[LR241]

The Committee on Health and Human Services met at 1:30 p.m. on Wednesday, December 18, 2013, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LR241. Senators present: Kathy Campbell, Chairperson; Tanya Cook; Sue Crawford; Mike Gloor; Sara Howard; and Dan Watermeier. Senators absent: Bob Krist, Vice Chairperson.

SENATOR CAMPBELL: Good afternoon and welcome to the hearing for an interim study. We are so pleased to have you all here today. I do not expect that Senator Krist will be able to join us today. He is having a visit by some federal officials.

SENATOR COOK: In a good way. (Laughter)

SENATOR CAMPBELL: And so I totally understood the importance of his being there for his business. I do expect Senator Howard to join us. I'm Kathy Campbell and I serve as the Chairman of the Health and Human Services Committee. And it is our practice here...and now Senator Watermeier...I was like all ready to go "and starting on my...," but we introduce ourselves here at the Health and Human Services Committee. So, Senator Watermeier, would you start for us?

SENATOR WATERMEIER: Dan Watermeier from Syracuse, southeast district.

SENATOR COOK: I'm Tanya Cook, Legislative District 13, which is northeast Douglas County and city of Omaha.

MICHELLE CHAFFEE: I'm Michelle Chaffee. I serve as legal counsel.

SENATOR GLOOR: Senator Mike Gloor, District 35, Grand Island.

SENATOR CRAWFORD: Good afternoon. Senator Sue Crawford from District 45, which is eastern Sarpy County, Bellevue, Offutt.

BRENNEN MILLER: I'm Brennen Miller. I'm committee clerk.

SENATOR CAMPBELL: And our two pages today are Audie and Phoebe. So if you need some assistance, please let them know. Senator Howard, would you...we're going to give you a chance to introduce yourself at the same time you take your coat off.

SENATOR HOWARD: I'm Senator Sara Howard. I represent District 9 in midtown Omaha.

SENATOR CAMPBELL: And there was no speeding from Omaha I take it. Okay. All right. This afternoon, I want to remind you to please silence your cell phone or turn it off so that you do not bother anybody. Our guest will have as much time as she needs to have. But other than that, we will go to the testimony, and we will use the light system to kind of keep everybody on schedule. If you are testifying today, please complete one of the orange sheets and give it to Brennen so that he can make sure we get the spelling of your name correctly. I'm going to go ahead and give a few opening remarks to this before we go to Ms. Wilson, our invited guest. I am Senator Kathy Campbell, and I will spell my name as I will ask all of you to do when you come, K-a-t-h-y C-a-m-p-b-e-l-l. And I am here to give some opening remarks on interim study LR241. Today's hearing will continue the focus on what options for Medicaid coverage for newly eligible Nebraskans under the Affordable Care Act. As you're aware, I introduced LB577 to expand eligibility for individuals in Nebraska's Medicaid program utilizing enhanced federal funding. We spent more than ten hours of debate on LB577, during which I listened to my colleagues' questions and concerns. Senators suggested to me at the end of last session, let's take time to see what states do. In response, I promised I would work during the interim to gather information, and I have continued to pursue options which may be available under Medicaid expansion to structure a Nebraska plan

providing healthcare coverage for working Nebraskans. Today's hearing is part of fulfilling that commitment to my colleagues. During this interim, we have researched other states' options and studied the response of CMS to different states' Medicaid waiver applications. I have contacted my colleagues and, I have to say, with a lot of help from some of my other colleagues who stepped up and helped me finish out and talk to some folks, and invited their suggestions and continued dialogue on this important issue. Now, today, we have an opportunity for a public hearing, and I have invited Joy Wilson, head policy research...health policy research director for the National Conference of State Legislatures, to provide testimony on what is being proposed for Medicaid expansion in other states. My commitment is to bring a new bill next session that is a Nebraska plan, a plan to provide health coverage for uninsured Nebraskans through the enhanced federal financing available under the ACA through Medicaid. I believe today's hearing will provide pertinent, important information to be considered as we move forward. We are still asking people for their suggestions and their ideas, certainly from my colleagues as well as from you who have come today. We continue to work on people's questions because we feel that is so important. So with that, we'll welcome Joy Wilson to be with us. She has been with us before and provided information. We just felt that it would be helpful to hear what other states are doing. And, Joy, it's a pleasure to have you back in Nebraska. And thanks for coming during a holiday season. That's for sure. [LR241]

JOY JOHNSON WILSON: (Exhibit 1) Well, thank you, and it's a pleasure to be here. Madam Chairman and members of the committee, I'm going to fairly quickly go through the presentation so that we can get to your questions because I know that that's usually the most important part of testimony. So I'm going to get going here. As you know, the Medicaid expansion in the original Patient Protection and Affordable Care Act was a requirement on states. So every state would have been required to provide eligibility to the new categories that were established in the act. There were also some other major Medicaid and CHIP provisions that I thought I'd remind you of, that CHIP is now a requirement for states to have the Medicaid program. So it is a grant condition of the

Medicaid program. Prior to the ACA, that was not the case. It extended the maintenance of effort requirement on Medicaid and CHIP--through January for Medicaid and through September 30, 2019, for CHIP, although CHIP is only funded through September 30, 2015. So there is a policy decision pending on what happens with CHIP after this fiscal year coming. And then there is the requirement to decrease funding for the disproportionate share hospital program beginning next month. So those are some big Medicaid issues that will be an issue that people will be talking about the next few weeks. The Supreme Court surprised everybody not only in upholding the constitutionality of the Affordable Care Act under the Commerce Clause and tax issues, but also found that the Medicaid expansion...we have over the years as states looked at, at what point does the federal government commandeer state funds. And although we believed that there was such a thing, we've never seen it; or if we'd seen it, no one else saw it. And so this was the first time that the Supreme Court or any court has found commandeering. And in that way, they said that then they did not repeal that provision of the law. And I think that's important to note. What they did was prohibit the Secretary from implementing the penalty for failure to expand the Medicaid program to the adult new category. So the other expansions are in effect. The optional provision is the expansion to childless adults who are not pregnant, who are not children, and are not Medicare eligible. I think that gets...oh, and they're able-bodied. So with all of those requirements, those people are the...that's the category that is optional. And you note, there's the new eligibility level where they've switched Medicaid from one where you assess assets and resources and do some other calculations to one that is pretty much strictly based on income except for individuals that come into the Medicaid program through another program. So for instance, if you are eligible for Supplemental Security Income, SSI, there are asset and resource requirements that are part of that program. But one of the other provisions of that program is that you are categorically eligible for Medicaid. So if you are on SSI, you are on Medicaid, they're not doing the income requirement because you came to Medicaid through another program--same thing for children in foster care and there's some...and people who come on to Medicaid because they are low-income Medicare beneficiaries. So all of those people still have resource

and asset tests that are associated with the programs that made them eligible for Medicaid, so just to clarify how that all works. The new mandatory category we talked about, I did highlight that. Former foster children under age 26 are a new required category, but there's a twist here. If the individual was a foster child in your state, they are categorically eligible for the extended eligibility up to age 26 in your state. If they go to another state, the other state is not required to provide Medicaid benefits, although they can opt to do so. There is currently not a process in place yet to organize this effort. And there is not a card that people get when they leave foster care. When they age out of foster care, there is no certificate or card that you get that shows that you have that. And so the question then becomes, if another state was supportive of providing that care, how would you know that they meet the requirements? And so this is something that will have to be addressed by rule sometime next year hopefully fairly quickly so that former foster children that are not living in the state where they were foster children can still avail themselves of that coverage if the state they're living in chooses to do so. So there's two steps. First, the state has to decide whether it wants to recognize foster children from other states. And then there has to be some process by which those individuals can get some sort of certification that they did indeed age out of foster care. So just to...because I think you're going to hear about that in the next session, just so you know what that's about. We talked about changing to modified adjusted gross income. The reason for doing that was that that is the requirement, that's the eligibility process for getting into the marketplaces--used to be exchanges, now they're marketplaces. And so assuming that people may move from one, from Medicaid to the marketplace, back and forth, it makes sense to have one eligibility standard to make that work. And then, of course, as you know, for the new eligibles, these are people who were not previously Medicaid eligible and now are, there is the enhanced match. And that is the process. The enhanced match is specifically by year. So if you start your Medicaid expansion in 2017, you don't get any of the 100 percent reimbursement that everybody is talking about. You would start at 95 percent. So it's not that you get a guaranteed three years of 100 percent, then one. It doesn't work like that. It is statutory how the enhanced match is spread across the years. And then, of course,

in 2020 and thereafter, the match for those newly eligible individuals would be 90 percent. There's a definition of newly eligible. So if you had people who were eligible for Medicaid and hadn't enrolled, they're not newly eligible. That's the bottom line to that. We've talked about the MAGI, modified adjusted gross income. That is the new income standard that most people will go into Medicaid and into the exchanges using as their eligibility standard. So what is the deal on the Medicaid expansion? First of all, for the new adult population, it is optional. So there is no penalty if a state fails to do that part of the expansion. There is no deadline for a state to enact an expansion or to go forward with an expansion. You could expand and quit. You could come back a couple years later if you want to. So you can go in and out at will. There is no penalty, and there is no deadline. We have 25 states and the District of Columbia that have currently decided to expand, and I say, in 2013. I think you have a map that's highly footnoted and that's because...and I always date my maps now because things change on a day-to-day basis. So what you say on December 16th may not be true on the 18th. I don't know that anything has changed between when I did this map but...and 25 states that will not expand in 2013 but may be expanding in 2014. So for instance, Michigan has submitted their waiver application, but they have not been...it's not been approved and they weren't planning to implement until sometime later than 2013. So while technically they've got something pending, I didn't count them as a yes. So you have to explain what's a yes, what's a no, what's maybe. So I tried my best to parse that out in this map. You may have heard that New Hampshire went into special session in November, attempted to pass legislation. They failed to get the votes. They are going to bring it back up when they go into session in January, but we don't know how that's going to work. We have a couple of states that are in litigation. Arizona, the governor...the legislature actually passed a Medicaid expansion bill. The governor signed it, and they are moving forward. And now they have been challenged by a group of state legislators over a technicality in the law. And so that is pending court consideration. And in Ohio, Governor Kasich used his controlling board. They approved the Medicaid expansion. The legislature was not in session, and the controlling board makes appropriation decisions in the absence of the legislature. And the governor moved forward on the

Medicaid expansion. That is being challenged in court as well about whether the controlling board acted appropriately. And the Ohio Supreme Court has provided expedited consideration. And it should be considered late this month or early next month, although the governor has said he plans to move forward on January 1. So that will be interesting watching the newspapers on that one. And then there are a number of governors that are having conversations with HHS about their various ideas about how to move forward on an expansion but have not yet come forward with a formal proposal. And so there's a lot going on. The latest of the states, and we're going to talk about that, Pennsylvania, the governor has put together a proposal and he has started the 1115 process. The first step of that, of course, is a period of public comment. And he has set the hearing dates that, I think, begin this month and run through January, and then he will submit his proposal that would include any comments that he receives from the public hearings to CMS and start the formal process. So if a state doesn't expand, then what? So here is the short story about what happens. Individuals with income above 100 percent of the federal poverty level are eligible to enroll in the state's marketplace. Whether it's a federal marketplace or a state marketplace, it doesn't matter. They are eligible to seek coverage in the marketplace. Individuals with income below 100 percent of the federal poverty level are not eligible for Medicaid because the state did not expand, nor are they eligible to participate in the marketplace. And this is what is now being called the gap group. So these are people who currently aren't eligible for Medicaid. In some cases they might be eligible for some state-funded Medicaid waiver program usually at a very low percent of percent of poverty, somewhere in the 30 percent of poverty range or thereabouts. But for the most part, these are people that were not currently eligible for Medicaid and are not now eligible for Medicaid. So they are...they do not benefit from the Medicaid expansion that's in the ACA. So a question we are often asked is, then does the noncoverage penalty apply to the gap, the people who are the gap individuals? And the answer is no. The Secretary has the ability to offer hardship exemptions to any group that she feels has a hardship. So it's a very broad exemption that is available to the Secretary. And there is also a provision in the law that says if it is not affordable to you, you will not be penalized. So most of the people in that

income area below 100 percent of poverty would either not be penalized because they would be exempted on the affordability issue or the Secretary would provide a hardship exemption. So they're not going to be penalized. So the Section 1115 waiver is not really a program, it's more of a process. And it is very particular to the administration that is in charge at the time because it is about what the Secretary of HHS determines would be the right policy direction for the Medicaid programs or promotes the objectives of the Medicaid program. And as you know, that changes from administration to administration. So 1115 waivers are kind of dependent on who's in charge of the department and who's in the White House. So that's important to note because the 1115 waiver is a process. It's a negotiation that has a policy aspect and, more importantly, it has a budget aspect. So you have to meet the policy objectives of the administration that is in charge, and you have to be able to demonstrate that your proposal is budget neutral to the Office of Management and Budget. I call it the green eyeshade guys. And regardless of administration, they're a tough group. So it's a big process. It's unwieldy, and it takes time because it is a negotiation. The Affordable Care Act added a new layer of complicity...complication to the process. Now, there's always been a public comment process. Every state has a public process of some sort. But let's just say the folks in Washington weren't totally happy with the various public processes among the state. So they wanted to have something that every state had to do. So they have put in place a state process and a federal process. And there are time limits associated with it. So you're never going to turn around an 1115 waiver in less than probably 90 days just because of getting through the public comment process. And that's 90 days starting from when you actually begin everything. That's not the negotiations that go before you start a public process. So just to throw that out there. This is a long thing. So the final rules were published in the Federal Register on February 27, 2012. And it establishes the state process and the federal process, and then there are ongoing reports that have to be submitted along the way. So there's evaluations going on during the 1115 waiver process and there's a review process that goes on to make sure that the things that the state says it's going to do, it does as the waiver goes forward. Waivers are generally three to five years. And it used to be that budget neutrality was an annual process.

They're now doing a more global process so that it has to be budget neutral over the life of the waiver but not necessarily budget neutral each year. So that way you can have some up-front spending and then save in the back end and still come out. So this is the quick and dirty of the state waiver process. This is making it as simple as one can, that you have to have a 30-day public notice and comment period. You must have a Web site. The materials related to the proposal have to be posted on to the Web site. And you also have to have at least two public hearings in two different places in the state on different days. And when you submit your proposal, you must show how you took into account the feedback that you received from the public. So you have the hearing, you note what was said, and you respond to the comments of the people in your state as they commented on the proposal. And either you made adjustments or you didn't, and you say why. Then there's the federal process. So in addition to your own, the people in your state submitting comments, the federal government will submit your...will put your application on to a Web site at the Centers for Medicare and Medicaid Services for the national public to critique your proposal and submit comments. And then the federal government is to take into consideration both the comments that were received from your state as well as those that are received from national advocacy groups, members of Congress and the like, and when they make a decision about whether to go forward with the waiver. And the public process for the federal government is 45 days. So it includes the 15 days that they have to let people know that they've received your proposal and then a 30-day comment period. So it's 45 days for the federal government, 30 days for the state. And then as the federal government looks at your proposal, they may submit questions that they need to have answers for before they can move forward. And then the negotiations continue until you reach some agreement. And that can go on for some time. So I'll talk briefly about four states, two that have approved 1115 waivers for the Medicaid expansion, and of Michigan's that is pending and Pennsylvania who hopes to submit their waiver application early next year. You've probably heard a little bit about Arkansas because they were first and Medicaid in Arkansas and Medicaid expansion was all one big word while that was all going on. They actually have an approved waiver and have begun enrolling people in their

Medicaid expansion. They are using a premium assistance, and they are including all of the new adult group with the exception of people who are deemed to be medically fragile. And that is something to keep in mind because that's going to go across all of the waiver proposals. So what they are basically doing is they are going to buy in their new adult group into their marketplace either by providing premium assistance to their employers or buying, taking them...their Medicaid dollars and paying for them to be on a silver-qualified health plan within the Iowa marketplace. So that is...you should note that Arkansas did have an adult program where they were covering people between 17 percent and 133 percent of federal poverty. It was a limited waiver. It was capped. And they always had a waiting list because they couldn't afford to put more people in it. So this is going to...so that waiver is going away, and they're putting them all into this...the expansion group into the marketplace. For medically frail people, if they choose, they can also buy into the marketplace and not be in the regular Medicaid program. So it's an option. The objectives that Arkansas put into their proposal was that they wanted to promote continuity of coverage. They believe that a lot of their adult population would end up moving back and forth between Medicaid and the marketplace as their income fluctuates, which is not very efficient if they can't keep the same healthcare providers. So the idea was that rather than having them move back and forth and changing plans and whatnot, if you buy them into the marketplace, they can stay. Whether they're in Medicaid or whether they're working for a private employer and getting coverage there, they can keep the same health plan, which they also felt would improve access to providers. You wouldn't be seeking new providers as you go back and forth. A seamless continuum of coverage is what they're looking for. A lot of times when people have to switch plans, they don't get a new plan and they kind of drop out of the system until they have a health event. And then they have some other initiatives that are ongoing that are delivery system initiatives, a lot of managed care, accountable care organizations, that kind of thing that they're looking to move towards. And their hope is that they can fold all of this into one initiative. They also have a wellness component to this where they're trying to encourage healthy behaviors and better use of preventative care, that kind of thing. They hope to enroll 200,000 people in the first year. The other piece that they're

really hoping is that this will help the financial viability of the marketplace. Iowa does not have very many participating insurers. And so having more people in the marketplace will make the marketplace more financially viable. So that's the other thing that they're working with. Iowa just received the approval, and they hope to start January 1 of next year. So on my map when I put the 2013, they didn't quite fit in, so. But they are...they plan to be up and running January 1. It's the Iowa Marketplace Choice, and it will offer premium assistance to some individuals and will...who have employer-sponsored insurance. And they will buy in individuals with incomes above 100 percent of poverty into the marketplace. They are not doing what Arkansas is doing, and at below 100 percent of poverty, they're not buying them into the marketplace, although they are...they have a separate program to provide incentives for the individuals below 100 percent of poverty to participate in some wellness activities and healthy behaviors. And they do exempt medically frail individuals. And again, I think you'll see throughout most of the applications, medically frail individuals will be exempted. And some states will put them in the regular Medicaid program, and other states will look to provide some special services for medically frail individuals around medical homes, accountable care organizations, and special programs for people with multiple chronic illnesses--so some way to organize the overall health effort around people that have a lot of things going on to really make sure that what is happening for them is coordinated across their medical conditions. We know that in fee-for-service in Medicaid, a lot of times there isn't that coordination, and sometimes individuals end up with doctors working at cross-purposes, and they don't know. And so that is something that states across the country, whether they're doing Medicaid expansion or not, are looking at because that's a big cost in the Medicaid program. They're going to offer multiple plan options in their Marketplace Choice. They'll at least be the silver-level plans. They hope that...they hope to show that this approach is more cost-effective than what they've been doing in the past. And so the demonstrations are supposed to be evaluated and to show that it's an improvement over current status. And so one thing they're going to look at is whether the multiple plan options that are available to people in the marketplace is better than the kind of singular plan options that they have now through Medicaid and whether there's any

improvement in outcomes that come out of this new process. They also hope that...now, in Iowa, it's a little different than a lot of states. There isn't a whole lot of difference between the rates in Medicaid...what Medicaid pays and what's paid in the private sector, which is not true most places. But it's a little bit lower and they're hoping that bringing up the Medicaid rate to the private rate in the marketplace will provide a little more stability and will show that you can do...that you can provide that higher rate and improve outcomes by hopefully getting some who didn't want to take that little bit lower in Medicaid into the program. They want to...they do have this proposal to charge a premium for the wellness package but that if you meet the requirements of the wellness package, the premium would go away. So this is something that was negotiated with CMS. And they're not big on premiums. And the Medicaid law does not permit premiums for anyone below 100 percent of poverty, but they are allowing Iowa to do this as part of the demonstration, and then it will be evaluated to see whether that works. So they are looking at, can you charge a premium and then say it'll go away if people will do X, Y, and Z, or will people just not do it, or what will happen? That's what they're going to look at. The other big issue, and the advocacy community has been...has provided feedback in a very big way on this issue, and under the Medicaid program, what sets Medicaid apart from private insurance is that it does cover, it pays for nonemergency transportation to medical appointments. Iowa asked to be allowed to not do that not for the...so but...remember, medically frail are exempt. So this is just for the rank and file, the people that are in this particular...so these are adults, able-bodied, childless, not pregnant, that group. Whether...if we eliminate the nonmedical transportation, will they not go to appointments? What happens if you don't have this benefit for this group of people? And so HHS has given them the ability to do this for one year, and then there will be an evaluation on the impact on access. So it also allows their Medicaid program to coordinate with the qualified health plans to keep in place a prior authorization process that they had in the Medicaid program--very important. And you will also see this across the proposals. There is no breach of EPSDT. Children, regardless of what state you're in, are going to get the EPSDT benefit, period. I don't see that getting waived. I just don't see that happening. So whatever age--and some

states have 19, some have states have 20, some for 21 in terms of who's a child--but whoever a child is, they're going to get EPSDT. And just like medically frail people are protected, children will be protected on the EPSDT benefit, I think, across the board. And then, like I said, it allows Iowa to post premiums in the second year of the demonstration to try out this incentive program. There are limits to how much you can charge. So there's an overall limit in the Medicaid law about what an individual can be required to pay out of pocket; it's 5 percent of income. And you will see across applications so far HHS has not allowed any state to breach that. So whatever cost-sharing they are allowing, it still has to come under that 5 percent of income cap at the end of the day. The Iowa Health and Wellness demonstration applies to the lowest income, so it's the people below 100 percent. It applies to those that are up to 133 percent. It's a very concentrated, healthy Iowa approach to life. And they really want to see what they can do in terms of engaging the Medicaid, these adults, into healthy behaviors to improve outcomes. And so they are hooking them into programs that they've already put in place--the accountable care organizations, managed care, and some programs that they've put together for people with multiple chronic illnesses. They're going to really try and get people in those and vigorously activate those to see if they can really improve outcomes for this group of people. Again, note medically frail people, American Indians, Alaska Natives, and people that are in employer-sponsored insurance don't have to participate, but they can if they want to. And again, in this program, they're not required to provide the nonemergency transportation. And in this particular program, there's no premium. So these are the people...so the ones for under 100, there's no premium for them. But they're going to aggressively try to promote the wellness program through incentives. Michigan submitted their proposal. I think it was in September or October. They have a different approach. They are doing up to the 138 percent of poverty, the...so they're looking at the whole group. But they are...and they are also covering. They had an adult group program that they were funding through a waiver that is...I think it ends on...at the end of this year. So they're subsuming that group in, which was another capped adult group program that always had a waiting list. And so now all of those people would become part of the Medicaid expansion. And they

are looking to enroll 300,000 to 500,000 people in the state of Michigan. So it's a big program. It's a little different. They plan to have...it's kind of a hybrid of a health savings account approach where there would be a certain amount of money set aside per individual. It would be a combination of state money, you know, the Medicaid money, private contributions. And it's not clear to me exactly how that works because they didn't have to be all that specific, because as you might recall, it's a negotiation. And they're negotiating. But the concept is that there would be an account, and each individual would have an account, and that there would be a premium associated with this account and that as you get services, certain money would come out of the account but that you would never not have money in the account. That's the part where I'm not that clear on. But having read it a couple times, I'm still not clear on that. And I'm going to have to give them a call because I don't quite get exactly how that works. Again, their cost-sharing can't exceed 5 percent, so they know they have to stay under that ceiling. But exactly how the money gets into the account and how it goes out and comes back in is not totally clear to me at this time. But they hope that...their hope is that having a little skin in the game will make people pay more attention to the money coming in and out and that they will manage their accounts in a way that is responsible but that...knowing that if they have an illness and there's not sufficient money in the account, that money will happen. So that's my understanding of how that's...of the concept. Exactly how it works on the ground is not that clear to me. But that's the concept, that there would be an account, there would be money in the account; you would have copays and deductibles and things like that limited to what's allowed under Medicaid but that you would get a quarterly report so you would know what your account looks like. You'd know what activity has occurred. So it's this kind of getting people to understand what's going on in their health life and what expenditures have occurred. So they are waiting for CMS to respond to their proposal. And I've not been able to find any official responses, but as you know, much of the response and the back-and-forth goes on behind the scenes while they negotiate changes to the proposals. Then of course, Michigan is getting public comment both from Michigan and from national organizations, some not so comfortable with the approach. So we'll see how that goes. Pennsylvania has just

begun the public comment process. They have put out their proposal. And it's called Healthy Pennsylvania, and it includes Medicaid reforms as well as a private coverage option. And they would be covering adults up to 133 percent of poverty, plus they had a waiver program like other states. They were covering people between 133 percent and 33 percent of the federal poverty level. They're going to put them into this new program. What sets Pennsylvania apart is that they are going to (a) impose premiums. They are going to have an incentive program that is tied to the premium so that if you meet certain benchmark healthy behaviors, then your premium is reduced and could go down to zero if you meet all of them. And the thing that has been most controversial about the Pennsylvania approach is it includes a work search activities requirement and ties the...a premium reduction could also occur if you are participating in a work search, a job search, or a work activity. So that...no other state has, at this point, put something forward that includes a work or a job search component. So that is where Pennsylvania is different. They are just starting on their getting comment. They're getting national comment before the national comment period has begun--so that does suggest that when their official national comment period starts, they've already...people have already gotten a jump on that--mostly around the work activity and the premium requirement, because the premium requirement would apply to people with incomes above 50 percent of the federal poverty level. So that would clearly be very different than what is in the Medicaid law. So this is going further down than any other state has proposed for cost-sharing. So I think that's kind of where we are. There are, as I said, a number of states that are having ongoing conversations with the administration looking at various proposals and trying, you know...I think a lot of them have very firm ideas about what they'd like to do and are doing the test run before they write a full-out proposal to see where the possibilities lie. So I suspect that next year there will be a number of states that will probably go forward with a full-blown proposal. So with that, I'm happy to answer any questions you might have. [LR241]

SENATOR CAMPBELL: Questions from senators? While you're thinking of your question, Joy, one of the things that Arkansas was trying to prove in their program, and I

thought you might want to amplify, and that was, they saw the cost saving, some of the cost savings coming from the fact of this churning... [LR241]

JOY JOHNSON WILSON: Yes. [LR241]

SENATOR CAMPBELL: ...that, you know, as you move from Medicaid to a regular and maybe back. And we do know that people do that. They go on and off Medicaid. Do you want to talk a little bit more about that? Because obviously the federal government took into account their argument. Would that be an accurate statement? [LR241]

JOY JOHNSON WILSON: Yes, and I think everybody has been concerned about the churning issue from the very beginning because we know that occurs and we lose a lot people along the way. Because once they have it, then they don't, they wait until they need it, and then they try...you know, then the application process begins. And what happens is people that have chronic conditions that then...their prescription runs out. Now they're not covered, and then they go, oh, I won't get it. So we believe there's a lot of costs that are generated by people not following through when they lose coverage. And so they felt like the whole, from Medicaid to the marketplace and back, that they might lose a lot people along the way because this is even newer than...you know, a lot times if you were on Medicaid and you became higher income, you just lost. You didn't have an option. Now, you have an option, but you don't really know about it. And so they felt like if there was some way of keeping people in the same plan regardless of the financing, that that would eliminate one of the reasons why people lose coverage. [LR241]

SENATOR CAMPBELL: So in the overall cost-neutrality issue, Arkansas argued that over the lifetime of this they could probably make it cost neutral. [LR241]

JOY JOHNSON WILSON: They believe so. And like I said, there were very...the financial aspect in their marketplace was another area where they felt like their proposal

would help make the marketplace financially viable. And so I think that also was an important aspect for that state. [LR241]

SENATOR CAMPBELL: Okay. Questions from the senators? Senator Watermeier. [LR241]

SENATOR WATERMEIER: Thank you, Chairman Campbell. Thank you, Ms. Wilson, for being here. A couple of questions, two unrelated questions: one about the Michigan plan being a similar or hybrid, as you mentioned, to an HSA. I'm as confused probably as you are of really how they're going to keep that pot full. It's not certainly a self-insured plan where the state is going to just say, we're going to be self-insured; otherwise it would be internally a Medicaid program. [LR241]

JOY JOHNSON WILSON: Right. [LR241]

SENATOR WATERMEIER: They're still going to try to transfer that cost to an insurance company in some way. That's the way you would view it? [LR241]

JOY JOHNSON WILSON: Well, it sounds to me like the state holds the account. [LR241]

SENATOR WATERMEIER: Um-hum. [LR241]

JOY JOHNSON WILSON: But they're talking about having private contributions, public contributions, and contributions from the individual. I'm not sure how that aspect of it works. [LR241]

SENATOR WATERMEIER: But no matter what...and excuse me for interrupting,... [LR241]

JOY JOHNSON WILSON: Um-hum. [LR241]

SENATOR WATERMEIER: ...because I always come back to this requirement of the 5 percent max. No matter what of a personal contribution, it's always limited to 5 percent of their income. [LR241]

JOY JOHNSON WILSON: Right. [LR241]

SENATOR WATERMEIER: That would be the requirement no matter what plan. And the feds have never wavered on that waiver part of it. [LR241]

JOY JOHNSON WILSON: Right, the... [LR241]

SENATOR WATERMEIER: Okay. There's been some asking for that, but they've never wavered over the 5 percent. [LR241]

JOY JOHNSON WILSON: No. [LR241]

SENATOR WATERMEIER: Okay. [LR241]

JOY JOHNSON WILSON: I mean it's statutory and I cannot recall when they've waived the overall 5 percent. They've...maybe they're allowing a premium. Whether you can actually impose the penalty, I think, is...yeah. [LR241]

SENATOR WATERMEIER: Right. Well, I asked that question because I'm kind of intrigued, too, with the HSA concept of doing something like that, so. [LR241]

JOY JOHNSON WILSON: Well, I'll tell you, it's patterned after a waiver program that's operating in Indiana at the present time. But they've been able to fund a lot of the account through public...private contributions. [LR241]

SENATOR WATERMEIER: Okay. [LR241]

JOY JOHNSON WILSON: And so that's how it's worked, but it's a small program. It's, you know, it's capped. But it's very popular, and it's worked in that state whether...you know. [LR241]

SENATOR WATERMEIER: We'll have to see how that all pans out. [LR241]

JOY JOHNSON WILSON: Exactly. [LR241]

SENATOR WATERMEIER: See... [LR241]

JOY JOHNSON WILSON: It's about, can you keep the contributions along with everything else to make that work? And of course, you see the Michigan program is...they're looking at a very big group of people, so. [LR241]

SENATOR WATERMEIER: Yeah, 300,000 to 500,000 people. [LR241]

JOY JOHNSON WILSON: Right. So I cannot visualize exactly how that works. But I've not talked to them since they've actually put their proposal in. So I'd like to hear how they... [LR241]

SENATOR WATERMEIER: Yeah. I'm just more curious on that question. So if I have time for a second one? [LR241]

SENATOR CAMPBELL: Sure. Absolutely. [LR241]

SENATOR WATERMEIER: The second question involves the cost. And if we're thinking of all these waivers in which we've compared to other states, basically, you're going to

take the federal money that's potentially coming into the state and use it to turn around and buy private insurance. But the insurance cost per individual, we really haven't talked about that. And I thought maybe in your slides today you would talk about the actual cost. There's a...let's just say the cost of the people that we are insuring today through the Medicaid are $500 a month. And that's a group of people that are covered because they had...or they're ADC...their kids are...they have children. So typically, that group of the population is...I guess, I've read enough to think that those are less expensive because they're typically younger. And the people that we're leaning towards maybe insuring, covering under the expanded group are going to be two, maybe three generations typically older. So they won't have the same costs per person. I mean, I thought I've read several studies that showed them being 60 percent higher. So if we mandate that that's going to be insured by our state or the insurance companies in our state, who's going to potentially want to offer that to that population? [LR241]

JOY JOHNSON WILSON: Well, I'll tell you, one thing is the fact that medically frail, whatever that means, those people are outside of these waivers for the most part. They're...so medically frail can be someone that has behavioral issues or that has substance abuse issues, which are two of the areas where there was a lot of concern about putting them into the marketplace. They're going to be weeded out as medically frail and put into those other, those managed care programs that states are putting together to address people with complicated medical issues which would include behavioral health, substance abuse, and multiple chronic illnesses. [LR241]

SENATOR WATERMEIER: They're weeded out though because they're in the expanded process or because they would be weeded out anyway? [LR241]

JOY JOHNSON WILSON: Well, what I'm saying is...no, they'll be weeded...well, for the new group, which is anybody between...that's not a child under age 65 that's not technically disabled, that means they're not in a disability program of some sort. They may actually be disabled but are not disabled enough to qualify for SSI or SSDI or some

other eligibility program. Those are not going to be in the marketplace for the most part. And so that's where your big costs would come. If they're medically frail, they're not going to be included in that group that goes to the marketplace. [LR241]

SENATOR WATERMEIER: Okay. [LR241]

JOY JOHNSON WILSON: And so each state that's doing these proposals, most of them have had some consultants come in and help them assess what their adult group looks like. And it's very different by state. So in some states, that adult group has a high level of people with disabilities, and they've been able to document that and think about what that means for them. In other states, they're finding that that group is generally healthy and shouldn't be...and fits more into the normal...the other people that would be in the marketplace. In fact, they're probably healthier than the average person in that state's marketplace. [LR241]

SENATOR WATERMEIER: Well, you lost me there. I guess everything I've seen is the complete opposite of that. [LR241]

JOY JOHNSON WILSON: Well, remember they're... [LR241]

SENATOR WATERMEIER: They're not because they're that older group. They may have potential problems in life, and they're just generally not. There's...I've seen study after study that shows that there's 60 percent... [LR241]

JOY JOHNSON WILSON: It's how many you have...and remember...so it's, you're looking at that whole population, how many and what does it look like. And it varies a lot by state. So what CBO did was they said exactly what you said: Wow, they're probably going to not be that healthy because of demographics in general. But demographics in general doesn't work when you break it down by state. And so what they found is that it's very different depending on what state you're in and what level of insurance those

states have... [LR241]

SENATOR WATERMEIER: Um-hum. [LR241]

JOY JOHNSON WILSON: ...so that some of those people were being treated and...you know. So it really matters. And that's when the money that came early on in the Affordable Care Act when states were doing demographic studies to determine where they needed health facilities and where they were short of practitioners, they also looked at the health status. And we found that it really varies a lot by state. And so that's an important thing for every state to look at is, what does your population look like, not nationally... [LR241]

SENATOR WATERMEIER: Oh, certainly. Yes, yes. [LR241]

JOY JOHNSON WILSON: ...but where are your...and if you have areas of your state even where people are less healthy and how you address that structurally within your state, so. And it is amazing the differences among the states. A lot of it has to do with the individual market... [LR241]

SENATOR WATERMEIER: Certainly. Thank you. I guess... [LR241]

JOY JOHNSON WILSON: ...and the level of coverage. [LR241]

SENATOR CAMPBELL: Did we get your questions? [LR241]

SENATOR WATERMEIER: Well, probably, yeah. It probably brought up more questions maybe for the future. Just curious, what do you think, Senator Campbell, as far as at the end of the session, a chance for questions back to Ms. Wilson after we have other public... [LR241]

SENATOR CAMPBELL: Sure. Absolutely. [LR241]

SENATOR WATERMEIER: ...if I have something come up? [LR241]

SENATOR CAMPBELL: Knowing NCSL, you can ask them questions almost every day. [LR241]

SENATOR WATERMEIER: Sure. Yeah. [LR241]

JOY JOHNSON WILSON: Oh, yeah. You can always find...you know where to find me. And I'll see if I can get you some of that data because I know that it's out there. [LR241]

SENATOR WATERMEIER: Um-hum. [LR241]

SENATOR CAMPBELL: It's a good question. Thank you, Senator Watermeier. We can come back. Senator Howard. [LR241]

SENATOR HOWARD: On your PowerPoint, you mentioned that CHIP has only been authorized through September 30, 2015. Can you speak to what would happen for states that don't expand Medicaid but if CHIP is not reauthorized? [LR241]

JOY JOHNSON WILSON: Well, we don't know on that. There is a policy question about whether if the marketplaces are successful, is there a need for the CHIP program? Now, this is a hot-wire issue for sure. But when they passed the Affordable Care Act, they couldn't finance the CHIP program through the 2019 maintenance of effort date that they put on there. And that's why it looks like it does. But the conversation now is about whether or not it should be reauthorized or whether it can be subsumed by the marketplaces. So that will be a very hot topic in the next couple years. [LR241]

SENATOR HOWARD: Thank you. [LR241]

SENATOR CAMPBELL: Any other questions? Thank you very much, Joy, and I hope that we can take you up on the question from Senator Watermeier. If we have any additional questions, we can come back. But it's very helpful to know at least what other states are doing because that was part of the question posed. So thank you very much. [LR241]

JOY JOHNSON WILSON: Thank you. It's always a pleasure. [LR241]

SENATOR CAMPBELL: Could I have a show of hands of those people who wish to testify today? Let's see. What have we got? Somebody, Brennen, can you count for me? [LR241]

SENATOR WATERMEIER: Seven. [LR241]

SENATOR CAMPBELL: About nine. Okay. All right. We will begin taking testimony this afternoon. So if you've come to testify, come on forward. One of the nine has to go first. Good afternoon. [LR241]

RALPH L. MOROCCO, JR.: Good afternoon. [LR241]

SENATOR CAMPBELL: And what we'll have you do is state you name and spell it for us and then start right in. [LR241]

RALPH L. MOROCCO, JR.: Okay. All right. Senator Campbell, members of the committee, I'm Ralph Morocco spelled R-a-l-p-h, Morocco, M-o-r-o-c-c-o. I live at 11223 William Plaza in Omaha, and I'm currently retired but worked for 10 years as a hospital executive and 20 years as cofounder of the Midlands Choice Managed Care Network. I'm here to encourage your support for an expansion of Medicaid under the Patient Protection and Affordable Care Act. I urge you to support Medicaid for five reasons.

First, it will improve the healthcare available to low-income Nebraskans not currently eligible for Medicaid but who do not earn enough to buy coverage under the Affordable Care Act. It will strengthen our healthcare delivery system and may be critical to sustaining it in rural communities in the state. It will make Nebraska more competitive in attracting new business to the state. It will be a significant economic benefit to state. And it will make health insurance less expensive for those of us who have coverage either through employer-sponsored plans or through small-group or individual health plans. By expanding Medicaid, low-income Nebraskans can get needed preventative care, helping them avoid expensive illnesses that can be prevented, and better manage chronic diseases like diabetes. That will make future healthcare less expensive either if those individuals remain as Medicaid beneficiaries or move on to private health plans. As the National Council of State Legislatures' spokesman, Joy Wilson, pointed out, starting expanded coverage prior to 2017 allows the full initial cost of that coverage to be paid by the federal government, providing time for those people's health status to improve and lower the future costs for the state of Nebraska. The expansion of Medicaid is particularly critical in Nebraska. Many hospitals are working to recruit physicians to replace those who are retiring or to provide additional services in their communities. Recruiting physicians to Nebraska counties in or near some of the highest uninsured population will become increasingly difficult in the future. When other states expand Medicaid but Nebraska does not, it becomes harder to convince young physicians that Nebraska is a good place to practice medicine. If we have 10 percent to 15 percent of our population uninsured, it becomes really difficult to convince somebody to come here versus a state like Iowa that has made the decision to do so. It also becomes harder to keep local hospitals running and able to afford new medical technology when a large percentage of their patients don't have access to a means to pay for care. It also becomes difficult to attract employers to Nebraska when they know their health plans must bear the high cost of an uninsured population they would not have to bear if they located in a state that provided Medicaid expansion and dramatically reduced the number of uninsured individuals. A Commonwealth Fund study released earlier this month estimates that the 2022 cost of expanding Medicaid in this

state at about $55 million will be only 3 percent of what we spend to attract new business to the state in that year. Their estimate was about $1.7 billion. Take 3 percent of what we spend to attract new business, use it to fund Medicaid expansion, and allow all businesses in the state to benefit from lower premiums and a healthier work force. There will also be significant expansion...or a significant economic benefit in the state. Commonwealth Fund estimates about $444 million in federal funds associated with Medicaid expansion would flow to Nebraska, dwarfing the $371 million we get in federal highway funds in 2022. As those dollars flow into the state's economy and the economic multiplier, as they roll through the economy, takes effect, it probably produces over a billion dollars' worth of economic benefit. Finally, expanding Medicaid will slow healthcare costs for all Nebraskans who actually have health insurance and for large employers like the state of Nebraska that self-fund their health plans. As a managed healthcare plan, I saw higher healthcare costs in those portions of the state that have higher percentages of medically uninsured individuals. Uncompensated care adds to the healthcare delivery...or adds to the healthcare costs of every Nebraska health plan and every insured Nebraskan as hospitals and physicians necessarily charge higher fees to cover the services they provide. As a Nebraska taxpayer, I'd ask you to do the right thing for Nebraska, our healthcare delivery system, and our state's economy, and that's expand Medicaid. [LR241]

SENATOR CAMPBELL: Thank you, Mr. Morocco. Questions from the senators? Senator Gloor. [LR241]

SENATOR GLOOR: Thank you, Chairman Campbell. Ralph, it's been a while. [LR241]

RALPH L. MOROCCO, JR.: It has been. [LR241]

SENATOR GLOOR: I didn't recognize you at first. I was doing some housekeeping the other day and found a Midwest Select hat... [LR241]

RALPH L. MOROCCO, JR.: Oh. (Laugh) [LR241]

SENATOR GLOOR: ...that I would be happy to sell you very, very reasonably (laughter) as a memento. [LR241]

RALPH L. MOROCCO, JR.: I might have a couple of bucks. [LR241]

SENATOR GLOOR: Yeah, that does go back a ways. So in your involvement in the managed care industry, would you say that one of the significant changes between now and then is that back then we really weren't too interested in measuring outcomes? [LR241]

RALPH L. MOROCCO, JR.: Absolutely, yeah. It was price only. [LR241]

SENATOR GLOOR: Yeah, price only. Do you see that change as significant? And if so, now and then, how do you see that playing out as it relates to Medicaid, Medicaid expansion? [LR241]

RALPH L. MOROCCO, JR.: I do see it as significant because I think ultimately it will lead to lower costs both for Medicaid and for the private pay beneficiaries as we do a better job of making sure that healthcare gets delivered in the most efficient and effective way possible. [LR241]

SENATOR GLOOR: Are you comfortable because, as most people know, my concerns here are, we spend the money but we aren't sure that we're improving people's general health status, that we still operate as we did back in the days of Midlands Choice and Midwest Select with...under the premise that access equals improvement in health status and I'm...that's obviously one of the big hang-ups that I have. [LR241]

RALPH L. MOROCCO, JR.: Yeah. And I think absent data, it's hard to prove the fact

that quality and health status improves. But I'm willing to bet a big pile of money that, absent access, health status is not going to improve. [LR241]

SENATOR GLOOR: Well, actually the bet is ours. [LR241]

RALPH L. MOROCCO, JR.: Yeah, yeah. [LR241]

SENATOR GLOOR: So you don't have to worry about it. But that's one of the reasons that we're taking a hard look at it. Thanks. I appreciate your taking the time to come out today. [LR241]

RALPH L. MOROCCO, JR.: Yeah. [LR241]

SENATOR CAMPBELL: Any other questions from the senators? Thank you, Mr. Morocco, very much. [LR241]

RALPH L. MOROCCO, JR.: Thank you. [LR241]

SENATOR CAMPBELL: Our next testifier. [LR241]

REBECCA RAYMAN: Good afternoon. [LR241]

SENATOR CAMPBELL: Good afternoon. [LR241]

REBECCA RAYMAN: (Exhibit 2) My name is Rebecca Rayman, R-e-b-e-c-c-a R-a-y-m-a-n, and I'm the executive director of the East Central District Health Department and the Good Neighbor Community Health Center in Columbus. I am also the chair of the Health Center Association of Nebraska, which represents the now seven federally qualified health centers in Nebraska. Nebraska's federally qualified health centers are also known as FQHCs, and we serve 63,000 primarily low-income patients

in 27 locations across the state. And soon we'll add a location in Grand Island, Nebraska. We are key safety-net providers in Nebraska's healthcare system. The majority of our patients are uninsured. Our uninsured patients are almost entirely low-income working adults, people whose employers do not provide health insurance and people who aren't making enough money to afford a private premium. Most of our patients, 65 percent, have incomes below 100 percent of poverty. Nebraska's health centers were fortunate to receive funding to provide assistance in helping people in our community enroll in the Affordable Health Care Act. The FQHCs have added 30 certified application counselors, or CACs, between the start of the fall and today to assist people in our communities with enrollment in the new healthcare marketplace. These CAC staff members conduct community educational meetings and they provide one-on-one assistance to patients and individuals in our communities. We are still collecting data on the open enrollment period, but we estimate that we have done over 4,000 one-on-one meetings in our federally qualified health centers. At our center, the center that I'm with, despite the challenges of rollout, our four CACs are continuously busy. There is great interest among our patients and in our community to find affordable healthcare insurance. We see people daily who are realizing now that they are not going to qualify for the help they thought on the exchange or through Medicaid simply because they are just too poor. It is frustrating for them to go to work every day and still be left out of what many of us take for granted. These men and women are the ones left behind by the decision not to accept Medicaid expansion. They can't get an insurance product that is affordable, and they are not eligible for the subsidy in the new health insurance marketplace. We see these people every day. One of those that we've just counseled recently is a 59-year-old farm worker. So John is a father, grandfather, and lifelong rural Nebraska resident. John has never taken governmental help. He has worked hard on Nebraska farms. Some months he makes $4,000 a month during the busy farm season, but offseason he makes little. He works every day. But winter days are not full days, and he is only paid for the hours he works. Now, he finds himself at 59 concerned about his future. He has about six years of farm labor before he's old enough for Medicare. After years of hard farm work, he's very concerned about his future. He's

concerned about his body's ability to keep up with the farm work that is all he has ever known. He is concerned about what will happen if he gets hurt or what will happen if he develops a chronic illness. And he was anxious to purchase insurance for the first time in his life. John came into our FQHC anticipating that he would finally be able to afford insurance. John's income, though, places him in the gap or the doughnut hole. John was unable to obtain a subsidy as he is an adult male without disability, and he is not eligible for Nebraska Medicaid. The cost of insurance for John would have been $500 a month, or 43 percent of his total gross income. We hear a lot about people who are angry with the ACA, but I will tell you that John is angry. John is angry that the ACA is not working for him. He is angry that he has been excluded from a health insurance solution. He doesn't understand how the promise of healthcare could pass him by. This is just one story that we're hearing. People like John are in the Nebraska doughnut hole, and the only way things will improve for them is to provide a path forward to get coverage, coverage that is now available for other low-income people in some other states but that is not available for them. Some of our patients are people who don't have primary healthcare homes. They are people who end up with costly emergency room care. But most importantly, they are our neighbors, our family, our friends, and our neighbors. They are good, hardworking people. We urge the committee to support a way to transform Medicaid so that it can serve this segment of people who are left out, these Nebraskans who want a promise of a healthier future. [LR241]

SENATOR CAMPBELL: Thank you, Ms. Rayman. Questions from the senators? Thank you. [LR241]

REBECCA RAYMAN: Thank you. [LR241]

SENATOR CAMPBELL: Our next testifier. Good afternoon. [LR241]

JAMES GODDARD: (Exhibit 3) Good afternoon, Senator Campbell, members of the committee. My name is James Goddard; that's J-a-m-e-s G-o-d-d-a-r-d, and I'm the

director of the economic justice and healthcare access programs at Nebraska Appleseed. I do want to thank Senator Campbell and the committee for its continued interest in this subject and all of the work and discussion that is going on about making sure families can access healthcare in our state. The ACA, or Affordable Care Act, has given us an unprecedented opportunity to ensure Nebraskans have access to quality, affordable healthcare which will keep our families strong and our economy moving. The ACA contemplated originally three avenues for coverage: Medicare, premium tax credits for low- and middle-income families, and insurance to low-income folks through Medicaid. Where any of these avenues closes, a large coverage gap is created. I'm sure we're all aware at this point that the health insurance marketplace opened with difficulty in October. But as we just heard, there is a lot of interest and demand in this. Recent data shows about 11,000 applications have been completed in the Nebraska market--I think that's just through November--as well as nearly 2,000 individuals that have signed up for coverage. This also does not include people that enrolled directly through carriers or agents. We also know that about 170,000 people are eligible for credits to help pay for the cost of premiums in the marketplace. But those, as we've heard, are only available for certain individuals, namely people who are between 100 percent and 400 percent of the poverty level. This means there's a coverage gap in Nebraska for at least 50,000 low-income individuals who are trying to make ends meet. Insurance coverage through Medicaid is the only realistic option for thousands in our state. Thankfully, we can ensure that these hardworking Nebraskans can get insurance coverage through Medicaid. If we fail to take this option, on the other hand, we would choose to leave tens of thousands without access to care. We would do that while tens of thousands of others who are higher income would be able to get access through the marketplace, many of them for the first time. This disparity is unnecessary, it's unwise, and it would be unproductive for us all. In addition, I did want to point out something that was discussed a little bit in Ms. Wilson's topics, that there are some holes left through other programs for specific populations that the new Medicaid program might fill. Specifically, the Affordable Care Act extends Medicaid coverage to foster youths who age out of the system, and they can stay under the coverage until they're 26. This is

meant to align them with their peers who might be able to stay on their parents' coverage through the age of 26. But foster youths in guardianships or those who are discharged to independent living before the age of 19 are not covered. There are about 100 of the latter each year that are discharged in that way. Many of them would be able to get coverage if we took up this option and extended coverage under Medicaid. Not only can we ensure we cover more people in Nebraska, we can take this opportunity to innovate and design new strategies for healthcare delivery in Nebraska. In other words, we have the opportunity not just to ensure coverage for more people but to reform the system to better serve everyone. Providing insurance through Medicaid is a good deal for our state. It'll grow our economy. And it's the right thing to do. Thank you. [LR241]

SENATOR CAMPBELL: Questions? Senator Cook. [LR241]

SENATOR COOK: Thank you, Madam Chair, and thank you, Mr. Goddard, for coming today. When Mrs. Wilson was speaking with us and mentioned one of the examples--I can't recall which state--I was reminded of some work that we've done in the area of behavioral health for children ages zero to five making certain that they can access care, if they're Medicaid eligible, through EPSDT. Would Nebraska's Medicaid expansion include those children as providing services to those children in the same way the other states have? [LR241]

JAMES GODDARD: The expansion at this point is primarily geared towards adults... [LR241]

SENATOR COOK: Okay. [LR241]

JAMES GODDARD: ...so working families and adults without dependents. So most children, at this point, with CHIP expansion who are under 200 percent in Nebraska should already have access to EPSDT and, therefore, should be able to access services, behavioral health services. As we've discussed in the past, there are some

barriers... [LR241]

SENATOR COOK: Um-hum. [LR241]

JAMES GODDARD: ...for younger children in accessing behavioral health services that are, you know, an unrelated issue. But those are certainly there in the Medicaid program in our estimation. [LR241]

SENATOR COOK: Right. I guess I just saw EPSDT and got excited, but absolutely we are speaking of an adult population. Thank you. [LR241]

JAMES GODDARD: Sure. [LR241]

SENATOR CAMPBELL: Senator Crawford. [LR241]

SENATOR CRAWFORD: Thank you, Chair Campbell. Thank you, James. I wonder if Appleseed has done any research on the likely characteristics of this excluded population to address the question of whether they're likely to be younger or healthier or older or sicker. [LR241]

JAMES GODDARD: We have not ourselves done that research. And I was interested in Senator Watermeier's questions on that point. I think we can take a look at what we know about what the population would look like in terms of their health. I mean, what we do know is, in general, the folks that are more...take a little bit more Medicaid dollars to pay for our primarily folks with disabilities or in long-term care. And that's, you know, takes up quite a bit of the budget and is traditionally not the adult group even looking at the ADC or poverty level category. So we would be happy to try and get some more information and speak with Mrs. Wilson on that. [LR241]

SENATOR CRAWFORD: So right now, just to clarify, the most expensive groups would

be people in long-term care. And this wouldn't be those folks likely... [LR241]

JAMES GODDARD: Right. [LR241]

SENATOR CRAWFORD: ...and also the people who are in those medically frail categories who aren't in our expansion population. [LR241]

JAMES GODDARD: That's right. [LR241]

SENATOR CRAWFORD: Right. Thanks. [LR241]

SENATOR CAMPBELL: Because we have to remember that currently in Medicaid, we cover children, pregnant women, disabled, and the elderly. And the elderly are usually in that dual...what they call duals because they're probably in both Medicaid and Medicare. The most...the greatest number of people in our current Medicaid program are children. And fortunately, I mean, children are not as expensive. The most expensive part of our regular Medicaid program is the disabled and the elderly. Mr. Goddard, I wanted to clarify in your statement the part about the foster children. I think it's been my understanding that you have to age out of the foster care system. You can't have been in at age 12 and then, you know, not in the foster care program. But to qualify, you have to age out as a foster. Would that be accurate, are we...? [LR241]

JAMES GODDARD: That's my understanding. [LR241]

SENATOR CAMPBELL: Right. [LR241]

JAMES GODDARD: And those would be the individuals that would, if they didn't technically age out, if you left at age 17 or were discharged at age 17, then you would not be eligible for this extended coverage. [LR241]

SENATOR CAMPBELL: Yeah, right. [LR241]

JAMES GODDARD: And those are some of the...I believe there are approximately 100 young persons that are in that position every year that presumably would be picked up by extending the Medicaid program. [LR241]

SENATOR CAMPBELL: Exactly. Okay, I just want to make sure that I clarified that. Any other questions? Thank you very much, Mr. Goddard. [LR241]

JAMES GODDARD: Thank you. [LR241]

SENATOR CAMPBELL: Our next testifier. Good afternoon. [LR241]

JON BAILEY: (Exhibit 4) Good afternoon. Senator Campbell, 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 the Rural Public Policy Program at the Center for Rural Affairs in Lyons, Nebraska. And I wanted to provide you some information about our dealings with the people in rural Nebraska in the coverage gap over the last few months, the coverage gap, as Ms. Wilson explained it to you. And you may have seen this report, but the Kaiser Commission on Medicaid and the Uninsured have estimated there are just under 33,000 Nebraskans in this coverage gap. So over the past five months, we have done a series of about 20 educational presentations in rural northeast Nebraska on the Affordable Care Act. And we've done those in collaboration with local public health departments and also with the Northeast Nebraska Community Action Partnership, the entity who handles the ACA navigation responsibilities in northeast Nebraska. So of the people who have attended those presentations, we estimate that about 75 percent of those people fall in the gap, fall in the coverage gap and would be eligible for a Medicaid expansion, and just a few general observations that we've made from these presentations and talking with these people, very similar to what Ms. Raymond talked about. Almost everyone comes to these presentations very excited and very hopeful

that they'll find a way to get insurance, many of them for the first time. People want to be covered. They want to have health insurance. They understand why it's needed. And they want themselves and their families to be covered. And so they figure they're coming to these presentations to get some information and to get some help, especially from the Community Action navigators. But as we go through the presentation and give them the information about the Affordable Care Act, they soon come to realize...a lot of them soon come to realize that their hopes have been just, like that, dashed. They're no longer eligible for the premium assistance because of their income. There's no Medicaid expansion in Nebraska. And so they learn that they're in this coverage gap, and there's really no way for them to get out of the gap. And you can see the looks in their faces just...and it's really heartrending because you can see the looks in their faces just change from excitement to despair just like that. And we have to tell them...I mean, the only thing we can tell them is sorry, that's the law, and that's your circumstances. So there's essentially nothing we can do to help these people. They don't qualify for the marketplace tax credits. They can't afford insurance on the marketplace. They can't afford to buy their own insurance. Most of these people, their employers don't provide insurance. They're usually working for very small businesses or patching together a lot of part-time jobs in their communities. So there's essentially nothing that can be done for these people. And you have to be truthful, and you have to explain that to them. Say you're sorry and then send them on their way. And they came in happy and excited, and they leave dispirited and still uninsured. I also want to tell you about a report we released this week called Medicaid Expansion is a Rural Issue: Rural and Urban States and the Medicaid Expansion. We made two findings. One is that states who are more rural, a larger percentage of their population is rural, are less likely to expand Medicaid. The converse is true for urban states. That really wasn't surprising given the political makeup of these states. But one thing I did find surprising that we found was that the number of rural people in the Medicaid coverage gap by percentages is almost equal to the group of people who we heard a lot about and continue to hear a lot about who had insurance in the individual market who had ACA noncompliant policies. The President, the Congress, the media have moved heaven and earth to address these people's

concerns. But we have an almost equal number of people in rural America who are in this coverage gap, and no one is paying them any attention. There's nothing anyone is doing about these people. So I would urge you to, in the 2014 Session, to continue your fight to expand Medicaid either in LB577 or some alternative to continue to provide these people the health insurance that they need. Thank you. [LR241]

SENATOR CAMPBELL: Thank you, Mr. Bailey. Questions? Mr. Bailey, I'm going to go back to Senator Watermeier's question because I think it's a good one. And that is, just anecdotally, the people that come and then hear that they're in this gap, generally age and health condition? I know it's anecdotal. [LR241]

JON BAILEY: Yeah, it's totally anecdotal. [LR241]

SENATOR CAMPBELL: We're going to get demographics for Senator Watermeier but... [LR241]

JON BAILEY: Yeah. I think that those are very good questions. And I think the data on that is going to be critical. And I would be interested in it. From the anecdotes, from the people we've talked to, I'm not sure I can make any general statements. I mean, agewise they're all over the board. [LR241]

SENATOR CAMPBELL: Okay. [LR241]

JON BAILEY: I mean, some are very young, probably in their mid to late 20s, 30s. But some are probably in their 40s and 50s. [LR241]

SENATOR CAMPBELL: Excellent. Thank you. Senator Gloor. [LR241]

SENATOR GLOOR: Thank you, Senator Campbell. And thank you for coming, Mr. Bailey. [LR241]

JON BAILEY: Um-hum. [LR241]

SENATOR GLOOR: When you were addressing Senator Campbell's question, was that just related to people who are in the gap, in the doughnut hole? [LR241]

JON BAILEY: I think that was your... [LR241]

SENATOR CAMPBELL: Yes, it was. [LR241]

JON BAILEY: Yes. Yeah. [LR241]

SENATOR GLOOR: Yeah. Okay. Let me ask, since you're not holding these for just people who are in the doughnut hole, of the people who in fact are there who do qualify, how do they fit demographically? Are we talking about people who are older, younger, the same sort of cross-section? I mean, I'm looking at, okay, those people who do qualify, we hear some concerns about are we going to get a preponderance of unhealthy... [LR241]

JON BAILEY: Right. [LR241]

SENATOR GLOOR: ...versus healthy and young enrollees. I'm just curious. [LR241]

JON BAILEY: Right. Yeah, again, it's anecdotal. Just by observation, I think they probably tend, those people, the ones who are going to buy insurance on the marketplace, qualify for the tax credits. They appear to be probably more centered in the probably 40s, 50s age group. [LR241]

SENATOR GLOOR: I think those are young people, but then that's just me. [LR241]

JON BAILEY: Well, yeah. I'm starting to believe that too. [LR241]

SENATOR CAMPBELL: It's relative. [LR241]

JON BAILEY: But I think they're not quite as dispersed agewise as the coverage gap people. [LR241]

SENATOR GLOOR: Interesting. [LR241]

JON BAILEY: I mean, just my observation. [LR241]

SENATOR GLOOR: Interesting. Thank you. [LR241]

SENATOR CAMPBELL: Any other questions, Senators? Thank you, Mr. Bailey. [LR241]

JON BAILEY: Thank you. [LR241]

SENATOR CAMPBELL: And we certainly do want to thank those people who are serving as navigators. That's an important...we spent a lot of time on that in Insurance and Banking Committee. [LR241]

SENATOR GLOOR: Oh, yeah. I remember. [LR241]

SENATOR COOK: Yes, we did. [LR241]

SENATOR CAMPBELL: Our next testifier. Good afternoon. [LR241]

ANISAH NU'MAN: Good afternoon. [LR241]

SENATOR CAMPBELL: And your name for the record and spell it, please. [LR241]

ANISAH NU'MAN: (Exhibit 5) Yes. Good afternoon, Senator Campbell and members of the Health and Human Services Committee. My name is Anisah Nu'man; that is A-n-i-s-a-h, Nu'man, N-u-'-m-a-n, and I am the social action committee chair for the Lincoln alumnae chapter of Delta Sigma Theta Sorority, Incorporated. We, the members of the Lincoln alumnae chapter of Delta Sigma Theta Sorority, Incorporated, support the Medicaid expansion bill on the grounds that it will help to provide healthcare coverage to up to 80,000 Nebraskans. Founded in 1913 as a historically black sorority, Delta Sigma Theta Sorority has for 100 years taken an active interest in the political, social, economic, and legislative affairs of the United States of America. We are committed to ensuring that laws have a positive impact in our community. Recently, our national headquarters has charged us with two tasks that we believe are important to promoting public health. Our first task is to continue to educate the public about the Affordable Care Act and assisting in enrolling eligible citizens for healthcare coverage. Our second charge has been to advocate for the Medicaid expansion. Although LB577 was filibustered during the last legislative session, we are urging our senators to pass the Medicaid expansion bill immediately at the beginning of the 2014 Legislative Session in January. Not expanding Medicaid will impact constituency groups such as young adults, Latinos, African-Americans, and lower-income people. In 2011, 20 percent of African-Americans...in 2011, 20 percent of African-Americans were uninsured. Furthermore, at least 59 percent of uninsured African-Americans with incomes below the Medicaid expansion limit reside in states not expanding Medicaid. African-Americans are at risk of facing coverage gaps due to states that choose not to expand Medicaid. Passing LB577 or any new legislation that supports the Medicaid expansion is our opportunity to ensure healthcare access to thousands of Nebraskans and to keep our community strong by their contributions of work and volunteering. Healthy citizens who are able to work and contribute to their community are how we build a better and stronger Nebraska. We conclude with the words of Senator Nordquist: Access to quality, affordable healthcare should be a priority of all of us who represent the good life in Nebraska. We, the members of Delta Sigma Theta Sorority,

Incorporated, are urging you to vote yes on any new legislative bill or LB577 when it is introduced again in January. Thank you. [LR241]

SENATOR CAMPBELL: Thank you very much. Any questions? We appreciate you coming today. Thanks a lot. [LR241]

ANISAH NU'MAN: Thank you very much. [LR241]

SENATOR CAMPBELL: Our next testifier. While we are getting ready for our next testifier, I want to remind you to be sure to have your orange sheets filled out. It makes life for Brennen a whole lot easier. Good afternoon. [LR241]

TAMMY FIECHTNER: Good afternoon. [LR241]

SENATOR CAMPBELL: And state your name and spell it, please. [LR241]

TAMMY FIECHTNER: My name is Tammy Fiechtner, T-a-m-m-y F-i-e-c-h-t-n-e-r. I'm here from Stapleton, Nebraska. I'm here to represent myself, my family, and my friends and my neighbors. My husband and I are ranchers in McPherson County, and I also am a sales associate for an insurance company; so I know the insides of the health insurance business. I was very excited when we got to go on to the exchange and find out whether or not we would qualify for help. And we're not going to. We fell into the Medicaid gap. Our adjusted gross income last year was $10,100. We are too far below. So, therefore, I am too poor for Obamacare but I am too rich for the state of Nebraska's Medicaid. A lot of my family and my friends are in the same boat, and it's a great burden on us. I had cancer in 2011; I had colon cancer. And I know that every year now I will face medical bills. That is a great burden to my family. The problem was, my premium didn't go up very much, but my deductible went from $3,000 a year to $5,000 a year, which I could swallow and handle; but the out-of-pocket went to $12,700, which I did not have before. I've been with Blue Cross Blue Shield the entire time that we've lived in

Nebraska, which has been 19 years. I've paid a premium every month, and now I am going to be faced with the question of how to pay my medical bills. If I go to a coverage that I can actually afford the deductible with, it's going to cost me $1,070 a month, and that's just for my husband and I. I am here to represent a lot of people and answer your question. Most of my clients are young families like ourselves who have children, who have been covering their assets so they would not lose their farm or their business because of a medical condition. And now that's being taken away from them. Most of my clients, their premiums went up substantially but they also found themselves going into this huge deductible and an out-of-pocket cost that is just outrageous. Yes, there are other places to go shopping for insurance, but you have to remember, we don't qualify for any kind of assistance. So even if we chose not to go with Blue Cross Blue Shield anymore, we still have to come up with these massive deductibles and out-of-pocket expenses. I'm here to ask you to find some way to help us. We pay a great burden to this state in our property taxes already, and this is just one burden that I don't know that rural Nebraska can afford. And it's not just farmers and ranchers; it's dog groomers, it's plumbers, it's contractors, it's grocery store owners. It's also the people who work for farmers and ranchers. They are, a lot of times, uninsured. They've come to me asking for help for insurance, but they don't make enough to qualify. And that's what I was here to ask you guys to do, is just to help us. [LR241]

SENATOR CAMPBELL: Thank you, Tammy. Telling one's personal story is always difficult, so I very much appreciate your testifying today. [LR241]

TAMMY FIECHTNER: It's not just my personal story. [LR241]

SENATOR CAMPBELL: Absolutely. [LR241]

TAMMY FIECHTNER: It's western Nebraska's personal story. And we're hardworking people, and we've been forgotten not just by the federal government but by our state. [LR241]

SENATOR CAMPBELL: Questions, Senators? Thank you very much for taking time to come today. [LR241]

TAMMY FIECHTNER: Thank you. [LR241]

SENATOR CAMPBELL: Our next testifier. Good afternoon. [LR241]

KEVIN NOHNER: Good afternoon, Senator Campbell and all of the other committee members. I'm Dr. Kevin Nohner, Kevin, K-e-v-i-n, Nohner, N-o-h-n-e-r. I am here before you today with three hats on. I'm president for the Nebraska Medical Association. I've been a family medicine physician in Nebraska for 30 years. And I spend about half my time now working with UniNet and Alegent with their ACO. You know, I don't have to come up and tell you any stories because Tammy bravely came in front of you and told you hers. I'd like to tell you she's the exception. But as a primary care physician, I hear that way too much--families that are worried about going bankrupt because they can't make ends meet. And it doesn't take much time with a serious illness like a colon cancer or a stroke or any of those kinds of things to eat up whatever resources. And now you've really destroyed a family and made them homeless in a lot of conditions, you know, depending on what their resources are. You have people who are struggling to work every day with depression. And they can't afford their medicine. It's, you know, do I feed my kids or do I take my medicine? And we can do what we can do with, you know, trying to...hooking them up with free medicines. I know that Senator Howard with OneWorld, this is a fight that we have all the time. I take care of working-class people. So I think that, you know, I'm coming in front of you today with all three of those hats and saying I'd like you to do the right thing. We need to pass this. And if the Governor vetoes it, we need to overcome his veto. This is something that is really, you know, it's just one of the most important things we can do. I wanted to kind of personalize it for you guys. So I had the NMA staff pull some numbers. So, Senator Watermeier, in your district there's 14,000 households approximately; about 1,900 are eligible. That means

that 19.4 percent of your district is uninsured. Senator Howard, 14,000 households; 4,700 are eligible, and that's 38 percent uninsured. Senator Krist, 15,700; 2,900 eligible, 22.4 percent uninsured. Senator Cook, 13,129 households; 2,366 eligible at 23 percent uninsured. Senator Campbell, 19,372 households; 1,461 eligible, 9.8 percent uninsured. Senator Gloor, 14,814 households; 2,931 eligible, 24.8 percent. And then, Senator Crawford, 14,000 households; 1,776 eligible, and at 15.7 percent. You know, it's really easy in the press to concede numbers and 50,000 uninsured or whatever. But I think you need to take stories like Tammy's into consideration even for her children. Colonoscopies can prevent--not just detect, prevent--80 percent to 90 percent of colon cancers. But the last thing you're going to do is fork out four grand if you've got something else to do. And those are the kind of things that we as physicians are pushing for when we're trying to transform healthcare in the state of Nebraska. I've been very involved with the patient-centered home. And we made an important step today by signing that agreement. And with Alegent, we've been able to show, you know, we've been able to cut way into chronic disease expenses by doing good management. The last point I want to take, if you'll indulge me, is I'm going to actually quote the Governor out of an article that he gave for the Omaha Medical Society. "Finally, I would like to discuss rising health-care costs. The first priority for the federal government, state government, businesses and the health-care industry should be to control health-care costs. As Governor, I am working with state employees to make wellness a part of our everyday lives. The state of Nebraska offers an innovative wellness program and a health insurance package designed around wellness." And then he goes on to say how they got the award. "After just three years, the state of Nebraska has seen a $4.2 million reduction in claims. Our focus on wellness is resulting in a healthier work force." I would put forth to you that the patients that I have, the patients of the other doctors in Nebraska, your neighbors, your coworkers, they deserve the same shot at that wellness program as everybody else. And in his own words, the Governor knows that it works and yet we're not putting it forth. And so I'm here to ask you to do the right thing. Help us to help the people of Nebraska feel and get better and stay healthy. [LR241]

SENATOR CAMPBELL: Thank you, Doctor. Questions? Thank you very much for coming today and your testimony. Our next testifier. Good afternoon. [LR241]

BOB RAUNER: Hi. I'm Dr. Bob Rauner, spelled B-o-b, last name is Rauner, R-a-u-n-e-r. Thank you, Senator Campbell and committee members, for letting me testify today. I'm wearing my Nebraska Academy of Family Physicians hat, but I also have a day job as medical director of the Rural Accountable Care Organization of Nebraska. I'd like to encourage you to choose the expansion path that Iowa and Arkansas have used using the waiver process because it allows us to tailor the process to our needs. It also allows us to use a more privatized approached which I think would be more effective. The two issues I'd really like to address that were discussed, though, one is the churn issue. This isn't just save money on the insurance side. Actually, it would save quite a bit of money on the administrative side for the clinics and hospitals as well. When our patients are constantly flipping in and out of plans, that's a burden for us as well. And then most people don't realize how often that happens amongst the Medicaid and the lower-income people. They churn in and out of plans pretty frequently. And also, that churning limits all of the quality improvement projects we do in the patient-centered medical home and Accountable Care Organization projects. So if I've got them lined in because they have Coventry or something, I can put them into a quality improvement project. But when they drop out, now they're out of it again. And for these things to work, they require some sustainability over time. And when people are on one plan for six months and off for six months, it limits the effectiveness of those programs which are needed for prevention. The other thing I'd like to just address really is the wellness benefit, which I think is a great innovation to add. Whenever you can reward people for being responsible consumers, that's a win-win. And there's a lot of things thrown out about this group maybe not being so responsible. Why not provide some good incentives? I really like the fact that they actually reward people for doing the right thing. And then wellness can save a lot of money. If you look at something like, for example, if you have untreated high blood pressure and it leads to kidney failure, if you end up on dialysis, it's hundreds of thousands of dollars a year to take care of that. You can take

care of a lot of people with uncomplicated high blood pressure for that amount of money. And if you can do that on the front end, it can save a lot money. It may not show up for a year or two, but five and ten years down the road it can save a lot of money. And so I'd really encourage you to focus on the churn issue and the wellness benefit issue. Thank you. [LR241]

SENATOR CAMPBELL: Thank you, Dr. Rauner. Those are good suggestions on those two. Are there questions or follow-up from the senators? Thank you, Dr. Rauner. Our next testifier. Good afternoon. [LR241]

ANN FROHMAN: Good afternoon. While I can't speak as quickly as Dr. Rauner...(laughter) [LR241]

SENATOR CAMPBELL: He was probably... [LR241]

ANN FROHMAN: I'm still going to... [LR241]

SENATOR CAMPBELL: ...got a gold star today. [LR241]

ANN FROHMAN: I'm still going to try to get it all in, in the time allotted. Thank you. [LR241]

SENATOR CAMPBELL: You need to just say your name and... [LR241]

ANN FROHMAN: (Exhibit 6) My name is Ann Frohman; that's spelled A-n-n F-r-o-h-m-a-n. I'm the registered lobbyist for the Nebraska Medical Association here to testify on the issue, in particular, on financing Medicaid expansion in Nebraska, which would indeed insure the last segment of the population currently without access to health insurance. One financing option that is in the plan Dr. Rauner mentioned, drilling down into Iowa, is a cost-sharing component. And as you may be aware, historically it's

been viewed as kind of a Draconian measure by the NMA and for good reason. It's a cost shift to medical providers to pick up an unpaid tab due to the administrative expense of the nonpay of the lower dollars. However, we are merging into a new healthcare frontier. We recognize that. The NMA understands and appreciates that it's important to Nebraskans that individuals take ownership of their health status, take ownership and manage their conditions and engage in wellness efforts. We recognize that expanding Medicaid with cost-sharing creates an opportunity here. A thoughtfully designed cost-sharing component can make a difference if it requires individuals to examine healthcare costs and contribute on a regular basis to utilization. Also, there's no free lunch. For these reasons, the NMA recognizes that all stakeholders must do their part to bend the cost curve as well as improve the quality. We must rethink the system and do what it takes to ensure everyone is on a path forward toward managing health and disease proactively rather than reactively through the emergency room. Hence, while cost-sharing is not ideal, the NMA is willing to live with a nominal amount of cost-sharing here and stands ready to work with you to advance these outcomes. We need full participation within the managed delivery system and not the ER system. Financing Medicaid expansion creates another challenge that, I think, within it lies an opportunity. And that is to say the absence of accurate cost information in healthcare is astounding. It is like no other sector. Fragmentation of financing is the reason for this. We have public payers. We have private payers. We have large networks, small networks, no networks. Including the working poor, this uninsured segment, on to the public insurance grid pulls in all of the folks into an, you know, into an insurance scheme that reduces much of the fragmentation. It's not perfect. It doesn't get us on 100 percent of where we need to be. But it's getting us moving. It's starting the momentum. Here's the opportunity. Less fragmentation improves data management on cost information, it impacts quality measures on delivery of care, and it drives value. So quality measures that drive outcomes cannot occur in the emergency room, again, the setting in which the primary care is the delivery arm for the uninsured in Nebraska. For this reason, the discussion of financing healthcare cannot occur absent discussions of modification to the delivery of healthcare. And the NMA fully supports alternative access points to

healthcare delivery from increased 24/7 delivery outside of the ER to encourage providers to practice to the full extent of their credential. Just last session, the NMA supported nurse practitioners performing acute as well as chronic delivery of care in a team-based environment. The team-based coordinated care models led by physicians to integrate care delivery will improve the value proposition. We're all recognizing that and moving in that direction. The NMA understands that more needs to be done with community health organizations, clearly. Expanding access through satellite facilities, technology is happening as well. We do not have the financing pressure either that I think some of us thought initially when this rolled out. We have an opportunity here to look at some financing that is available due to the closing out of the Comprehensive Health Insurance Pool by virtue of the Affordable Care Act. The Milliman study missed it by millions. And when I say millions, if you're looking at the trajectory the Milliman study looked at--and I've spent a lot of time with actuarial reports over the last 20 years, and a lot my friends are actuaries--they missed the recognition of the $25 million to $30 million of funding the state provides to the Comprehensive Health Insurance Pool. If you multiply that out into that report, you're looking at $150 million to $200 million. So we don't have that challenge here in Nebraska that other states have because they didn't participate in the funding of their Comprehensive Health Insurance Pools. So with that, Senator Campbell, I want to thank you for your leadership on this, spending the time to do the study and take the, you know, thoughtful analysis. It's a measured approach. And I'm really excited about the results. Thanks. [LR241]

SENATOR CAMPBELL: Thank you, Ms. Frohman. Questions? As an Insurance Director, former Insurance Director, you probably can help us at some point. I expect that we will work with the Budget and Fiscal Office. We have been in communication with them through the whole thing, but we anticipate that we would need an actuarial study as we finish up the Nebraska plan. So we may be in touch with you to give us some advice on that if we can impose upon you to do that. [LR241]

ANN FROHMAN: It's all about the assumptions that go into it. They do great analysis,

but you've got to start with the baselines. And I'd be happy to do what I can. [LR241]

SENATOR CAMPBELL: That would be great. We can use your expertise. Any other questions or comments? And I do want to say that the Nebraska Medical Association was probably ahead of the game in which they had a plan for coverage of all Nebraskans in healthcare in, what, 2007? [LR241]

ANN FROHMAN: That was one of the reasons I wanted to be their lobbyist. I saw that. [LR241]

SENATOR CAMPBELL: Yeah. I can remember being a candidate for the Legislature and reading that and thinking, wow, this is really interesting. And I didn't want to fail to note that because they were ahead of it and we very much appreciate your testimony today. [LR241]

ANN FROHMAN: Yeah. They are recognized, I think, nationally on the cutting edge of this. [LR241]

SENATOR CAMPBELL: Right. We probably ought to roll out that plan and take a look at it again. [LR241]

ANN FROHMAN: We have it. It's not gathering dust. [LR241]

SENATOR CAMPBELL: Okay. Well, perhaps we'd ask for copies for all the committee... [LR241]

ANN FROHMAN: Okay. [LR241]

SENATOR CAMPBELL: ...because I'm not sure I can still find mine in a box hidden in my office. [LR241]

ANN FROHMAN: Okay. We'll do that. [LR241]

SENATOR CAMPBELL: Okay. That would be great. Thank you. [LR241]

ANN FROHMAN: Thank you. [LR241]

SENATOR CAMPBELL: Our next testifier. Anyone else in the hearing room who wishes to testify today? Okay. Seeing no one, I want to once again reiterate that we are working with the Budget and Fiscal Office. Liz Hruska is here. We've had several conversations with them. And we know that in order to keep it of cost neutrality, we will most likely have to do additional work. So as we get that Nebraska plan together, we certainly will work with the Fiscal Office for the Legislature. I would like to just say a personal thanks to all of you who have sent comments to our family. It's appreciated. And with that, we'll conclude the hearing for the day and thank you all for coming. (See also Exhibits 7 and 8) [LR241]