We will pay all the bills. The question is, by what method will we pay them? Thank you. [LB577]

SENATOR KRIST: Thank you, Senator, for coming. Any questions for Senator? Senator Howard. [LB577]

SENATOR HOWARD: Senator Kruse, it's nice to see you again. And just for the record, we go way back. [LB577]

LOWEN KRUSE: A little bit. [LB577]

SENATOR HOWARD: He actually presided at my sister's funeral. And so I just wanted to thank you for your testimony, because it really helps to remind me of what we're doing here. So thank you. [LB577]

LOWEN KRUSE: It becomes more extraordinary to me the further I come along. Like I said, back in those days I was just balancing the bills like you all are doing...like you all are doing. It drives me crazy a little bit from the appropriations thing. It just was maddening that we would never deal with long range. One year, Senator Wickersham introduced a bill that we have a long-range planning committee, a task force. It didn't pass. And the reason stated on the floor was, we are not going to pay any attention to what we know is going to happen ten years from now because we're trying to meet this year's budget. That is foolishness. [LB577]

SENATOR KRIST: I don't have to tell you there are so many initiatives going on now for strategic planning... [LB577]

LOWEN KRUSE: Yes. Yeah. [LB577]

SENATOR KRIST: ...and so your leadership eventually paid off. [LB577]

LOWEN KRUSE: Well, you're turning the corner. But I'm just acknowledging that's a tough corner to turn... [LB577]

SENATOR KRIST: Yes, sir. [LB577]

LOWEN KRUSE: ...because by nature--and I'm not excluding myself from it--I was

trying to balance that year's budget. [LB577]

SENATOR KRIST: Yes, sir. Thank you so much for coming. [LB577]

LOWEN KRUSE: Thank you. [LB577]

SENATOR GLOOR: Thank you, Senator Kruse. [LB577]

SENATOR CRAWFORD: Thank you. [LB577]

SENATOR KRIST: Next proponent. Hi. Welcome. [LB577]

PATRICIA JURJEVICH: (Exhibits 40 and 41) Good afternoon, Senators. My name is Patti Jurjevich, P-a-t-t-i J-u-r-j-e-v-i-c-h, and I am the regional administrator for Region 6 Behavioral Healthcare. I appear today on behalf of the Nebraska Association of Regional Administrators in support for LB577. The Nebraska Association of Regional Administrators is a coalition of the six regional administrators for behavioral health across the state of Nebraska. We'd like to express our appreciation to Senators Campbell, Krist, and Nordquist for their efforts to bring this bill and the concept of Medicaid expansion embodied in the Affordable Care Act to this committee and to the Legislature for its consideration. We support LB577 and the potential it has for providing coverage for individuals for both mental health and substance abuse needs. We have long believed that the purposeful and deliberate expansion of Medicaid into these services is absolutely essential and have appeared before this committee in support of legislation that we thought did so. I could easily echo the supportive comments made by many others, and I will not take your time in doing so. Rather, we would like to focus attention on the financial analysis performed by the Division of Behavioral Health and provided to the Fiscal Office. That document indicates a potential savings to behavioral health of $14 million in the first year and $29 million in each year thereafter. We advise the committee to proceed with caution in this area. For your use we have provided the committee with an inventory which is an initial prediction of services which we believe likely, might in the future, and will not be included with expanded coverage. In this regard, while there may be alternative funding sources in the system due to insurance and Medicaid coverage, there remains a need for additional services. Only 14 days ago we appeared before this committee on LB556, Senator McGill's telehealth bill, and indicated there is a $3.5 million unmet need across the regions for the Professional Partner programs. That is just one example. The value in creating or expanding early intervention activities for our youth and their families, treatment for services for women with children, support for transition-aged youth, and further development of community alternatives to higher, more restrictive levels of care, to name a few, are worthy of consideration for the potential reinvestment of dollars. Ultimately, if the cost savings that are projected are realized, it is our strong recommendation and belief that those dollars should be recommitted to the behavioral health system to fund programs that can

provide even more savings going forward. In conclusion, we support LB577. We would also like to thank you and the cosponsors for introducing this legislation, and I would be happy to try to answer any of your questions. I also do have, for the record, a letter of support from the Children and Family Coalition of Nebraska. [LB577]

SENATOR KRIST: Thank you so much. Any questions for Patti? Thank you for your testimony. [LB577]

PATRICIA JURJEVICH: Thank you. [LB577]

SENATOR KRIST: The next proponent. Welcome. [LB577]

LINDA DUCKWORTH: Thank you. Thank you, Chairman...I mean Vice...whatever... [LB577]

SENATOR KRIST: Whatever, yeah. [LB577]

LINDA DUCKWORTH: ...Senator Krist and everybody. I'm Linda Duckworth, L-i-n-d-a D-u-c-k-w-o-r-t-h. I am president of the League of Women Voters of Nebraska, and I'm here to let you know that the League of Women Voters does support LB577. And I've got four points and none of them really flow very well, so I'll just go ahead and make them and this will be pretty quick, I think. I just wanted to say I have been thinking of what it takes to make a well-run community. And Senator Kruse kind of talked about that too. But a well-run community, to me, is one that recognizes that not everybody has good luck in a lot of different ways. And so they figure out...the community, and by that I might mean a state or a country or whatever, but they figure out a way to make it work for everybody, whether they are lucky or whether they're hardworking or whatever--but especially that luck factor, you know. Because a lot of people end up sick or ill, injured, whatever, and you just never know who that's going to be. And I think it's important for us to have coverage, healthcare coverage, in the case of bad luck. Another thing is when I first came in, I sat next to a young man who was planning...he had been planning to testify against this, and then he decided he wasn't going to do that after all. He wasn't feeling well enough or something, I don't know. But anyway, he told me that he was very concerned about this actually happening, that he believes he doesn't trust the government to actually pay that 90 percent...pay the 100 percent for the first three years and then pay the 90 percent after that. And so I would like somebody to address that, because I fully...I sincerely believe that it will be that there is not going to be any reneging on this. But at the same time, yeah, what is the...exactly how do you answer that and what is the...what kind of mechanism do we have that will guarantee that this is, what they say is going to happen, is going to happen. So that was his...I'll just help him out by mentioning that. And then another person has...more than one person has said they have talked with people who are confused about their coverage or about what kind of coverage they would have. And so I would like to ask Senator Campbell,

Senator Krist, anybody who is involved with this about perhaps having some really good communication between the insurance, the Medicaid, and the people who actually will receive it, because I don't think necessarily getting on your computer and trying to get the answers is going to work. I think there will have to be some actual persons on the phone that can answer questions and can really help. And I have no idea what that's...how...where that is with this. And then the fourth issue was...actually it was...it's kind of a response to you, Senator Gloor. You were asking about this, how this is so complicated and is this really going to work and should we jump in. And all I wanted to say about that is, I think that miracles happen and I think that may be what it takes for this to happen, for this to go reasonably smoothly. I think we probably know smooth isn't something we can...well, of course, we can hope for that. But reasonably smoothly? Let's work for that and let's go ahead and count on some miracles too. So please advance the bill. I think this would be a good thing for Nebraska. [LB577]

SENATOR KRIST: Do you want to comment? [LB577]

SENATOR CAMPBELL: No, no. [LB577]

SENATOR KRIST: Thank you for your testimony and all of the well-placed cautions, and especially for talking about someone who has a concern. I like to do that when I present a bill, when I hear that there's testimony that's in opposition, to speak to those things to make sure. We're in a position where not everybody sitting behind this counter agrees 100 percent on what's going on. [LB577]

LINDA DUCKWORTH: Right. [LB577]

SENATOR KRIST: So we're going to have to have 49 policymakers agree on how to go forward. [LB577]

LINDA DUCKWORTH: Another miracle. [LB577]

SENATOR KRIST: Yeah, it will be a miracle. This is not going to be an easy task, so all of your cautions, warnings, they're all well-placed. Thanks for your testimony. [LB577]

LINDA DUCKWORTH: You're welcome. Thanks. [LB577]

SENATOR KRIST: Next proponent. [LB577]

MARK INTERMILL: (Exhibits 42 and 43) Thank you, Senator Krist and members of the committee. My name is Mark Intermill and I am here today on behalf of AARP. I'm also submitting a statement from the Nebraska Nurses Association. And Don Wesely now owes me so I want that on the record. [LB577]

SENATOR KRIST: I know where he's at. Go ahead. [LB577]

MARK INTERMILL: We do strongly support LB577, and I just have two points that I'd like to make. The first has to do with our youngest members, those between the ages of 50 and 64. The policy of the state of Nebraska is to allow unlimited age rating of health insurance. As a result, Nebraskans who are closing in on Medicare age are paying some of the highest health insurance premiums in the world. I have an example here. I looked at the CHIP program to identify what the cost of insurance would be for a 64-year-old male who is a nonsmoker. It's $1,473.78 a month, or $17,685 per year. The group of individuals we're talking about today are people who have incomes, at most, around $15,000. So a CHIP policy...I should add that this is for a policy with a $2,000 deductible. So this individual, if a person had $15,000 in income, they would pay 118 percent of their income for the CHIP plan and then have the privilege of paying a $2,000 deductible. We have about 19,000 Nebraskans who are between the ages of 45 and 64 who are uninsured. We're squeezing these individuals out of the market. We need some sort of means of addressing their health insurance needs, and we think this is part of the answer to that problem. The second point I want to make has to do with the fiscal argument about LB577. We have looked very closely at the fiscal issues surrounding all of the Affordable Care Act, because basically AARP is an association of taxpayers and we're interested in making sure that government expenditures are made wisely and that they're made efficiently. We have looked at...as we looked at the Affordable Care Act we...it was enacted under congressional rules that required that the cost, any costs that were included in the act, are offset either by spending cuts or tax increases. In fact, the Congressional Budget Office says that, at least in 2010, that it would result in a net reduction in the federal deficit of $143 billion. So for every dollar that's spent in the Affordable Care Act, at least $1 is offset in either spending cuts or tax increases. Those spending cuts and tax increases have been...they're in the cake. They have been cooked in. Nebraskans are starting to pay those taxes. Nebraskans are starting to feel the effect of those spending cuts, and a lot of the spending cuts are in the Medicare arena. The question before you as you think about LB577 is not whether Nebraska will pay more taxes to support the Medicaid expansion in Nebraska; the question is whether we get anything back from the taxes that we've already paid from the Medicare cuts that have already been incurred. If we don't do the Medicaid expansion, we won't. We will forgo those funds. And we will continue to leave the 50- to 64-year-olds with these exorbitant health insurance costs. We will continue to leave those who have behavioral health needs without opportunities to get the care they need. So for those reasons, we believe that this is as close as any bill I've seen in the Legislature in the time I've been coming here, that's as close to a win-win as anything I've ever seen. And so we would encourage you to advance LB577 to General File, and I'd be happy to try to answer any questions. [LB577]

SENATOR KRIST: Thanks, Mark. Any questions for Mark? Senator Gloor. [LB577]

SENATOR GLOOR: Thank you, Senator Krist. And Mark, bear with me. You know, I'm playing contrarian roles, so people like you and Mr. Cunningham have to field questions I try and ask and bring up issues that I think are important. I'm speaking specifically about those individuals you represent who are over the age of 65. Do you get complaints from them about the difficulty of getting in to see physicians? [LB577]

MARK INTERMILL: We do. [LB577]

SENATOR GLOOR: And you know...go ahead. [LB577]

MARK INTERMILL: Especially those who are just turning 65. I think...which leads me to believe that it's going to become a growing issue, and I think a lot of it has to do with Medicare physician payment policy. [LB577]

SENATOR GLOOR: Which isn't a big leap then to say, and if Medicare pays better than Medicaid, we're talking about the same level of problem when it comes to Medicaid in the (inaudible). And I'm guessing that you would agree with me if I said that seniors are less likely to be insistent like young, youngsters like me and Senator Krist, you know, when they call up to the physician about getting in. In other words, you know, I need to get in; my blood sugars, I know it's time for me to have my blood sugars. They're less likely to make that phone call and be insistent with the nurse or the scheduler to get in. Is that a fair representation? [LB577]

MARK INTERMILL: Well, then there are people under 65 like me who have been sick for ten days and haven't gone to the doctor yet. [LB577]

SENATOR GLOOR: You look great, though, for what it's worth. And so herein lies part of the conundrum we're faced with, and that is we are excited again about an increase in the population that can supposedly access physicians at a time when we don't have the number of care providers we should have, and although we talk about the lives we're going to save, I worry about the lives we're going to lose of seniors who, because they're less insistent, don't get on the schedule and get that hypertension and that blood sugar taken care. I worry about my parents. I worry about my friends who are elderly and their friends who can't get on the schedule because we just don't have enough people and enough slots to get people in. So again we walk away feeling great about the increased number of people who have insurance, but what are the ramifications of that if we don't have enough doctors' schedules to fill in this state--and other states across the nation, as far as that goes? [LB577]

MARK INTERMILL: And I have two analogies that are...and I'm trying to figure out which one to use here. But I'm going to use the Jenga analogy. Jenga is a game we used to play with my kids where you have a stack of blocks and the objective is to try and take one out without knocking over the tower. And the access to physicians is one of those

blocks. You know, we need to make sure that we don't pull that one out so that we topple over the tower. But my other analogy is the chicken and the egg: which one comes first. Does coverage come before supply or does supply come before coverage? I think that without coverage, I don't know that we'll ever get the supply. So I guess that's how I would answer. [LB577]

SENATOR GLOOR: It's a fair point; certainly a fair point. Thank you. [LB577]

SENATOR KRIST: Thanks, Mark. Next proponent. How about the first opponent? Welcome, Director. [LB577]

VIVIANNE CHAUMONT: (Exhibit 44) Welcome. Thank you, Senator. Good afternoon, Senator Krist members of the committee. My name is Vivianne Chaumont, V-i-v-i-a-n-n-e C-h-a-u-m-o-n-t. I'm the director of the Division of Medicaid and Long-Term Care for the Nebraska Department of Health and Human Services. I'm here to testify in opposition to LB577. And in the interest of time, I want to give you the good news that I'm not going to read my entire testimony. But before I get started on the testimony, I do want to take the opportunity to point out one important area in the fiscal note of the department and the Legislative Fiscal Office that are starkly different. One of those requirements of the Affordable Care Act is the health insurer fee which, by the way, is one of the funding mechanisms that Mark just talked about. They forgot to exempt government programs. So the insurer fee that is charged to insurance companies, the managed care companies, private managed care companies is also now charged to Medicaid managed care companies. And, of course, either way the rate gets passed on to the state to pay to the managed care companies that do Medicaid work or for policyholders to pay for the insurer fee that's involved in the ACA. So we contract with several insurers through the managed care programs and, therefore, that increase will cost us an increase in payments. The Legislative Fiscal Office calculates that the cost of that fee is about $7.9 million and attributes it all over the first two years--fiscal year '14, fiscal year '15--and attributes that entirely to federal funds. The department estimated in its budget or in its response to the fiscal note we calculated about a $9.45 million fee, but allocated $3.75 million over the two years in General Fund. A comparable allocation using the Legislative Fiscal Office's number would increase the General Fund to $3.5 million General Fund dollars for fiscal year '14 and '15. The federal government has yet to issue any guidance on this health insurer fee. However, recent actions related to the increase in payment rates that I'll talk about in a little bit have indicated that although the increase in the payment rates is 100 percent federal funded, the federal government is saying that the insurer tax fee on that 100 percent federal funded will be assessed at the regular match rate. So it is not clear what they're going to do with that. And we believe that we should be cautious and that there is a $3.5 million to $3.75 million General Fund impact that's not noted in the legislative office's fiscal note. We wanted to make sure that you knew that. I just wanted to let you know that there's mandatory provisions of the ACA and those are found in...we've

accounted for those in the Governor's budget. And then we estimate that as a result of those mandatory provisions involved in implementing the Affordable Care Act that we'll have more than 48,000 Nebraskans will enroll in the Medicaid program through fiscal year 2020, requiring more than $770 million additional funds for the Medicaid program. This impact to the Medicaid program is a direct result of the ACA. It's a mandatory expansion of the Nebraska Medicaid program even if Nebraska does not choose to add a new category of individuals as proposed in LB577. For this required Medicaid expansion, the federal government will provide funding at the same match rate that it currently provides funding at. We estimate that the expansion under LB577 will result in an additional 95,000 clients through 2020 and a cost of $2.7 billion to Nebraska taxpayers. We believe that we have not...that those do not estimate the additional services that are required by the ACA to be offered to the expansion population, and this includes the early periodic screening diagnosis and treatment services for the 19- to 21-year-old population and habilitative services which are currently only offered through home and community-based services developmental disabilities waiver. It's impossible for us to estimate what those additional costs will be. But when we're talking about one in five Nebraskans being covered by Medicaid, we have to set aside...setting aside the impact to the budget, this large increase in Medicaid enrollment raises serious concerns about access to care. And many healthcare providers either limit the number of Medicaid clients they see or refuse to see any Medicaid clients. Expanding enrollment in Medicaid will exacerbate this problem. Access to care issue always increases pressure to increase rates which would further increase the cost to the state budget. Even with initial support of initial federal support, federal funds will decline by 10 percent over the six years, shifting a staggering burden on the state. I would recommend you review the department's fiscal note on this bill and the budget regarding the ACA expansion. We're going to experience a large increase in our population, even without expanding Medicaid. And this increase will put pressure on Nebraska's budget as well as on the healthcare delivery system. LB577 can only aggravate that pressure. I'd just like to clarify a couple of points that some other folks made if that's okay. [LB577]

SENATOR KRIST: Sure. [LB577]

VIVIANNE CHAUMONT: I just want to talk about the rate increase for physicians. That is a requirement in the Affordable Care Act that Medicaid is to increase for certain physicians certain things, increase to 100 percent of the Medicare rate. The difference between the Medicaid rate and the Medicare rate is paid at 100 percent federal dollars. I think Senator Gloor keeps making the point it is hard for people to get access to Medicare these days and their rates are higher than Medicaid rates. So that is not a cure-all for the access issues that we think are going to happen. And we also had hospital folks talk about the disproportionate share hospitals. We see no fiscal impact to Nebraska hospitals at least until fiscal year 2018, and we are not seeing the hundreds of millions of dollars that they're saying that are going to be impacted. Much of the DSH payment in Nebraska, the General Fund, is provided by the hospitals themselves, and

then Medicaid matches that General Fund to get the federal match. So even if ongoing 2018, even if there is a change, and the federal government has yet to issue any regulations, any guidance, any anything on DSH. I will believe that cut when I see it. But here in Nebraska regardless it will not come until 2018. I just wanted to make clear that everyone knew that. Several people testified about expanding coverage for kids. We're talking about 19 to 64, that's the expansion population. And then I just want to talk about the hidden tax. You know, everyone talks about how we're going to save the hidden tax that we all pay as policyholders. I haven't seen any insurance company come out and say that they're going to have lower premiums on January 1, 2014. I haven't seen any hospitals, anybody say that they're going to lower their charges or do anything like that in 2014. I do not believe that we're going to see a shortage or a downturn in premiums. We may see some premiums stay flat while deductibles increase and copays increase. But that's still a tax on...we just don't believe that there's any documentation to show that the hidden tax that supposedly we are all paying is going to go away. So that hidden tax is going to be there and Nebraska taxpayers are going to spend $2.7 billion more through the next...through fiscal year 2020. And for all those reasons, we oppose this bill. [LB577]

SENATOR KRIST: Can one of the pages come over. Were you here for the initial testimony from the doctor from UNMC? Did you hear that, the first one? [LB577]

VIVIANNE CHAUMONT: Yes. [LB577]

SENATOR KRIST: Okay. I'm going to give you a copy of this because everybody is throwing numbers around. [LB577]

VIVIANNE CHAUMONT: Um-hum. [LB577]

SENATOR KRIST: The Governor is throwing numbers around, you're throwing numbers around. Milliman study started out saying one set of numbers. Now we add a new set of numbers. I would love for you to take a look at these numbers, not now, I'm not putting you on the spot. I'm just saying... [LB577]

VIVIANNE CHAUMONT: Sure. [LB577]

SENATOR KRIST: ...this does not match what the administration is saying. And some of the numbers that you just said in the $2 billion range seems like it's on the other side of it they're saying there's savings involved. And it would be our intent to capture that savings as we come in. So what we're after really is the truth. And I don't think that the truth is on the left or the right. But we have to decide here before June, before we leave, and we will as policymakers, how we're going to go forward. The only thing I would ask you today is for your promise that whatever we do, Medicaid is going to...your department is going to support whatever is going to go forward. [LB577]

VIVIANNE CHAUMONT: And we are charged with implementing state and federal law as is adopted. [LB577]

SENATOR KRIST: Okay. [LB577]

VIVIANNE CHAUMONT: And there is no doubt in my mind...and, you know, we are as interested in the truth as you are. We...my division contracted for that study in 2010 shortly after the ACA got passed because we wanted to have information about how much we thought this was going to affect Nebraska. There was a lot of unknown. There were no federal guidance. There wasn't anything. We did that and we got certain numbers. As federal guidance became known and we got better data, we asked, we asked Milliman, this administration asked Milliman to update their report and lowered it substantially, if you see the 2010 report and the 2000...January, what is it, January 8, 2013, report because we, too, are interested in what the truth is and how that truth applies to everyday Nebraskans. [LB577]

SENATOR KRIST: The one thing you and I are going to agree 100 percent on is that the federal government is not forthcoming with any of the information that we need as policymakers to make long-term decisions. So together we'll get to the end of this road. [LB577]

VIVIANNE CHAUMONT: The federal government has a lot on their plate and they have not, you know, I have to be sympathetic to them as well. The ACA threw a big huge chunk of stuff on their plate. But they have not been very timely in coming out with guidance, which makes it very difficult for all 50 states to implement something where, you know, January 1, 2013, when the guidance comes out in December and says and by the way, there's more guidance coming in January. [LB577]

SENATOR KRIST: Yeah, stand by. [LB577]

VIVIANNE CHAUMONT: But we are doing the best we can to implement the federal law, and we will do the best we can either way. But in the meantime we oppose the bill. [LB577]

SENATOR KRIST: And again I will tell you thank you for appearing and thank you for testifying. It helps us incredibly. [LB577]

VIVIANNE CHAUMONT: Did you want me to do something with this? [LB577]

SENATOR KRIST: No. I would like you to get back to us with that... [LB577]

VIVIANNE CHAUMONT: Okay, okay. [LB577]

SENATOR KRIST: ...because the numbers...I would like to hear your assessment of that part of it. [LB577]

VIVIANNE CHAUMONT: Okay. [LB577]

SENATOR KRIST: Any other questions for the director? [LB577]

SENATOR HOWARD: I have a question. [LB577]

SENATOR KRIST: Senator Howard. [LB577]

SENATOR HOWARD: I always do. I'm sorry. [LB577]

VIVIANNE CHAUMONT: That's fine. [LB577]

SENATOR HOWARD: I'm learning a lot here. [LB577]

VIVIANNE CHAUMONT: I'm here to answer them. [LB577]

SENATOR HOWARD: I made a list. If this legislation were going to pass, do you think the newly eligibles would also be in managed care? [LB577]

VIVIANNE CHAUMONT: That would be the plan. [LB577]

SENATOR HOWARD: That would be the plan is that they would go... [LB577]

VIVIANNE CHAUMONT: Yes. [LB577]

SENATOR HOWARD: And so can you talk about the role of managed care in ensuring provider access for Medicaid recipients. [LB577]

VIVIANNE CHAUMONT: The role of managed care is to have a primary care physician, I mean one of the roles, there's a lot of roles. One of the roles related to what you are talking about is to have a primary care provider for every Medicaid client. That right there can be a struggle, and we're talking about adding another 150,000 people...the 48,000, I rounded there, the 48,000 that we estimate are going to happen anyway and then the 95,000. That would be their role. But the managed care company cannot produce doctors, they cannot produce nurses, they cannot produce physical therapists, and they cannot force anyone to take the Medicaid program. So their role is to facilitate access into managed care so that people get the care they need when they need it, which saves money. It makes for healthier people, which saves us, you know, money. But, you know, they can't create providers where there aren't any. [LB577]

SENATOR HOWARD: But when we began managed care, didn't we talk about using managed care to improve access in the first place? [LB577]

VIVIANNE CHAUMONT: Yes. [LB577]

SENATOR HOWARD: And has it done so? [LB577]

VIVIANNE CHAUMONT: I think it has. I mean they have programs to try to help people to have...to give them a doctor so they don't go to the emergency room. It is hard to...it's a cultural change for a lot of people, you know, to...for a variety of reasons to wait, make an appointment with their doctor as opposed to just go to the emergency room. But I think we've done a good job in providing current Medicaid clients the care that they need. But we're talking about another 145,000 to 150,000 more people. [LB577]

SENATOR HOWARD: So since I asked the question about the role of managed care and we've been talking about provider rates left and right, can you talk about the role of provider rates in ensuring provider access? It's the same question, just different. [LB577]

VIVIANNE CHAUMONT: Well, in the last 5.5 years I've never heard so many providers happy with their rates as I have at this hearing (laugh) so it's been great. It's duly noted. You know, for the last 5.5 years what I hear is we don't pay hospitals enough, we don't pay physicians enough, we don't pay anyone enough. And Medicaid's, you know, Medicaid's rates are some of the lowest, without a doubt. [LB577]

SENATOR HOWARD: So when providers say that they would rather have compensated care at low rates than uncompensated care, would you say that's strategically wise for them? [LB577]

VIVIANNE CHAUMONT: For private providers, yes, definitely. And I think for the federally qualified health centers as well because they are required to take uninsured people. That's their mission. That's their goal. And they do, you know, ability to pay. And Medicaid rates for federally qualified health centers are the highest provider that we pay. So, yeah, it makes sense for all of them. [LB577]

SENATOR HOWARD: And then I have some questions about efficiency as well... [LB577]

VIVIANNE CHAUMONT: Um-hum. [LB577]

SENATOR HOWARD: ...because you've done a really good job with that, according to the last Medicaid report. So what's been the growth in payments under...obviously I

read everything, what's been the growth in payments under the Medicaid program in the last several years? [LB577]

VIVIANNE CHAUMONT: I don't remember this last one. [LB577]

SENATOR HOWARD: For in our FMAP. [LB577]

VIVIANNE CHAUMONT: It's been...oh, I'm sorry. [LB577]

SENATOR HOWARD: Oh, our growth in Medicaid payments, yeah. [LB577]

VIVIANNE CHAUMONT: Our growth in Medicaid payments. [LB577]

SENATOR HOWARD: Growth in payments under the Medicaid program. [LB577]

VIVIANNE CHAUMONT: A percentage. [LB577]

SENATOR HOWARD: Yeah. [LB577]

VIVIANNE CHAUMONT: Yeah. I don't remember this last year one, but if you have that Medicaid reform report it's right there in front of you. [LB577]

SENATOR HOWARD: I don't have it with me. I should have brought it. I'm sorry. [LB577]

VIVIANNE CHAUMONT: I think the... [LB577]

SENATOR HOWARD: I just brought my questions. [LB577]

VIVIANNE CHAUMONT: I think we have been very lucky in Nebraska and I think we have done things to manage the Medicaid program and it has, you know, it used to be double digits. It hasn't been double digits. It's been less than 5 percent, even with, you know, increasing clients. But that's as a result, I believe, of some of the things that we have done to make the program more efficient and as a result of managed care. So, but some of the things are trying to keep people in the community as opposed to nursing homes. We have increased the percentage of people in the community as opposed to in nursing homes, so that saves money. And then we have done some other things. We've done radiology management. We did the preferred drug list, preferred drug list in managed care, and so we have worked very hard to make this program as affordable and provide the best coverage that we can for the people that are our clients. [LB577]

SENATOR HOWARD: So would you say it's a fair statement that we have a really lean and efficient Medicaid program here in the state of Nebraska? [LB577]

VIVIANNE CHAUMONT: I think that there's things that we could do way more efficiently. I mean I think there's always room for improvement and we constantly strive to try to improve. We also strive to try to be as efficient as possible and put as little burden on the providers as we can. Sometimes our friends in Washington, D.C., don't help with that. You know, they keep adding audits and things that we are required to do and that's an administrative burden that may or may not, I think, in the long run pay off to the Medicaid program. But we try to make things more efficient so that there's less administrative costs for providers. We've done a lot of work with nursing homes on that, and I think are implementing some new things to make their administrative...and if we can't give them higher rates but we can cut their administrative costs, that is hopefully money in their pocket. So I mean we have done a lot of work, but I would say we still have a lot of work to do. [LB577]

SENATOR HOWARD: That's actually really...thank you for your testimony. It makes me feel better that if we were able to expand Medicaid to this new population that they would be going into a Medicaid that is efficient and lean and has managed care focusing on access. I think it's wonderful. [LB577]

VIVIANNE CHAUMONT: Well, you know, we try to run the best Medicaid program that we can. When you say lean, I don't know if you mean administratively lean. [LB577]

SENATOR HOWARD: I mean just efficient. That's what I mean by that. [LB577]

VIVIANNE CHAUMONT: Oh, okay. [LB577]

SENATOR HOWARD: Yeah, because you're doing a good job. [LB577]

VIVIANNE CHAUMONT: Well, thank you. [LB577]

SENATOR HOWARD: Okay. I think that's it. I got through the whole thing. [LB577]

SENATOR KRIST: Anybody else? Senator Crawford. [LB577]

SENATOR CRAWFORD: Thank you. Thank you, Senator Krist, and thank you... [LB577]

VIVIANNE CHAUMONT: I was hoping we could end on that happy note: you're doing a good job, done. [LB577]

SENATOR CRAWFORD: Oh, well, I'll go that that I'm very encouraged to hear the work you're doing with nursing homes and the ways that you've improved efficiencies and brought down those costs, and that makes me all the more confident that we can work

together to try to find ways to improve coverage. You talked about improving efficiencies and improving managed care. So as we do that, that's also the case that while we want each patient to have a primary care provider of some kind, the managed care then also allows us to use middle-level providers as well. Right? So we are... [LB577]

VIVIANNE CHAUMONT: Only if they're allowed through the licensing requirements. [LB577]

SENATOR CRAWFORD: Um-hum. [LB577]

VIVIANNE CHAUMONT: But let me just add, you know, about the efficiencies. We have done things to make the program more efficient, and that is actually the biggest change between the 2000 Milliman report and the 2012 Milliman report. It actually said more people that we had done efficiencies to do the cost of care, to lower the cost of care. But I could tell you that through 2020 there is no way I have $2.7 billion of efficiency to bring to this program, and that's what the cost of this program will be. [LB577]

SENATOR CRAWFORD: You are also currently now working on revamping some of the IT systems and the program as well. Is that correct? [LB577]

VIVIANNE CHAUMONT: We are...to implement some of the changes in the mandatory ACA, we are going to be working on a new eligibility system, Medicaid eligibility system. We are not working on a new MMIS system at this time. [LB577]

SENATOR CRAWFORD: Oh, okay. Okay. Okay. [LB577]

SENATOR KRIST: Senator Gloor. [LB577]

SENATOR GLOOR: Thank you, Senator Krist. I was just going to help you out here and, you know, remind you of patient-centered medical homes being one of the efficiencies that you finally embraced. You're welcome to elaborate on that for the record if you'd like. [LB577]

VIVIANNE CHAUMONT: I, you know, that is the medical home and the health home now, which is a medical home plus behavioral health, are two models that are being widely talked about. We had a pilot in two separate practices as a result of LB396, that was your bill in case you don't remember, and... [LB577]

SENATOR GLOOR: Don't remember the number. [LB577]

VIVIANNE CHAUMONT: And we are in the process right now, the studies...the pilot is over and we are in the process of analyzing that data to see if, in fact, it improved quality and improved efficiency so we should be getting some data shortly and then we

can talk. [LB577]

SENATOR GLOOR: And would you...here's one of my questions since we're not upgrading MMIS. How do we efficiently measure our improvement and efficiencies when we don't have an MMIS system out there that allows us to look in some collated fashion at information that most routine businesses would be evaluated on a monthly basis to see how they were doing? [LB577]

VIVIANNE CHAUMONT: Our MMIS is a challenge. [LB577]

SENATOR GLOOR: You need some money from us? [LB577]

VIVIANNE CHAUMONT: No. I think that right now I'm pretty busy (laugh). [LB577]

SENATOR GLOOR: Well, okay. Do you need some help prioritizing from us? [LB577]

VIVIANNE CHAUMONT: I think I just heard and we believe that our first priority is complying with federal law, and that's the mandatory expansion that we are dealing with the ACA. [LB577]

SENATOR GLOOR: Just trying to help you open a door that you can step through if you want to. Thank you. [LB577]

SENATOR KRIST: The question I have left to ask is related to MMIS. I think that when we talked last year it was a priority for you, but not necessarily a priority for the Governor as I understand his priority list. Can you speak to that? Would you like to speak to that? [LB577]

VIVIANNE CHAUMONT: I work for the Governor. His priorities are my priorities. [LB577]

SENATOR KRIST: That's fine. Thank you. Understand. Senator Howard. [LB577]

SENATOR HOWARD: Okay. I thought of some more. Just in anticipation of opposition testimony that may come behind you, has the federal government ever not paid our FMAP? [LB577]

VIVIANNE CHAUMONT: No. The federal government has not paid our FMAP, but what you have to...but the concern about whether or not the federal government will, you know, where you can rely on the statutory provisions I think is a legitimate concern. One of the first budgets that President Obama put together after passage of the ACA called for a flat FMAP for the states, a flat FMAP which would save the federal government, I cannot remember how many billions or trillions of dollars. If the President is proposing a flat FMAP, which saves the federal government money, guess where the money is

coming from? They're not giving it to the states. Now President Obama has pulled that budget and said that that was off the table. But that's what causes people concern. [LB577]

SENATOR HOWARD: But they've always paid our FMAP since like 1966. [LB577]

VIVIANNE CHAUMONT: Five, yes. [LB577]

SENATOR HOWARD: Okay. And then the other one was do we have a lot of Medicaid fraud in this state, just in case...? [LB577]

VIVIANNE CHAUMONT: You know, I don't know what you mean by a lot. Is there fraud and abuse? Probably more abuse, yes, there is some. I do not believe that there are the millions and millions of dollars that people say, if you just found the fraud you would get it. But Congress, when it passes bills, in the past has passed, in the last three or four years, numerous things we're about to...as part of the ACA we're about to implement the RAC, one of my favorite Medicaid acronyms, recovery audit contractor, where we're required to contract and then we'll do audits and it's supposed to find fraud and abuse. Some states that had implemented that years ago found nothing and some states have found some money. So there are several programs. We have a Program Integrity program that we run, the Attorney General has their Medicaid fraud control unit, and there are a variety of things. Some of the...we did implement a federal requirement whose initials I can't recall right now, but it was NCCI, National something Coding Initiative, that we think clarified some rules; and there will be some savings from that. But I don't really believe that Medicaid fraud is as rampant as some people would like to believe it is. [LB577]

SENATOR HOWARD: Thank you. [LB577]

SENATOR KRIST: Follow-up, Senator Gloor. [LB577]

SENATOR GLOOR: Thank you, Senator Krist. And it is a follow-up on fraud. And I think I might have known this five, six years ago, but I've long since forgot. Failure to document. [LB577]

VIVIANNE CHAUMONT: Um-hum. [LB577]

SENATOR GLOOR: Whether it's a physician or institution that medication was ordered but not documented given, but billed...supplies fall into the same category and whatnot; does that fall ultimately into a category, and then the reconciliation Medicaid does shows that there is no documentation that justifies that a medication was given, the supplies delivered, whatever, is that classified as fraud? [LB577]

VIVIANNE CHAUMONT: I think that's probably more abuse if it's not intentional. It's the intent that, if I remember, makes the difference. And the issue is that in healthcare, period, not just Medicaid or Medicare, private insurance and anything, if it's not documented, it did not happen. And so to say, well, I provided the services but I forgot to put it in the chart, we don't pay for that service. So there is some of that as well, um-hum. [LB577]

SENATOR GLOOR: Well, and I mean I bring it up. It's probably an educational issue, a statement on the record. There is...you hear the two of them thrown together--fraud and abuse. A world of difference between the two... [LB577]

VIVIANNE CHAUMONT: Um-hum. [LB577]

SENATOR GLOOR: ...for fraud and abuse. And just because it's not documented, which can be unfortunately too common occurrence in some places... [LB577]

VIVIANNE CHAUMONT: Um-hum. [LB577]

SENATOR GLOOR: ...doesn't mean that there was an effort to defraud the government of something, but a paper trail that wasn't complete and, therefore, payment isn't going to be made. And it isn't even an abuse of the system I would certainly comfortably argue, but those do get thrown together. And that doesn't mean the care wasn't provided, medication wasn't given, supplies weren't used. Again, I just point out what you already know. [LB577]

VIVIANNE CHAUMONT: Right. [LB577]

SENATOR GLOOR: That we hear fraud and abuse thrown together and shouldn't comfortably do that in a discussion I think. [LB577]

VIVIANNE CHAUMONT: Yeah. And I'll be honest. I don't know if when we use the term fraud and abuse that when my folks that do that when they say fraud and abuse, I don't know if they're including the lack of documentation as either fraud or abuse. [LB577]

SENATOR GLOOR: Well, it may be that that changes... [LB577]

VIVIANNE CHAUMONT: Yes, maybe that's the third thing. [LB577]

SENATOR GLOOR: ...somewhat depending upon the payer too. [LB577]

VIVIANNE CHAUMONT: Yes. [LB577]

SENATOR KRIST: Senator Crawford. [LB577]

SENATOR CRAWFORD: Thank you, Senator Krist. Thank you. Earlier you said something about 150,000 people coming on the system. How are we going to handle 150,000 people coming on? Just to point out then, I guess Senator Krist already gave you a copy, the Milliman study and the administration suggests in 2014 the newly eligible from the expansion would be about 50,000. It's not a small number either, but it's a much smaller number than that. So 50,000 new people coming in because of the expansion, and so we had testimony earlier talking about, you know, turning that into numbers of physicians or primary care providers. You assume each one would see about 2,000. So as we're trying to figure out how many additional slots we would need, it looks like the number 2014 is by your study and the UNMC study both have it in the neighborhood of 50,000 of the newly eligible from the expansion itself. And granted, there are somewhere between 20,000 and 30,000 that are likely to become new enrollees it says because of the other things that happen, regardless of what we decide to do with expansion. So one of the questions that I had, since this is an important part of your testimony, you've talked about the $2.7 billion a couple of times and I see it here in testimony as well. But I don't really see how we get to $2.7 billion from the other information provided. So I wondered if you would walk us through where that $2.7 billion number comes from. [LB577]

VIVIANNE CHAUMONT: Well, our $2.7 billion number comes from the fiscal note that we did. But I can tell you that if you look at the legislative fiscal note that the Legislative Fiscal Office did I believe their numbers add up to $2.5 billion through 2020. So we have some discrepancy. If you look at...and I'd be happy to provide you all with a copy of the department's fiscal note which lays out where the money is coming from and the number of eligibles and then the administrative costs, the computer costs, and all of that associated with that. We come out with $2.7 million, billion, billion, "b" and the Legislative Fiscal Office, I believe, comes out with $2.5 billion through 2020. But I'd be happy to give you a copy of the fiscal note. [LB577]

SENATOR HOWARD: Do we not have that one? [LB577]

_____: It's in your binder. [LB577]

SENATOR KRIST: Is it in the binder? [LB577]

SENATOR HOWARD: It's in the binder. It's not on the Internet. [LB577]

_____: The fiscal note is? [LB577]

SENATOR HOWARD: I'm looking for... [LB577]

VIVIANNE CHAUMONT: Our legislative fiscal note should be on the Internet, but I'd be

happy to send it to Senator Krist, to send it to everyone. [LB577]

SENATOR KRIST: Well, that was the essence of my question that I didn't necessarily because I don't like being put on the spot myself. So I'd like you to look at those numbers because they don't match. That was the essence of my question. The eligible people, the people who are going to come into the system, and how much money we're going to incur. And again, that's the essence of Senator Crawford's question as well. So if you'd like to take some time and get back to the committee, that... [LB577]

VIVIANNE CHAUMONT: Right. But you want us to get back on UNMC's study... [LB577]

SENATOR KRIST: Well, the... [LB577]

VIVIANNE CHAUMONT: ...because the Legislative Fiscal Office's study is pretty close to ours. [LB577]

SENATOR KRIST: The point I think is that if you look at the Milliman study that's at the bottom of that page and it compares it with the UNMC study, and you pay for the Milliman study or you ask them to update the numbers, that's where I don't know where you go off, off the Milliman study at that point for eligibility and then start adding up dollars and cents. And I think this discussion could happen at a different time when we all get a chance to really look at the numbers because that's where my disconnect is. Milliman agrees with the UNMC study. UNMC and Legislative Research there's a difference in the dollar figure. We need to get to that figure in terms of eligible...newly eligible people who just woke up and figured out they can do it, all those kind of things. So we'll...Senator Crawford. [LB577]

SENATOR CRAWFORD: And it's important that we have a fiscal note that is just the added impact of the expansion. There are a couple of notes in our...the legislative fiscal note response to your fiscal note that said that it included other components of ACA that were not just the expansion component so. [LB577]

VIVIANNE CHAUMONT: No, that's correct. [LB577]

SENATOR CRAWFORD: Yeah. [LB577]

VIVIANNE CHAUMONT: It sets it out at the beginning and then it says the expansion, LB577 and sets out exactly what the fiscal note for this bill is. And it's fairly close to the fiscal note that the Legislative Fiscal Office gave. [LB577]

SENATOR HOWARD: And the $2.7 billion includes the federal funds. [LB577]

VIVIANNE CHAUMONT: Yes. [LB577]

SENATOR HOWARD: Okay. [LB577]

VIVIANNE CHAUMONT: In both, yes, um-hum. [LB577]

SENATOR HOWARD: Okay. That makes more sense. [LB577]

SENATOR CRAWFORD: So it's not $2.7 billion of Nebraska funds. [LB577]

SENATOR HOWARD: No, it's... [LB577]

SENATOR COOK: Of General Funds. [LB577]

SENATOR HOWARD: $116 million. [LB577]

VIVIANNE CHAUMONT: It's $2.7 billion of Nebraska taxpayer funds, yes. [LB577]

SENATOR CRAWFORD: But not Nebraska General Funds. [LB577]

VIVIANNE CHAUMONT: Correct. [LB577]

SENATOR KRIST: Senator Cook. [LB577]

SENATOR COOK: I have to...because I have to sit down and study and memorize as well. Thank you, Senator Krist. You said it was $2.7 billion of Nebraska taxpayer dollars. The way I'm thinking about it is that Tanya Cook, everybody around here sends their money into D.C. and then they make sure, ooh, that's Tanya's and then they send back those dollars. I think that it is the taxpayers' dollars to the United States federal government from United States and from people who owe us all over the world, individuals and corporations. That's where the $2.7 billion comes from. Is that yes or no? [LB577]

VIVIANNE CHAUMONT: No. Well, I don't disagree... [LB577]

SENATOR COOK: You have a... [LB577]

VIVIANNE CHAUMONT: I don't agree with that. The federal government gets tax dollars. [LB577]

SENATOR COOK: Yes. [LB577]

VIVIANNE CHAUMONT: The federal government is going to spend according to this,

you know, 2, whatever it was, $2-plus billion... [LB577]

SENATOR HOWARD: 2.5 [LB577]

VIVIANNE CHAUMONT: Well, 2.7 is the total. Some of that is General Fund, but let's say $2 billion in federal dollars, that comes from taxpayers. [LB577]

SENATOR COOK: Yes, but not...the way I heard you, it sounded as though you said it was coming from Nebraska taxpayers, and that's not how I understood it. That pot of money is filled in from taxpayers and corporate entities all over the globe, actually, who happen to owe into that pot of money. That's the distinction that I wanted to make. [LB577]

VIVIANNE CHAUMONT: And I think we probably disagree with that distinction, but okay. [LB577]

SENATOR KRIST: Well, and that's exactly why I think we just take the time... [LB577]

VIVIANNE CHAUMONT: Yeah, yeah, um-hum. [LB577]

SENATOR KRIST: ...and get to the...but your question is well put. [LB577]

SENATOR COOK: Okay. [LB577]

SENATOR KRIST: Yeah, absolutely. [LB577]

SENATOR COOK: Thank you. I thought so. [LB577]

SENATOR KRIST: That's why I don't understand it either, but. Senator Crawford. [LB577]

SENATOR CRAWFORD: Thank you, Senator Krist. One other point about our role here as Nebraskans who pay into federal taxes, whether we (laugh) talk about coming back directly from us or pooling... [LB577]

VIVIANNE CHAUMONT: Right. [LB577]

SENATOR CRAWFORD: ...coming back to us, whatever. It is the case that the ACA provides access to the exchange and to federal government subsidies for people who go down to the 100 percent of poverty rate. And so if we expand Medicaid, then those individuals in Nebraska who are between 100 percent and 138 percent of the poverty rate would be covered by our expanded Medicaid. If we do not, then those individuals who are from 100 percent to 138 percent of poverty then are covered by us as

Nebraska taxpayers paying federal tax dollars at a tune of like $3,000 more per person in that range. So in terms of if we're thinking about this...we don't have that in the fiscal note. I mean if we're thinking about what is the cost of not doing this, it is also the cost to us as federal taxpayers of paying $3,000 more per person in that 100--138 percent of poverty range. That's a cost that we don't really have in our fiscal notes, but is an important cost to consider. If our concern is saving the federal government money, then there are arguments that even if it's $2 billion that that's less than it would be if we...it could be less than it would be if instead we're paying for those folks in that range at a much higher rate. [LB577]

SENATOR KRIST: Absolutely. That's where I think we need to get to, and the fiscal note does not reflect that range that we're cutting out. So why don't we table this and sit down over some cup of coffee and some crunching some numbers and figure out because the numbers don't add up. Any other questions for the director? [LB577]

SENATOR HOWARD: Are there any other efficiencies that you could think of if we did expand, efficiencies in other areas of DHHS or other programs that maybe could be supplanted? [LB577]

VIVIANNE CHAUMONT: I only manage the Medicaid program. You can't ask me to manage anything else. We, like I say, we continue to do efficiencies. I don't believe we have that kind of money in efficiencies available to us anymore. [LB577]

SENATOR HOWARD: Thank you. [LB577]

SENATOR KRIST: Thank you, Director. [LB577]

VIVIANNE CHAUMONT: Thank you. [LB577]

SENATOR KRIST: The next opponent. Welcome. [LB577]

LINDA ROHMAN: (Exhibit 45) Thank you. My name is Linda Rohman, that's L-i-n-d-a R-o-h-m-a-n. On my little orange sheet I indicated that I am a member of a group called Grassroots in Nebraska. However, I'm here on my own behalf just as a citizen of the state and someone who's interested in this issue. I have a confession to make. I'm something of a data nerd. I read lots of reports. I do lots of research. Partly it's because I have a degree in social psychology, a Ph.D. I'm interested in human behavior for that reason. And I think a lot of the assumptions that have been made about this program and about expansion are really not merited because you're assuming that human behaviors are going to change, yet there's no incentive for human behaviors to change in a lot of different ways. I've made a lot of points in my written comments. I'm not going to try and go through all those because we'll be here until 10:00 and you only gave me five minutes. But I do want to address some things that seem to have come up over and

over again. Senator Gloor has questioned a lot of people who have sat in this chair about emergency room usage and efficiencies to be realized if Medicaid is expanded. I've read a lot of reports and there are at least three that were published by the CDC--they were not done by the CDC, but they were published by the CDC. One was in 2007, one in 2010, and I believe one in 2011; and all of them analyzed federal data, tens of thousands of visits to the ER. And each of them concluded that as a group the uninsured are not those people who are most likely to go to the emergency room for a nonemergent, nonurgent problems. Medicaid people, people who are covered by Medicaid, are roughly across all three of those studies 2.5 times more likely to be what the ER people call frequent flyers. There is a doctor shortage in Nebraska, primary care physicians in particular. A recent report that I read said that there are about 1,400, a little over 1,400 primary care physicians in Nebraska now. This report was estimated...estimating that there would be a need for 20 percent more of them by 2014, and they were not taking into account the ACA, and they certainly were not taking into account what you are contemplating doing with this bill. Without...in that same report they were looking at the numbers of primary care physicians in Nebraska since 2007 to just last year. And basically the numbers have remained essentially flat since 2007. So we aren't seeing an increase. We haven't seen an increase. And, you know, if past data is indicative of future data, we're not going to see one. The other point I wanted to make--and this gets closer to, you know, the human behavior point I made--expanding Medicaid to people who are not insured now, and even the Medicaid people who are insured under Medicaid now, and saying that you're going to change their behavior and make them use emergency rooms less; they have no incentive to do so. They have no skin in the game. They are not paying the increased cost of going to an emergency room and receiving this inefficient and high-cost care. What is there that is going to make them change their behavior? You can educate them. You can tell them it costs somebody else more money if you use that type of care, but there's no personal incentive for them to behave any differently. And very often it is, as somebody made a point earlier, it is more convenient for them because they work during the day. It's more convenient for them to have immediate access at an emergency center than it is to make an appointment to wait to take off work to take their child or to take themselves to a doctor's appointment. So that's a problem. With this doctor shortage and given the data that Medicaid patients are more likely to go to an emergency room, I think your hopes that these people are going to find a lot...they're going to find a medical home with a particular doctor and they're going to begin to use them I think, you know, it's unrealistic. I see my time is up. I have a lot more to say. You know, if you have any questions about any of the points I've made...I didn't have...I didn't know that I was going to be able to show up today because I've been ill. And so I put my comments together and I did not have time to annotate them and footnote them and put the cites in there. But if you want the cites to these studies, I'd be happy to provide them. [LB577]

SENATOR KRIST: We get to hear a lot of people come in and testify and that's our job. And what's very helpful is when someone comes in and gives us the 2008, 2009, 2011

study. And you've been self-professed as a data nerd. If you have it, love to see it. [LB577]

LINDA ROHMAN: Yeah. [LB577]

SENATOR KRIST: Footnote it and bring it in, because Brad is one of those people that brings us reams of information and it's very, very helpful. And that doesn't discount your testimony at all. Thank you for coming; but, yeah, please do. We'd love to see it. Any questions? Senator Howard. [LB577]

SENATOR HOWARD: I actually did a lot of research in ER diversion, so I've read that CDC article that you talked about. And the 2011 one did say that individuals on public health insurance were using the ER more often and that folks who were uninsured were using it because they had nowhere else to go. But public health folks were using it, I believe, because their doctor's office wasn't open. [LB577]

LINDA ROHMAN: Well, they were saying when they looked at the reasons, yes. They were saying that either their health clinic or their doctor's office wasn't open. And frankly I think that just supports what the prior testimony was: that these people, they're working. It's inconvenient for them to take off from work. And what I'm saying is convenience is going to rule. It's...you can educate people. You can tell them that it's going to cost other people more money if they use the emergency room, but convenience is going to rule and behavior is not going to change. [LB577]

SENATOR HOWARD: And I was just thinking about how earlier we heard from the Hospital Association and the federally qualified health centers about how they're expanding hours and they're going into the evenings, they're doing early morning clinics... [LB577]

LINDA ROHMAN: Um-hum. [LB577]

SENATOR HOWARD: ...and so they're really trying to meet that need to divert patients out of the ER. And so I would be really interested if the CDC has done anything more recently to address that issue. [LB577]

LINDA ROHMAN: The last...the most recent report I saw was the 2011 one. I cannot imagine that there aren't...I mean they crunch data in so many different ways. It may be there and it just may not be something that popped up in my research, although I was able to backtrack from the 2011 and see the 2010 and 2007. I can try and work forward and find something more current, but at this point the 2011 was the most current I could find. [LB577]

SENATOR HOWARD: Thank you. [LB577]

LINDA ROHMAN: Um-hum. [LB577]

SENATOR KRIST: Thank you, Senator Howard. Thank you for your...oh, I'm sorry. Senator Crawford. [LB577]

SENATOR CRAWFORD: Oh, thank you, Senator Krist. I just wanted to also affirm that it would be very nice to see the citations of the studies as well and in terms of data. I don't know if you were here when the...and also to acknowledge that it is not in any way easy or automatic that, you know, the changes that would need to be made to change behavior. I think you hit it...convenience is a key, and so it really is a case that we would have to see people stepping up to make those changes to make sure that there is convenience and that people are able...that access is convenient in other ways. I think we heard quite a bit of testimony about people who were committed to doing that and already starting to do that. And the one other data piece for you as a data nerd, I don't know if you were in here to hear the testimony from the gentleman from Bryan who talked about they had been tracking this uninsured versus Medicaid patients. And their experience was that in Bryan uninsured...the uninsured was about 86 percent and then the Medicaid patients, he had a third less, 60 percent less... [LB577]

LINDA ROHMAN: But see, he's not comparing...his data and my data are talking about two different percentages. [LB577]

SENATOR CRAWFORD: Okay. [LB577]

LINDA ROHMAN: What he's doing is saying I have X many uninsured; 86 percent of those uninsured present to the emergency room because...I think he said because they have nowhere else to go. Then he said I have X many Medicaid patients; 60-some odd percent of those, I think he said 62 if I heard him correctly, present at the emergency room. And then he said the insured, and I forget the percentage he said, I have X many insured people and private pay people and that percentage...a certain percentage of those appear. What I'm saying is that the CDC report looked at, let's say, 100,000 people. [LB577]

SENATOR CRAWFORD: Um-hum. [LB577]

LINDA ROHMAN: And they said they divided...their percentages added up to 100 percent because they put all these people in one pot. Okay? And they said why, I mean, they said, okay, how many of you...what percentage of you are...okay, let me back up. A hundred thousand people went to the emergency room. And the CDC looked at what percentages of those people were Medicaid, what percentage of those people were uninsured, and what percentage of those people were private pay. And those percentages added up to 100 percent. Okay? When you compared them, the uninsured

people were two...there were 2.5 times more uninsured people than there were Medicaid people. And there were even fewer self-insured, I mean self-pay or insured. So you see the difference? [LB577]

SENATOR CRAWFORD: So you're...that study is of the people who show up in an emergency room, 2.5 times more of them in that more people showing up were Medicaid patients. [LB577]

LINDA ROHMAN: Right. [LB577]

SENATOR CRAWFORD: Whereas his was of Medicaid patients... [LB577]

LINDA ROHMAN: Yeah, right. [LB577]

SENATOR CRAWFORD: ...of uninsured patients, 86 percent of uninsured patients show up in the emergency room. [LB577]

LINDA ROHMAN: Yeah. To explain... [LB577]

SENATOR CRAWFORD: I'll look at that so I'll look between the two. [LB577]

LINDA ROHMAN: To explain the difference a little better, I could have 100 people who were on...who were uninsured and 86 of them could show up at an emergency room for nonemergent care and I would have 86 percent. Right? [LB577]

SENATOR CRAWFORD: Um-hum. [LB577]

LINDA ROHMAN: Out of 100 people, if 86 showed up I'd have 86 percent of them appearing for emergent care...for nonemergent care at an emergency room. If I had 1,000 Medicaid patients and 62 percent of those people showed up, that would be 620 people. Now that's a lot more Medicaid patients than the 82. You see what I'm saying? So what he's talking about is totally different. It's a different way of looking at the data than what the CDC was doing. Do you understand the difference? [LB577]

SENATOR CRAWFORD: I think I do. I think I do. [LB577]

LINDA ROHMAN: It's not comparing apples to oranges to look at those studies. [LB577]

SENATOR CRAWFORD: Right. Right. There are two different ways of looking at the issue, right. [LB577]

LINDA ROHMAN: Exactly. And looking at the data and quantifying it. You know, they say that, you know, you can prove anything with statistics. [LB577]

SENATOR CRAWFORD: Exactly. And that's why it's very important... [LB577]

LINDA ROHMAN: You just look at it...just look at it in a different way. [LB577]

SENATOR CRAWFORD: ...to settle these differences. [LB577]

LINDA ROHMAN: Yeah. [LB577]

SENATOR CRAWFORD: So it will be interesting to see the study. If I understand you correctly, it was really this study was showing that more of the patients showing up were Medicaid patients... [LB577]

LINDA ROHMAN: Yeah. [LB577]

SENATOR CRAWFORD: ...not...and that's different than what he was talking about which is the percent of patients who use the emergency room. [LB577]

LINDA ROHMAN: Exactly. [LB577]

SENATOR CRAWFORD: All right. Thanks. [LB577]

SENATOR KRIST: Okay. Thank you. Senator Gloor, did you have... [LB577]

SENATOR GLOOR: We covered mine. Thank you. [LB577]

SENATOR KRIST: Okay. Senator Cook, did you have? [LB577]

SENATOR COOK: Thank you, Senator Krist. And thank you for coming today, Doctor. I have a question about point number 9 on your handout, and I'll read it out loud for those of you in the audience that don't have one. Number 9. "Medicaid is one of the means-tested welfare programs that disincentivizes work, savings, and marriage. The results?" Are you saying that LB577 or Medicaid in general there's a causal link between taking advantage of Medicaid or any other temporary aid to needy families or any other program, there's a causal link between using Medicaid and wanting to work, save, and be married? Is that what you mean? [LB577]

LINDA ROHMAN: The point I'm trying to make is that it presents a disincentive. It's interesting and thank you for the question--Congress recently held hearings, I believe it was in the House, on the question of whether or not means-tested welfare programs actually disincentived work. I think that was their particular question. There was a congresswoman, and I'm sorry I forget the woman's name, who testified that she had been on Medicaid when...and on other types of public assistance when she had been

younger. And she particularly testified about the fact that she actually asked her employer not to give her a 50 cent an hour raise. And the reason why was because it would raise her income over and above what would qualify her for Medicaid, and she would lose her healthcare. Now that is a structural problem with Medicaid because...and that's why I say it disincentivizes work. Because if you work more and make more, then you stand to lose benefits which are more costly to you than the increase in your income from working, from taking that second job. You know? And what I'm saying is, I'm not saying that people who are on Medicaid are lazy and shiftless; quite the opposite. These people want to work. But when you structure a program in such a way as Congress has where if they try and better their own condition as a result of their own efforts, they're penalized for it. And it's unfair to them. It puts them...this gets to the human question. It puts them in an untenable position. And I think it's very, very bad to consider extending such a program until these kinds of problems are resolved because we're just going to be creating that same situation, only more so, here in Nebraska. It's the same with marriage. Often if you have a two...if you have two incomes and you marry, then your eligibility, the amount of money you can make and still be eligible, changes. And so we see families who...where the father is absent or where people decide not to marry because of if there are two wage earners in the household who are married to one another, the eligibility amounts are going to change for the income levels, and they're going to lose healthcare or they're going to lose some other kind of public assistance that they're now qualified for. And so, therefore, you find a lot of women who are single parent heads of households. And I give you the data here. It's bad for families because what you're doing is you're setting up a situation where men are...and fathers...are made irrelevant in certain instances because their absence is more valuable...their absence in the home is financially more valuable to their families than their presence there would be. [LB577]

SENATOR COOK: Thank you for your response. I guess as I interpret the proposal it addresses the issue of that stairstepping. Why work an extra hour, get kicked off of this, that, and the other? [LB577]

LINDA ROHMAN: Um-hum. [LB577]

SENATOR COOK: And I guess I was just very concerned to be direct with you and I appreciate this, I was very concerned that that is perceived by some as the only causal relationship for the way that families have changed over the last 50 years. I think there's an idea that the public welfare system did some of the things that you mentioned--made a husband irrelevant. And I think there were some other things that happened that changed. [LB577]

LINDA ROHMAN: Yeah, I'm not saying it's the exclusive cause... [LB577]

SENATOR COOK: Thank you. [LB577]

LINDA ROHMAN: ...but it certainly is...its presence correlates very, very well with what we've seen in terms of social trends from the sociological point of view if you look from 1965 up to now. [LB577]

SENATOR COOK: Yes. [LB577]

LINDA ROHMAN: Yes. [LB577]

SENATOR COOK: Thank you. [LB577]

SENATOR HOWARD: I actually really love that argument about if you work...if you get 50 cents more you'll fall off. That's brilliant because that's what this bill is trying to fix. So thank you for your testimony. It was wonderful. [LB577]

SENATOR KRIST: All right. Any more questions? Thank you for your testimony. [LB577]

LINDA ROHMAN: Um-hum. [LB577]

SENATOR KRIST: Next opponent. Welcome. [LB577]

MIKE GROENE: Good evening, Senator, Senators. Mike Groene, M-i-k-e G-r-o-e-n-e. I represent the Western Nebraska Taxpayers Association out of North Platte, and I don't get paid for it (laughter). I guess today what listening proves to me again that the people who show up are the ones who benefit from a government program. Like the line from the movie says, follow the money. But anyway, I'm one of those folks and (inaudible) members who actually are old-fashioned. Our culture is we take care of our families. We pay our healthcare. We don't ask our neighbors through taxation to take care of this or to give us services that we do ourselves. We're the folks, remember, there are a group of us that pay more taxes than we get in government services. I mean at least 60 percent of us do or what is it, 50...54 percent now because we're borrowing 46 percent of the money so the rest of us are paying in 54 percent of it. But we can't do this. I'm paying for my family's healthcare, and then you're asking me to pay for somebody else's healthcare. I can't do it anymore. We work hard. I just did my income taxes. It's burdensome--the federal and the state. I can move to Wyoming and pay nothing at 6.8 percent here, and I don't get near the deductions I do on the federal. We're broke. This country is broke. They're arguing about cutting existing Medicaid program. The existing program is skyrocketing out of control, and now you're going to dump all this on it. It doesn't work. It just doesn't work. And I hear this with a wink and a nod that it's not going to cost us anything. It's going to come from the federal government. That's me. My family came over here on a boat and became Americans. I just happen to live in Nebraska. I'm an American first. You're asking me as a taxpayer to fund this for, quite

frankly, for people who don't have the motivation to take care of themselves. And all these studies and these numbers...I've listened. I heard one fellow up here say that people on Medicaid, without Medicaid have a 25 percent higher mortality rate. Well, excuse me. I thought we all had 100 percent mortality rate. You can talk all day, but nobody has ever gotten out of here alive. We all die. We all get sick. It's part of life. It's part of life. It's part about...you build your house, you build a family, you get sick, you have healthcare, you feed your family. It's just part of the circle of life. It's not an exception. It's what we do as human beings and then we die. And I heard Senator Krist and Senator Gloor say he was a Catholic and he was a...I'm both--born and raised a Catholic; served mass enough as a youth that I think I went to mass enough for a lifetime, so I married a Protestant and became a Protestant. I've read both Bibles. Nowhere in that Bible does it say I'm supposed to do my good works with my neighbor's tax dollars--nowhere. Nowhere does it say as a community you do it by forcibly confiscating your neighbor's money--nowhere; doesn't say it. It says you're supposed to do it. So when I hear this communal stuff that we're supposed to do it as a community, I don't believe that. I believe first, you're personally responsible for yourself; and second, for your family. I help others out. I've tried. But don't tell me I need to do it, as Senator Kruse said, as a community. I don't see that. I'll give you an example of studies. Let's say somebody has to do a study where we're going to pay...we're going to pick a kid up, your children up. We're going to take them to a public school. We're going to feed them breakfast, we're going to feed them lunch, and we'll take them back home to you. Now I bet you that study would say it would be 100 percent turnout. Who would turn that down? It's behavior. We've got some school districts where 50 percent of the kids with all of that free do not graduate. And I'll make a big assumption. These people we're talking about, I'll guarantee you the majority of them come from that 50 percent that don't graduate. I also heard Senator Campbell and Senator Nordquist and articles say, these are the working poor. It doesn't say you got to be working to get this. You could be a drug addict. You can be an alcoholic. You could be one of the fathers, and a lot of these are, of that child of that single mother--deadbeats I call them. That's the term we use in my culture. And you want me to buy their health insurance. And here's another point I haven't heard here. Four of the five states around us are going to turn this down. Iowa did, Kansas will, South Dakota did. Wyoming has got an opposite bill that in the future they will never allow the federal government to force them to do it. So what are you going to be--a magnet in the state of Nebraska where you're going to have everybody with chronic diseases from alcoholism to drug abuse to gunshot wounds from gang members, where are they going to go when they need healthcare? They're coming to Nebraska. And my time is up. [LB577]

SENATOR KRIST: Questions? Thank you for making the drive in and thanks for your testimony. Appreciate it. [LB577]

MIKE GROENE: All right. I realize it's...there's no hope here, but I think we can get 19 people in without (inaudible) 49 or 20. Thank you. [LB577]

SENATOR KRIST: (See also Exhibits 46-56) Thank you very much. Next opponent. Anyone in a neutral capacity? Okay, that will finish...I'm sorry. Senator Campbell, would you like to close? (Laughter) Senator Campbell, you don't want to close, do you? [LB577]

SENATOR CAMPBELL: I'm just...I'm going to stay right here and let Senator Nordquist come up. I just want to thank everyone who testified--everyone--because it gives us a better picture. And we will certainly sit down and go through the fiscal information. That's really kind of Senator Nordquist's part of this tandem team. So I thank you all for your patience. We saw a broad spectrum today of people committed to looking into the future and doing something for all Nebraskans. So I appreciate their testimony. Thank you, Senator Krist. [LB577]

SENATOR KRIST: So we will go (inaudible). [LB578]

SENATOR CAMPBELL: Go right ahead. [LB578]

SENATOR KRIST: Senator Nordquist will introduce LB578, and thank you for your patience. [LB578]

SENATOR NORDQUIST: (Exhibits 57-59) Thank you, Senator Krist and members of the Health Committee for your work today. We've heard for a couple hours now the why of we...why need to do this. I hope to spend a few minutes here to talk about the how, how the state affords to do it. Do you think it kind of feels like we're in Bizarro world when HHS comes in and complains about our fiscal note for once. (Laugh) Usually the tables are a little turned on that. But the...we'll probably start...I don't know, it's probably the first thing that Senator Campbell gave you and it's probably buried, but if you have the chart that Senator Campbell distributed and I think it's...hopefully, it's two-sided. The first side is off of the fiscal note directly from our Legislative Fiscal Office. And I'll just say, as an appropriator, we have this discussion in our committee quite a bit. We have agency recommendations. But ultimately, at the end of the day, we have a hired staff that goes through it, does their best job of analyzing it, and puts numbers together that are our independent budget analysts and give us their best recommendations of what the numbers look like. The fiscal note, my understanding is, the Fiscal Analyst took for the cost side, took the Milliman midrange and...well, let me back up here. I should say when we were working through the budget recently, the preliminary budget, we tried to come up with how are we going to decide what to put in for the mandatory populations, the required coverage under this. We have the Milliman high range, the Milliman midrange, I think we had UNO numbers, Urban Institute numbers, and the Legislative Fiscal Office numbers, which they built, for this interim, built for the Health Committee and the Appropriations Committee joint hearing, built from the ground up using our uninsured numbers, using utilization numbers. And at the end of the day the Legislative

Fiscal Office number and the Milliman midrange number were within a million dollars, and we are talking tens of millions of dollars. So we said, okay, we're just going to split the middle between those two, because our Fiscal Office's put their numbers together; the Governor's Office, their midrange estimate was here. We said, okay, it's within a million, let's just do that. And that is my understanding, the same methodology that Liz, the Fiscal Analyst, used in putting these numbers together. I think the department's fiscal note that they gave to the Fiscal Office uses a combination of the Milliman midrange and high range. I will just say that I have a...if I can find it in my large stack of papers, back when we were talking about the original Milliman study, the director of Medicaid, Director Chaumont, said that that high range was the worst-case scenario. So I think that maybe we can discount that high range and look at the midrange estimate. On this sheet you see the breakdown of what's included on the fiscal note of savings. These are indisputable savings that the department agrees with, I believe certainly most of it: the state disability program, $57 million of savings over this time period. That's because we cover up to 100 percent of federal poverty level for disability. That would be replaced with the expansion. The AIDS drug assistance program, same thing; up to 100 percent for drugs for HIV patients. That could be replaced with expansion. And some Department of Corrections costs. So when you net it out, over this time period the net cost is $75 million to the state. Now I'm going to talk about how it's not even $75 million. But even if it was, you break that down, it costs, for the numbers we're talking about of eligible people here, 45 cents a day or $170 a year for over...between now and 2020 to cover these people with state dollars, 75...$170 to cover them with Medicaid. I think that alone is a good deal. But if you flip it over and look at the other side, we can talk about additional cost savings that aren't yet accounted for in the fiscal note, but certainly should be considered for potential future offsets. The first, you've also been distributed an e-mail to my office from Director Scot Adams of the Division of Behavioral Health. In that e-mail he says, if we do this expansion we would estimate to replace about $6 million a year of substance abuse treatment that those services would no longer be paid for with General Funds under the Division of Behavioral Health, but could be paid for with Medicaid. That's a $6 million-a-year savings. The fiscal note does note this, and Liz wants to get more information before it is included in the fiscal note. But we're going to continue to work to find that number because that's $39 million right there off of that $75 million number we're working towards. I will talk about the CHIP savings in just a minute and that's the crux of this bill before you. Also Director Adams; I believe we distributed this memo to the Fiscal Office. It says in...because of mental health parity in the private sector in the health insurance exchanges, we can save potentially up to $29 million a year because of expanded mental health coverage in the private insurance market in our state. Now I'm not...and I think Patti Jurjevich was up here earlier talking about reinvesting those savings. I certainly think we need to reinvest most or a significant portion of those savings. But even if we were to take only half of them, keep half of them reinvested in behavioral health at $14 million a year and half of them count that as savings towards Medicaid expansion, that's $65 million. Again that's more than enough. And then there are a couple other smaller pieces of offsets. But these are actual state

program dollars we are spending right now, going out the door, for services that will be picked up by Medicaid expansion. So for people to come in and say it's going to cost $2.7 billion or throw numbers around; we've heard from the administration, $500 million, $700 million; they're not talking about actual cost savings. We're not doing dynamic forecasting here where we're saying this is going to spin off this much revenue. These are actual program dollars that will be offset by expanded Medicaid coverage and by other savings that the ACA generates for our state. None of these savings have been accounted for in the Governor's budget, in our preliminary budget, and certainly can be accounted for in the future. So I submit that. But let's get to the crux of the bill that's before us here, LB578; and this is the other piece. It relates to the CHIP Comprehensive Health Insurance Pool excess fund. I think we've distributed a couple handouts related to it. One is just a brief summary of where our current CHIP dollars are flowing. I think you've also been given a diagram about how those dollars come in. So we have insurance premium tax dollars that come in. Right now, out of that...it's about $39 million a year, we take $23 million to subsidize our high-risk pool. That high-risk pool will not be needed. Some states are getting rid of them right away, January 1, 2014. Some...we've...our Fiscal Office and the Department of Insurance says, well, we better have some...let's let people phase out of it. And it's because if the private health insurance market isn't going to discriminate based on preexisting conditions, you're going to be able to get a better rate in the private insurance market than staying in this high-risk pool which is quite expensive. So that pool is going to go away. That frees up that $23 million. If we let it flow through right now under current statute, that additional $23 million, 50 percent of that will go to what's called the Insurance Tax Fund; and out of that, that fund is broken up 60 percent to TEEOSA, 30 percent to the Municipal Equalization Fund, and 10 percent to counties. Of that money that comes down, 40 percent goes to the General Fund and 10 percent to the Mutual Finance Assistance Fund. So if you're looking at the diagram, it's probably helpful. So what we're saying is that money that would flow through to the General Fund, we are going to capture a portion...the new portion of that, the enhanced portion of it. So the General Fund will be held harmless. There will still be...there will be an increased growth in TEEOSA and the Mutual Equalization Fund and the 10 percent to counties. And I should say, I forgot to mention that this change is in an amendment that was distributed to the committee. I think at the last page you'll see something like this, and this gives you the fiscal breakdown of who's impacted. So we have $39 million of health insurance premium dollars coming in right now. We take $23 million off the top and $16 million flows through. If we leave things alone and don't make this change, all $39 million will flow through and be distributed. For instance, the General Fund will go from $6.4 million to $15.6 million. With this amendment that's been distributed to the committee, the General Fund stays at about $6.4 million or $6.5 million, and we're going to capture that additional $9.2 million and put into the fund that is in the bill that will support Medicaid into the future. Overall, it's about 40...what was the total on that; $46 million between now and 2020 that we could have sitting in an account to draw on to support Medicaid expansion or other aspects of Medicaid into the future. It will have no impact on the

General Fund in the future and we continue to give TEEOSA, counties, and the Municipal Equalization Fund the growth that...new growth that wouldn't be there if it wasn't for the Affordable Care Act and the elimination, ultimately, of the high-risk pool. I just want to note a couple other related budget things before we talk about the crux of this. One is on the Medicaid and Medicare provider rates. Milliman, in their study, said that our Medicaid rates in Nebraska for the services we're talking about are about 71...only 71 percent of Medicare rates. So if we go up to 100 percent of that, it's a 39...actually a 39 percent increase to go from 71 percent up to 100 percent; a 39 percent increase for primary care providers in our state. That is included in our preliminary budget for all other Medicaid, for our current Medicaid, for our new mandatory Medicaid provisions under the Affordable Care Act, and it's in the fiscal note to continue that. As long as the expansion were to be around we would be paying Medicare provider rates, a 39 percent increase, over what's happening now. And I think that combined with...you know, the managed care, combined with, you know, the work of all the people that testified today I hope would move us down the line of making sure we have the work force. But also related fiscally, Director Chaumont talked about MMIS in our preliminary budget. We did include $2 million of cash funds which are there for it, and that will draw down $20 million of federal funds. We did appropriate that money. My understanding is the Governor doesn't quite have confidence in the division to be able to do all this at this time, but the money is there for them should they be able to handle it. So a lot of things there; but ultimately, with the program savings, direct state program savings that we have available to us, there is without a doubt in my mind that we can capture those savings and apply it to this bill and have no state General Fund impact between now and 2020. [LB578]

SENATOR KRIST: Questions? Senator Gloor. [LB578]

SENATOR GLOOR: Yes. So the insurance tax premiums were established specifically to accomplish what goals? [LB578]

SENATOR NORDQUIST: Well, the original amount...the original pieces I don't know. I...looking at the high-risk pool, for me it looks like we diverted this money to the comprehensive high-risk pool to help people afford coverage when they had a preexisting condition and couldn't get it. Now I'm suggesting that we divert those funds to...that are no longer needed, to support Medicaid expansion, to help people get coverage because they can't afford it. I think it is somewhat along the same lines. Now, people could come in and say, why don't you just reduce the tax? That is one option. There are no proposals on the table that I know of to do that, and I don't know that the industry is even asking for that at this time, but that... [LB578]

SENATOR GLOOR: No, that was really where my question was leading... [LB578]

SENATOR NORDQUIST: Yeah, yeah. [LB578]

SENATOR GLOOR: ...is so what's the industry think of this (inaudible)? [LB578]

SENATOR NORDQUIST: Through informal discussions, and I don't think...no one has told me that they're here to testify on it. They know that they're paying the tax, they're going to continue paying the tax, and they don't have any intention to ask to eliminate the tax. I tried to pitch to certainly the health insurers, the...all insurers pay the premium tax; but to say, if you have this money, wouldn't...as an insurer, paying claims and you know pick up some of the uncompensated care or cost shift, wouldn't you rather use that...have that money to support Medicaid expansion and bring down...hopefully, bring down some of those uncompensated care claims and...which is good for your company versus that money just going to the General Fund to be used for whatever purpose the state chooses. And I don't know that they're going to...they're in support. I don't think they're here in opposition. I think they just, at this point, don't...aren't engaged in it. [LB578]

SENATOR GLOOR: Well, the question has to be asked that this money probably doesn't come off of their bottom line. This money is passed on to the... [LB578]

SENATOR NORDQUIST: Consumer, probably. [LB578]

SENATOR GLOOR: ...to the consumer. And so the question is, is there enough money there passed back to the consumer that makes a difference? I mean, I don't know if we have an answer for that. But it's if...so if every person who had health insurance got their monthly premium reduced, would it be 2 cents, $20, you know, what? Because... [LB578]

SENATOR NORDQUIST: I'm sure we can ask the department to run those numbers and see what they look like. [LB578]

SENATOR GLOOR: I can't imagine it isn't going to come up in the discussion, you know. [LB578]

SENATOR NORDQUIST: Yeah. Yeah, sure. [LB578]

SENATOR GLOOR: I can't imagine at some point in time somebody won't say, well, if we eliminate it and force the insurers to return...however we would do that...return it, is it enough that...is it so little that it wouldn't make a difference or is it enough that it's going to be an issue? I think we better know that. [LB578]

SENATOR NORDQUIST: Yeah. And we... [LB578]

SENATOR GLOOR: If it's possible. [LB578]

SENATOR NORDQUIST: I will say that we are...part of the amendment we pushed...we don't start putting this money into an account until FY '16 partly because the Governor had already started accounting for this money and we're accounting for it in TEEOSA. So if we were to say we're no longer using $23 million in the high-risk pool, let's cut it by $23 million, we would have a negative impact on the General Fund already and TEEOSA. [LB578]

SENATOR GLOOR: Yeah. [LB578]

SENATOR NORDQUIST: So that money is already being accounted for... [LB578]

SENATOR GLOOR: Spoken for. [LB578]

SENATOR NORDQUIST: ...but by starting this in the second biennium out and starting to divert that money to a fund, we don't affect any of those components, so. [LB578]

SENATOR GLOOR: Okay. [LB578]

SENATOR KRIST: Senator Howard. [LB578]

SENATOR HOWARD: How many people are in the pool right now? [LB578]

SENATOR NORDQUIST: I would have to get that. I don't have that with me. I think it was in a couple... [LB578]

SENATOR HOWARD: Okay. So... [LB578]

SENATOR NORDQUIST: ...probably around a couple thousand is my general sense. [LB578]

SENATOR HOWARD: It's probably not very big I would guess. [LB578]

SENATOR NORDQUIST: Yeah. [LB578]

SENATOR HOWARD: And your anticipation is that in 2014 they'll transition off of that pool... [LB578]

SENATOR NORDQUIST: Start to. [LB578]

SENATOR HOWARD: ...into something that's cheaper on the exchange. And they would have about a year to do so before the pool went away? [LB578]

SENATOR NORDQUIST: The fiscal note and the Department of Insurance is giving about a two-year window I think to do that. Like I said, some states are up and eliminating it right away, saying you're going to have access to much better premiums, much better plans, no preexisting condition exclusions in the exchange, so just go...our program is done; you just go there and buy it. That does make some sense, but if people aren't comfortable in the plan maybe we let that fall through, but. [LB578]

SENATOR HOWARD: Okay. Thank you. [LB578]

SENATOR KRIST: Thank you, Senator Howard. Thank you. [LB578]

SENATOR NORDQUIST: Yeah. I'll clean off my papers. [LB578]

SENATOR KRIST: How many people intend to testify as proponents on this one? Four. How many opponents? All right, first proponent please. How many neutral? Lovely. [LB578]

DAVID HOLMQUIST: I was going to say good afternoon but I think it's good evening. [LB578]

SENATOR KRIST: I think it is. Welcome. [LB578]

DAVID HOLMQUIST: (Exhibit 60) Thank you. My name is David Holmquist, D-a-v-i-d H-o-l-m-q-u-i-s-t. I appear today in kind of a triple role. I appear professionally on behalf of the American Cancer Society Cancer Action Network. I also appear personally and semiprofessionally as a member of the clergy of the Episcopal Diocese of Nebraska. In all three characterizations I am here to support the introduction of LB578 and its ultimate passage, we hope. I will read this briefly to you and then I have a couple of comments so I should be able to get down here before the yellow light goes on. I'm going to try. With the introduction of LB578, I believe that Senator Nordquist has taken a commonsense approach to planning ahead when the Legislature approves passage of a measure to expand Medicaid in Nebraska. And while the costs associated with Medicaid expansion will largely be borne by the federal government during the first three years, this legislation is a plan for the future. After the initial 100 percent coverage by the federal government, the match will decline to 90 percent over a three-year period. This sensible approach to the plan for those years when Nebraska will have to appropriate funds to meet the federal match is important to us. Funding for the plan will come from cost savings now associated with programs which will no longer be funded as patients with preexisting conditions are able to acquire insurance in the marketplace and will not need to depend upon the Comprehensive Health Insurance Pool. This program actually went into effect for some patients almost...about a year ago, and it's called the PCIP program--the preexisting condition program, basically. And some patients have been able to access this already. Shifting funds to provide for the health

and well-being of thousands of Nebraskans just makes sense. Savings associated with providing primary and preventive care through the expansion of Medicaid will reap both financial and social benefits for the state of Nebraska. My appearance here in terms of being a member of the clergy is that we really look at this as a social justice issue. I take great exception to the suggestion made by the gentleman who testified in opposition to the previous bill that the recipients of Medicaid are a bunch of deadbeats. My own grandson was born ten years ago with some severe conditions. He has been helped through Medicaid for the first ten years of his life here in Nebraska. Last fall, his family moved to Colorado, which has even better coverage for Medicaid for him as a special needs child who has many, many challenges, behavioral challenges and mental challenges. He's ten years old and cannot put a sentence together. He cannot form words the way most of us do because of something that happened perhaps during childbirth; we don't know. So there are many, many people who are receiving Medicaid who deserve to have this coverage. They are people who are working hard, they're trying to better themselves; and to position them as people who aren't interested in helping themselves I think is just a wrong thing to do. I'd also like to take this opportunity to make a suggestion that during the passage of the Affordable Care Act, and I waited...I made sure the press was gone before I did this because I don't want this to detract from...just watching... [LB578]

SENATOR NORDQUIST: They're still watching us. [LB578]

DAVID HOLMQUIST: They're still watching? Well, I won't mention it then. We had something called the Cornhusker kickback, and I think not doing the Medicaid expansion leaves us open to be calling the Cornhusker kickoff. We'll be kicking off funds that we are all paying to the federal tax pool and not receiving back to the state if we don't expand Medicaid, and other states will be using our tax money. So I call this the Cornhusker kickoff. So finally I'd like to simply say that we're always very proud of our athletic teams in this state and I'd like us to be proud of the care we give our citizens and I'd like us to make this a championship season with the passage of both LB577 and LB578. And with that I'll entertain any questions you might have. [LB578]

SENATOR KRIST: Any questions for the coach? [LB578]

DAVID HOLMQUIST: There's a new one...well, there's a new appellation for me. [LB578]

SENATOR KRIST: Thank you so much, David. [LB578]

DAVID HOLMQUIST: Thank you. [LB578]

SENATOR KRIST: Next proponent. Welcome back. [LB578]

SHARON LIND: (Exhibit 61) Thank you. All right, thank you, Senator Nordquist and Senator Campbell and Vice Chair Krist and members of the committee. My name is Sharon Lind, S-h-a-r-o-n L-i-n-d, and I am the chief executive officer of Ogallala Community Hospital testifying on behalf of the Nebraska Hospital Association and our member hospitals, 89 member hospitals, in support of LB578. The Nebraska Department of Insurance currently collects taxes based on premiums charged for insurance policies sold in Nebraska. Those revenues are distributed to governmental units such as the government fund, Workers' Comp Court, school districts, counties, municipalities, and the Nebraska Comprehensive Health Insurance Pool. LB578 redirects funding previously used to subsidize health insurance coverage for Nebraskans with preexisting conditions through the CHIP to a newly created Health Care Access and Support Fund that would be used to support coverage in the Medicaid program for Nebraskans who cannot otherwise afford health insurance coverage. The NHA supports the use of CHIP funds as proposed in LB578 and the corresponding amendment offered by Senator Nordquist to offset some of the state's projected costs for Medicaid expansion. It seems logical to use an existing funding source from a healthcare program that will cease to exist with the implementation of the Affordable Care Act. There are a variety of estimates as to the state's cost to expand Medicaid eligibility, ranging from the Nebraska's Legislative Fiscal Office estimate of $123 million through 2020, to the Kaiser Commission's net estimate of $153 million through 2022. For the first three years, the federal government would pay 100 percent of the costs for the newly eligibles. After that, the federal/state match gradually shifts to a 90/10 match into 2020 and thereafter. As of January 1, 2014, the Affordable Care Act prohibits insurers from denying coverage due to preexisting conditions. This provision, combined with the availability of premiums subsidized on the health insurance exchange, will make health insurance accessible and more affordable to Nebraskans with preexisting conditions, and thus, the need for CHIP will gradually be eliminated. The NDOI anticipates that funding will be necessary for fiscal '13-14 and for fiscal '14-15 to allow CHIP to be phased out. According to the NDOI, the amount of CHIP dollars that will no longer be necessary will be $23 million annually, beginning in fiscal '15-16. Some of the annual CHIP transfers have already been allocated to state aid to education and county assistance; however, nearly $9.2 million per year remains available for such a purpose as Medicaid expansion. The amendment to LB578 only captures the net savings that results from the CHIP that were slated to go into the General Fund, that $9.2 million. It still allows for other recipients of insurance premium taxes to receive additional dollars from CHIP savings as they would under the current statute. The Nebraska Hospital Association and its member hospitals support Medicaid expansion and the funding of a portion of Nebraska's associated costs through the use of existing CHIP funds as proposed by LB578 and its corresponding amendment. Failure to expand Medicaid will come at a high price. Healthcare providers will be forced to absorb more bad debt and charity care expense. Without expansion, the provider network will become even more fragmented. More importantly, if the state does not expand Medicaid, it will turn its back on billions of dollars of federal assistance, depriving many individuals of the opportunity

to improve their health and preventing them from being able to work and to learn. Thank you for the opportunity to offer comments on this important issue. And I would take questions if you have them. [LB578]

SENATOR KRIST: Any questions? Seeing none, thank you very much. [LB578]

SHARON LIND: Thank you. [LB578]

SENATOR KRIST: Thanks for putting in a long day. Next proponent. [LB578]

MARK INTERMILL: Good evening, Senators. My name is Mark Intermill, spelled M-a-r-k I-n-t-e-r-m-i-l-l, and I'm representing AARP. We support this bill. We supported it in its original version. We understand the need for the amendment. This is a program that we have...kind of have a love/hate relationship with. The CHIP program, because of the expense, we've seen the numbers of people decline over the years because it has become unaffordable; but it is a program that provides important assistance to people who don't have access to health insurance because of a preexisting condition. We think it makes sense to use at least the General Fund portion of the health insurance premiums to help sustain the Medicaid expansion. So with that I would entertain questions if there are any. [LB578]

SENATOR KRIST: Best testimony of the day. Any questions? Thanks, Mark. The next proponent. [LB578]

JAMES GODDARD: (Exhibit 62) Good evening. My name is James Goddard, that's J-a-m-e-s G-o-d-d-a-r-d, and I'm here to testify on behalf of Nebraska Appleseed in support of LB578. With the late hour, I would just refer you to my written comments and urge you to support the bill. I'd be happy to answer any questions if I can. [LB578]

SENATOR KRIST: I take that back. That was the best one of the day. (Laughter) Thank you, James. [LB578]

JAMES GODDARD: Thank you. [LB578]

SENATOR KRIST: I'm sorry. Any questions? Thank you very much. Any other proponents? Last chance at opponents. Last chance at neutral. Closing? [LB578]

SENATOR NORDQUIST: I'm sure you want me to close, right? [LB578]

SENATOR KRIST: (See also Exhibits 63-67) Well, you can just do this. All right. I see Senator Nordquist has waived. That concludes the hearings for the day. You don't have to go home but you can't stay here. [LB578]