[LR601]

The Committee on Health and Human Services met at 10:30 a.m. on Tuesday, December 2, 2014, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LR601. Senators present: Kathy Campbell, Chairperson; Bob Krist, Vice Chairperson; Sue Crawford; Mike Gloor; Sara Howard; and Dan Watermeier. Senators absent: Tanya Cook.

SENATOR CAMPBELL: I'd like to welcome you to the hearings for the Health and Human Services Committee. I'm Kathy Campbell and I represent District 25 and serve as the Chair of the Health and Human Services Committee. I'm going to take care of a few housekeeping things to start out with. First of all, if you have a cell phone or an iPad, or some kind of electronic device on you that makes noise, would you please make sure that it is off or silenced. This morning we have a list of testifiers which we'll go through. The first two testifiers...well, actually the first three, because Senator Davis will open, we're going to give them a little extra time in case they need it. But once we start with Amanda Gershon, we will run a light system and you have five minutes. For those who have not seen the light system before, it will be green in front of you, and it will seem like a very long time and then it will go to yellow, and you have a very short time, a minute left, and we'll be a little leeway, but we're trying to make sure everyone can testify on, that Senator Davis had planned on, for his list of testifiers as well as anyone else in the hearing room who would like to testify. I'd like to extend a special welcome today to Senator Norm Wallman. Norm, would you like to just wave? There you are. And with us today are senators-elect and we may have them stand because we'd like to meet them: Senator-elect Hilkemann, and Senator-elect McCollister, and Senator-elect Riepe. So, where is Senator McCollister? He's outside. All right. Thank you very much for attending today. We hope to see you in front of the Health Committee many times, let's put it that way. I think I've covered all of the housekeeping. We do want to introduce that we have a page today. Ryan is to my far left; he's from California, and is a student at UNL. And if you need assistance, you know, please let us know. If

you're testifying, please complete one of the orange...bright orange sheets on either side, so that we can make sure that it is spelled correctly for the record. We will ask you when you come forward to testify to identify yourself, state your name, and then spell it for the people who transcribe. Senator Schumacher is making his way into the room. Thank you for coming. As is our practice in Health and Human Services Committee, we do self-instructions here, so I'll start on my far right.

SENATOR WATERMEIER: Senator Watermeier from Syracuse, District 1.

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

SENATOR KRIST: Bob Krist, District 10, northwest Omaha and Bennington.

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

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

SENATOR CRAWFORD: Sue Crawford, District 45, which is eastern Sarpy County, Bellevue and Offutt.

BRENNEN MILLER: Brennen Miller. I serve as Clerk.

SENATOR CAMPBELL: And for many of the regulars who come to the Health and Human Services Committee, this is Michelle Chaffee's last day with us. She is going to become...I could have many comments about this, but she is going to become the public guardian which was passed in the legislation last session. If I had known she would be the person, I would have voted no consistently. (Laughter) It is sad for us to lose Michelle because she has been an integral part of developing extensive good policy over the last five years, so we really appreciate it. (Clapping)

MICHELLE CHAFFEE: Thank you. It's been my privilege.

SENATOR CAMPBELL: She's here until the end of the week, so we're working her very hard this last week. With that, we will open the public hearing today on LR601, Senator Davis' legislative resolution, which is an interim study to examine the impact of implementing and the impact of failing to implement Medicaid expansion in Nebraska. Welcome, Senator Davis.

SENATOR DAVIS: (Exhibit 1) Thank you, Senator Campbell. Good morning, committee members. I am Al Davis, A-l D-a-v-i-s, and I represent the 43rd Legislative District. Today, I'm introducing LR601. The resolution was offered to study the fiscal impact of implementing or failing to implement Medicaid expansion in Nebraska. We know the Legislature took up this policy issue in 2013 with LB577 and continued with consideration of LB887 in the 2014 legislative session. Fiscal analyst Liz Hruska will follow me to brief us on the fiscal impact of LB887. First, it is important to say that the Affordable Care Act, which while not perfect, did try to solve a very significant problem in the United States--the lack of insurance among a large number of residents of the nation, and the resulting cost shifting to those with insurance by providers who had no other recourse but couldn't turn people away on humanitarian grounds. The problem of the uninsured has driven healthcare costs for years. Without arguing over the rightness or wrongness of the ACA, Nebraska's decision to forgo Medicaid expansion has resulted in real significant losses to the state's hospitals, doctors, and providers. The state has forgone $930,000 per day--per day--in federal reimbursement dollars which equals $10.75 per second; $10.75 per second in federal reimbursement dollars which would help Nebraska's weakest and most vulnerable residents. A pragmatic individual would not think twice about accepting these dollars which will help 54,000 individuals who are working Nebraskans but who fall in the Medicaid gap--people like one of my constituents who suffered from colon cancer and lost her insurance but could not buy additional insurance through the federal exchange because she fell in the poverty gap, a gap created by the unintended decision made by the U.S. Supreme Court to not

require Medicaid expansion in all states. Unfortunately, implementation of the ACA became a political football in which about half the states adopted the program and the other half did not. But who is paying the price for not adopting Medicaid expansion? The poor, the vulnerable, the providers, but also the state, the employers, and the community in general as costs percolate out across the region. During the interim, legislative staff and subject matter experts reviewed the hidden costs, or unintended consequences, if you will, for our state and local communities as the Legislature prepares to consider again the issue of Medicaid expansion for newly eligible individuals under the Patient Protection and Affordable Care Act. No matter the specific design of the Medicaid expansion plan, eligible Nebraska residents will be individuals age 19 through 65 with incomes between zero and 133 percent of the federal poverty limit who do not currently qualify for Medicaid. These Nebraskans are working people who earn minimum wage or slightly more, and have no access to or cannot afford to pay for healthcare benefits. When they are sick, they may not seek medical treatment, or they may be denied treatment because they are uninsured. They may come to work while sick and infect others around them. Without treatment their condition will likely worsen and they might miss work days, lose income or even risk the loss of a job. Reduced or lost income would certainly compromise the ability of these low-income individuals and families to pay for even the most basic needs such as housing, food, utilities, clothing, and transportation. The inability to pay bills shifts the financial burden of the uninsured or underinsured to merchants like landlords, car dealers, grocery stores, utility companies, and retailers of all kinds. If a manageable illness becomes chronic due to lack of prompt medical attention, it can quickly become a series of life threatening conditions for which the individual in question is likely to seek emergency care from the nearest hospital. Medical care for the critically ill person then becomes the responsibility of our already compromised medical community, and the Nebraskans who are insured by and pay for policies that provide reimbursement rates high enough to cover some of the cost of care provided to the uninsured or the underinsured. For our uninsured and underinsured population, illness resulting in reduced wages or a possible job loss, combined with mounting medical bills, can lead to a bankruptcy filing. As with reduced

wages or the loss of a job due to untreated medical conditions, bankruptcy takes a serious toll on the affected individual or family, but it also has a direct impact on the businesses to which the bankruptee owes a debt. I've often heard that divorce is a financial disaster for both parties in a marriage. Uninsured individuals with massive medical debt are just as much a financial disaster for the families as assets disappear, credit ratings fall, and the family resources and opportunities become more and more limited. Prior to bankruptcy, there is a lengthy period of late payments, nonpayments, and the like. Just before the end, most debt is sold for pennies on the dollar to debt compactors who pursue the debtor in court to collect bad debt. In visiting with a collection agency, I learned that almost 100 percent of the bankruptcy debt they handle is largely medical debt, and often the amount is less than $500. The largest such debt at that agency was over $80,000 with assets accessible to the collection agency of less than $2,000. The scope of bankruptcy, which is difficult to measure, extends widely across a community. Medical bankruptcy doesn't just affect the doctor, pharmacy, or hospital, although they bear a significant portion of the cost of bankruptcy. If the individual taking bankruptcy has a home, the bank or lender is affected as the individual falls into default. The car dealer who has leased or sold a new car to the individual pays a price for repossessing the car, which the bankrupt person can no longer afford. Many individuals try to avoid bankruptcy and continue to work on paying their debts until they are overwhelmed. Medical bills are often charged on credit cards, so the bankruptcy drives costs for banks offering those cards and drives up the rate for the rest of society. In many of Nebraska's small towns, merchants extend credit at the grocery store, the gas station, or the local restaurant, and carry that debt themselves, so the bankruptcy affects that bottom line too. My point is that medical bankruptcy causes hardship all across a community, but it is often the only choice for many of Nebraska's uninsured who are unfortunate enough to become sick. Today, Nebraska Appleseed staff will present information gleaned from bankruptcy filings in three Nebraska counties. This information clearly shows medical bills account for a noticeable amount of the overall debt that is discharged through bankruptcy. The data from the three counties that were studied are undoubtedly reflective of what can be found across the rest of the state. My

office contacted three major credit card companies to request information about credit spending for medical services in Nebraska. Visa offered the most interesting response. For the period from January 1 through September 30, 2014, Visa credit payment volume in Nebraska totaled $4,905,347,599.06. Quite a mouthful there. (Laughter) Of this total, $188,910,361.05, or 3.85 percent, was for healthcare merchants in this state. Healthcare consisted of ambulance services; hearing aid sales and service; orthopedic goods; etcetera, etcetera. Drug store and pharmacy charges were categorized separately and totaled $59,995,225.81, or 1.22 percent of their total. How is this debt discharged when it becomes part of a bankruptcy action? We asked that question, but the companies could not really give us a good solid answer because the answer they gave us was oftentimes the debt is accumulated in January, but the person doesn't really end up defaulting until March or April or maybe the following fall, so it's hard to generate and guess at how much that debt actually is still due since other payments are going on. We have populations such as inmates in correctional facilities who are eligible for healthcare services while incarcerated through the state, but who will likely fall into a gap when they are paroled. While in custody at the State Penitentiary, Nebraska must pay the individual's medical costs. These same inmates, if requiring healthcare outside the prisons, would be eligible for Medicaid expansion dollars if they were taken to the Nebraska Heart Hospital, say, for open heart surgery. But without Medicaid expansion, Nebraska must pay those charges. Further, many inmates have extensive and expensive medical treatment issues which require expensive medications. Once released to the street, these people are not Medicaid eligible and will not receive the medications they require at an affordable rate. Whether that be blood pressure medication or medication to treat a bipolar disorder, it is likely these individuals will move off their medications. In the case of the bipolar individual, it might be probable that he will be a repeat offender, and the individual lacking blood pressure medications may end up disabled from a stroke and spend the remainder of his life as a dual eligible resident of a nursing home. Wellness pays dividends which are unseen by society. Does the loss of medical care for the new or preexisting condition such as Hepatitis C, which is extremely expensive to treat, create an increasing burden on the medical

communities which serve the parolees? Undoubtedly, it does. It is possible that the loss of medical care, especially for mental health conditions, increases recidivism rates. It certainly is. We need to learn more about how our veteran population is impacted by gaps in the healthcare services that are available to them. Most of us assume that all veterans receive comprehensive medical care through the U.S. Veterans Administration. This morning we will hear a report that will indicate that some veterans in this state would be eligible for healthcare through a Medicaid expansion program. As this committee and the entire legislative body consider how the next Medicaid expansion model should be designed, we should remember that we all pay federal taxes that support the Affordable Care Act and would support an expansion program if this state finally decides to move in that direction. We should think about employers with multiple employees who will pay penalties if we do not have an expansion plan. We should consider whether or not an entrepreneur, deciding where to locate a new business, might turn away from Nebraska and select instead a state where a Medicaid expansion plan is already in place as a better location for their new investment. And we really need to consider a copay component for a 2015 version of Medicaid expansion. There really is some truth in the adage that the value of a product is lessened if it is provided at no cost. I would be happy to answer any questions. However, individuals with data, as well as anecdotal information about this issue, are here today to provide information to be considered as a Medicaid expansion plan is crafted for the 2015 session. One final comment I'd like to make. The average individual making minimum wage in Nebraska brings around $1,300 per month before deductions are taken. Nebraska senators bring in $1,000 per month before expansion. I believe that if Nebraska's 49 senators were forced to live on their $1,000 a month, each and every one of them would look at the Affordable Care Act and Medicaid expansion as something which is incredibly valuable and something which we must adopt. Thank you. [LR601]

SENATOR CAMPBELL: Thank you, Senator Davis. Questions from the senators? I know you will be here to the end, so we may see if you want to close with any other

information. Thank you. [LR601]

SENATOR DAVIS: Thank you. [LR601]

SENATOR CAMPBELL: Our first testifier this morning is James Goddard. Oh, no, sorry, first testifier...that is not James Goddard. (Laughter) Sorry, is Liz Hruska, who is the fiscal analyst with the Fiscal Office of the Legislature. So, welcome. [LR601]

LIZ HRUSKA: (Exhibit 2) Good morning, Senator Campbell and members of the Health and Human Services Committee. My name is Liz Hruska, L-i-z, last name is H-r-u-s-k-a. As Senator Campbell mentioned, I'm with the Legislative Fiscal Office; and as always, it's always a pleasure to brief before this committee. I seem to be a regular here, and Senator Davis had asked me to review the fiscal impact of LB887, which was introduced last year. As I'm sure you're all aware, LB887 required a waiver to expand Medicaid. A federal waiver requires that budget neutrality, so the cost to the federal government cannot exceed what it would have otherwise cost if we just did regular Medicaid expansion. So the purposes of our fiscal note, my fiscal note, we assumed the waiver cost over time would be equal to or less than regular Medicaid expansion, so we basically projected the cost of Medicaid, regular Medicaid expansion. In order to gain approval, it would have to be budget neutral and that would require an actuarial study. The waiver had two components. One was when Medicaid coverage, and that was for individuals with incomes less than 100 percent or those who are either medically fragile or have exceptional Medicaid conditions, and they would basically receive Medicaid, regular Medicaid coverage. The other component was marketplace coverage, and that was for individuals with incomes above 100 percent and below 133 percent of federal poverty. And they would be eligible to...for premiums paid by Medicaid to either purchase a qualified plan on the health exchange or their employer's sponsored health insurance. And WIN participations, Wellness in Nebraska, that's what WIN stands for, with incomes above 50 percent of federal poverty, would be required to contribute 2 percent of their monthly income towards coverage. However, the assessment would be

waived for those who complete required preventative care and also engaged in Wellness activities. As I had stated in the fiscal note before, there's a great deal of uncertainty in projecting the cost for Medicaid expansion. This is not a population that was covered previously and so there needs to be assumptions made regarding their behavior as to whether or not they would participate, when they might participate, what their health status would be, and what their decisions are regarding to continuing health insurance coverage or opting for Medicaid. I'm not going to go through all the numbers. You do have a chart here, but I will kind of follow the chart down as far as the cost centers for Medicaid expansion. And the first is the administrative costs, the nonlabor administrative costs, and we used the same process to calculate the cost. It was $200 per estimated eligible enrollee that the Milliman report, which the Department contracted for, used. The application costs were the same as those projected by the department. As you can see, a waiver has additional up-front costs that regular Medicaid expansion would not. My assumption is that there would be savings down the road that would cover those up-front costs and we would still meet the budget neutrality provisions of the waiver. Additionally, there would be contract costs and IT costs. As far as the aid portion, the federal match rate started at 100 percent on January of this year, and over time it's phased down to 90 percent by the year 2020. And so the further out we go, the less our federal match is, but then at 2020 it levels off at 90 percent. In the fiscal note, we did projections beyond the current biennium for two reasons. One was the change in the FMAP over time and the other was the assumption that over time participation rates would increase. So we wanted to give a total picture to the senators over time. The Department of Health and Human Services, as I had mentioned earlier, contracted with Milliman, and in 2013, they provided two projections. One was full participation which they state would be assuming 80 percent of all eligible participants, or all eligible persons would apply for and utilize services and their midrange, which they projected to be 56 to 64 percent for childless adults and parents, and 38 to 56 percent for insurance switchers. In their report they say that although they provided the full participation scenario, they did not expect full enrollment to occur. The Legislative Fiscal Office, I had assistance from my Deputy Director, Tom Bergquist. We also studied the ACA and the

impacts and made our own projections. And those...and that...in our projections, the participation rate is 60 percent across the board, except for insurance switchers which is 25 percent. However, by the fourth year, our participation rate grew to 75 percent, except for insurance switchers which remained at 25 percent. What we did in the fiscal note, because our projections were different than the Milliman midrange, is we took the midpoint of their projections and our projections, so it's lower than Milliman, but it's higher than what we had come up with in the Fiscal Office. Another cost is the ACA required Medicaid to pay Medicare rates for calendar year '13 and '14. In Nebraska we are continuing to pay those rates even though the requirement expired. So that is an additional cost to continue those rates. The ACA also established a new tax on managed care plans and the state would have to pay for that as we offer Medicaid through managed care. LB887 also had some healthcare system redesign elements in it. One was the use of patient center medical homes and accountable care organizations. You know, though these have shown to reduce costs through more efficient and appropriate utilization of services and produce improved outcomes, we have not projected any cost savings for this. Additional study of these elements is needed. And the waiver also had a Wellness component, which in the private sector has shown to reduce medical costs over time. Again, we didn't project any cost from this. Those savings would not occur until outside of the biennium, and we just didn't have any way to assess what that might be. In addition, there would be savings to programs that state General Fund currently pays. One is the state disability program, which would be eliminated. Currently, Medicare provides medical coverage for a person deemed disabled after 12 months. The state pays for medical care beginning at six months. Under Medicaid expansion, these individuals would be covered. We also have a prescription drug program for low-income individuals who are either HIV positive or have AIDs. And again, that would be covered under Medicaid expansion. In the behavioral health regions, received General Funds to cover individuals who are either not insured or not covered by Medicaid or whose health insurance doesn't cover their services. We did assume some savings but they were gradual savings over time so as to not disrupt their services. In the Department of Corrections, inmates would...are

eligible for Medicaid if they are hospitalized outside of the Correctional facility. I did receive an estimate from Corrections. It was less than their total outpatient costs for this population and the reasons they stated were, not all of their inmates are legal residents and some inmates may not cooperate with applying for Medicaid. Counties would also see a reduction in their general assistance costs and also for inpatient hospital costs for their jail inmates. Those savings would vary from county to county, so I don't have any assessment on what that might be. And the Department of Insurance had indicated that they would need five additional staff, those staff would be paid for through cash, not General Funds. And another provision of the bill was the WIN Oversight Committee had the authority to hire a consultant. So there was a cost for that. And that concludes my presentation. If you have any questions. [LR601]

SENATOR CAMPBELL: Questions from the senators? Senator Crawford and then Senator Gloor. [LR601]

SENATOR CRAWFORD: Thank you, Liz. This is very helpful. I wonder if you could explain the jump that happens between 16 and 17 and 17, 18. You mentioned that's where you're assuming the usage jumps up? [LR601]

LIZ HRUSKA: Yes. [LR601]

SENATOR CRAWFORD: And what else is behind that? There's probably some shift in the reimbursement amount, but that seems to be the biggest shift over... [LR601]

LIZ HRUSKA: I think most of the costs are both your administrative costs go up and your aid costs go up as we project out. The savings though, we kind of take up-front. So those don't grow over time. So I think that...it's the combination of the program savings, you know, being flat once we take them and the participation increasing over time. [LR601]

SENATOR CRAWFORD: So the, for example, the aid costs for new eligibles, that's between 16, 17 and 17, 18, that, you know, doubles. Is that just new people? [LR601]

LIZ HRUSKA: Well, it's the General Fund, so if you're...you're just looking at the General Fund, right? [LR601]

SENATOR CRAWFORD: Right. Okay. [LR601]

LIZ HRUSKA: That reflects the gradual decrease in the FMAP. [LR601]

SENATOR CRAWFORD: Okay. [LR601]

LIZ HRUSKA: Because if you look at the bottom line, the total cost, it doesn't double. [LR601]

SENATOR CRAWFORD: I see. [LR601]

LIZ HRUSKA: It does increase. [LR601]

SENATOR CRAWFORD: Okay. Thank you. [LR601]

LIZ HRUSKA: You're welcome. [LR601]

SENATOR CAMPBELL: Senator Gloor. [LR601]

SENATOR GLOOR: Thank you, Senator Campbell. Thank you, Liz. Two questions. Do you recall why the Department of Insurance needed five new employees? [LR601]

LIZ HRUSKA: I don't recall off the top of my head and I didn't really look back at that. And I'm not the analyst for the Department of Insurance, so I actually took it to Sandy.

[LR601]

SENATOR GLOOR: Sure. [LR601]

LIZ HRUSKA: And she would probably be better to answer that question. [LR601]

SENATOR GLOOR: I'll make a note and might ask her. Can we talk a second about the ACA requiring Medicare rates for Medicaid. Is that regardless of Medicaid expansion, or is that for the states that do Medicaid expansion? [LR601]

LIZ HRUSKA: That applied to Medicaid in total, so regular Medicaid and expansion. [LR601]

SENATOR GLOOR: And that has gone away or is going away? [LR601]

LIZ HRUSKA: It's going away. It was just for two calendar years so after this month it goes away. But we did not assume that we would decrease our rates. We assumed we would continue at that same level. [LR601]

SENATOR GLOOR: But we don't know that that's the case. It could be when the budget comes in that it will revert again to the traditional lower levels of payment than Medicare. [LR601]

LIZ HRUSKA: Yeah, I don't...I don't think it did. [LR601]

SENATOR GLOOR: Okay. [LR601]

LIZ HRUSKA: I didn't see anything in their budget request that indicated that they were dropping. [LR601]

SENATOR GLOOR: But there's no longer any requirement within the ACA that that happened, so that's...okay. [LR601]

LIZ HRUSKA: That's correct, yes. [LR601]

SENATOR GLOOR: Thank you. [LR601]

SENATOR CAMPBELL: Other questions? Probably should note that at the bottom portion of this, that the total for the state over that period of time for total years would be $61,620,100, and then the federal dollars that would come to match that or as originally proposed, would be $2,187,303,591. [LR601]

LIZ HRUSKA: Right. And all of these numbers would have to be recalculated. One, we've lost the current fiscal year plus...well, we would need to look at whatever components are in a new bill that's introduced. [LR601]

SENATOR CAMPBELL: Exactly. Senator Krist. [LR601]

SENATOR KRIST: Are you done? [LR601]

SENATOR CAMPBELL: Yes, I am. [LR601]

SENATOR KRIST: I wasn't going to ask this question, but I can't resist. Talk to me about the Department of Corrections again. They're assuming that people won't participate, meaning not fill out the forms so they're not going to worry about Medicaid or possible...okay, and you're shaking your head, so for the record, that's yes. [LR601]

LIZ HRUSKA: Yes, yes. [LR601]

SENATOR KRIST: And the assumption is there that some of them are not legal

residents of the United States. [LR601]

LIZ HRUSKA: That's correct. [LR601]

SENATOR KRIST: So who's paying for those illegal residents of the United States when they need medical care right now? [LR601]

LIZ HRUSKA: The General Fund. [LR601]

SENATOR KRIST: The General Fund. Thank you. For the record. [LR601]

SENATOR CAMPBELL: Senator Howard, did you have a question? [LR601]

SENATOR HOWARD: Yes, thank you, Senator Campbell. Can you remind me what our current matching rate is? [LR601]

LIZ HRUSKA: It just dropped. It's right around 51 percent federal. [LR601]

SENATOR HOWARD: Okay. And then in your assumptions, did you assume that the matching rate would maintain at 51 percent? [LR601]

LIZ HRUSKA: This is Medicaid expansion so it has a different higher match rate. [LR601]

SENATOR HOWARD: Okay. So this only covers the expansion population. It doesn't cover our current. [LR601]

LIZ HRUSKA: Yes. Yes. [LR601]

SENATOR HOWARD: Okay. Perfect. And then there's no expectation that the matching

rate will go away for our current Medicaid population? [LR601]

LIZ HRUSKA: It changes every year, but there is a floor of 50 percent. We're getting very close to that. It's been dropping. This is the lowest it's ever been. I mean, starting in 1965 until now, this is the lowest match rate we've ever had. [LR601]

SENATOR HOWARD: And what's the match rate based on? [LR601]

LIZ HRUSKA: It's a three-year rolling average based on per capita income of our state compared to all other states. [LR601]

SENATOR HOWARD: So if we have a high income, then we have a lower matching rate? [LR601]

LIZ HRUSKA: Right. Right. [LR601]

SENATOR HOWARD: Perfect. Okay. So in 90 percent match, that's a high matching rate above the average? [LR601]

LIZ HRUSKA: Yes. Yes. [LR601]

SENATOR HOWARD: What's the highest amount that a state normally gets for a matching rate? [LR601]

LIZ HRUSKA: I think...I think it can go...we have never been up that high. (Laughter) From my memory of just understanding Medicaid, I think it can go up as high as 80 percent and no lower than 50 percent. The kind of high end has never really applied to Nebraska, so I haven't paid much attention to that. [LR601]

SENATOR HOWARD: Okay. [LR601]

LIZ HRUSKA: I think our highest that I can recall was about 65. I think during the Recession when we got the enhanced FMAP it was maybe up to 68. But normal...I think our normal highest I've ever seen is around 65. [LR601]

SENATOR HOWARD: Okay. Perfect. Thank you. [LR601]

LIZ HRUSKA: You're welcome. [LR601]

SENATOR CAMPBELL: Senator Crawford. [LR601]

SENATOR CRAWFORD: Thank you, Senator Campbell. So, a purpose of this interim study is to identify the cost of not choosing to expand last year. So just want to make sure I understand and that we have on the record what your figures tell us about the cost from losing FY '14-15, being in an expansion. And if I understand it correctly, that would be we lost a little over $2.5 million in savings from that choice, and we lost over $291 million of federal money from that choice. Those are the financial losses to the state and that does not include the financial losses to counties. Is that correct? [LR601]

LIZ HRUSKA: That's correct. Yes. [LR601]

SENATOR CRAWFORD: Thank you. [LR601]

SENATOR CAMPBELL: Okay. Thank you very much. As always, Liz, you do a great job, so thank you so much. [LR601]

LIZ HRUSKA: Thank you. [LR601]

SENATOR CAMPBELL: And now, we will have James Goddard. [LR601]

SENATOR KRIST: That's James Goddard. [LR601]

SENATOR CAMPBELL: That is the true James Goddard, yes. James Goddard is the director of economic justice and healthcare access for Nebraska Appleseed. Good morning. [LR601]

JAMES GODDARD: (Exhibit 3) Good morning. Thank you for giving me some time this morning. Again, 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. This morning, I'd like to discuss some information we've gathered relating to bankruptcy and medical debt in Nebraska in three counties. I'm sending around some handouts. It's really...it's an abbreviation of the information and analysis that we did. I didn't want to hand you 20 pages of spreadsheets, but I'd be happy to provide you with the entirety of the information and analysis if you're interested. So to start, I'd like to just look a little bit about a recent report on bankruptcy and medical debt nationally. There was a 2000 study printed in the American Journal of Medicine where they surveyed a random national sample of more than 2,000 bankruptcy filers. They got their court records and interviewed more than 1,000 of them. They found that 62 percent of all bankruptcies nationally in 2007 were medical in nature. They designated bankruptcies as medical based on what the debtors said their reason was for filing, the income loss due to illness, and the magnitude of their medical debts. So this...there are studies. This is a recent one, but it certainly indicates that medical debt is a significant aspect of bankruptcy. I am not aware of a comprehensive study looking at Nebraska that would give us the same sort of thing that you have in that study, and so what we wanted to...we endeavored to gather some information about bankruptcy and medical debt in a few counties in Nebraska. So let me just describe a little bit about what we did. We pulled Chapter 7 bankruptcy filings for a 12-month period in 2013 for three counties, and all the data that I'm going to talk about are derived from these filings. We acquired them through the PACER system, which is an on-line system to U.S. court records, so all these are publicly available documents. You just have to go find them. The key

information in each bankruptcy is the summary of schedules, specifically Schedule F, which contains the unsecured debt of each debtor, like a credit card or a medical service, as opposed to an auto debt or a mortgage. In Schedule F, debts are given a descriptive label, but there's no uniform requirement for what that label looks like. In other words, a label can be different from filing to filing depending on the person who is helping you. This is just a snapshot of what that can look like. You can see at the bottom, one of the debts for this individual was to a hospital, but it can be stated in different ways depending on who is helping you with your filing. So, we looked at three counties, Dawson, Otoe and Red Willow. And we...I'll tell you why we looked at these three counties. Dawson was selected because it's representative of mixed economic, ethnic, and racial groups and has major employers within the county. We selected Otoe because it's an eastern county with an urban and rural mixture, as well as some folks that commute. And we selected Red Willow because it's more agriculture in nature and rural as well. Ultimately what we're trying to get is something of a sample across the state of a different mixture of elements. We ultimately only did three counties. Part of that is resources and cost. There's a cost of pulling every filing and looking through each and every filing and analyzing. It takes quite a bit of time. So we looked at three and these were the three that we took a look at. Some of the assumptions, so some debt is clearly labeled medical debt where it's a doctor, a dentist, a hospital, a medical debt collector. So you look at the Schedule F that I just showed you, you can see it is attributable clearly to a medical provider. So that's one category that we looked at. The other category, in addition to that, was debts that may be medical debt. So looking at factors like large amounts of medical debt to one debtor that was accrued in a short period of time, lack of health insurance or a large amount of debt with no assets. So the information that I'm going to present to you now separates those into those two categories. So looking at Dawson County in 2013, there were 48 total filings. And looking at the numbers I have up on the screen is just the clearly labeled medical debt. So this is the most conservative estimate. It is very clear that this is a medical debt. So looking at that category, you can see that 33 percent or about 15 cases out of 48 had 20 percent or more of medical debt, 27 percent of cases or about 12 out of 48 had 30

percent or more, and 22 percent or about 10 cases had 40 percent or more. So if you...those, again, are what I would classify as a conservative estimate on that being medical debt. If you wanted to add in the may be medical debt, it would bump these percentages up; 45 percent of cases would have 20 percent or more; and 39 percent of cases would have 30 percent or more. Another factor we looked at was health insurance status in each of these counties. In Dawson, for those with that clearly labeled medical debt, 30 percent of those did not have health insurance or about 15 cases out of 48. The last major factor that we looked at that I'm going to talk about today is, who is the debtor, who is holding...who is holding that debt and what you see...what you'll see across all of the counties we looked at, it's a business located in Nebraska. So more than 97 percent of this debt was a local debtor within the borders of Nebraska. Moving on to Otoe, 26 total filings in 2013 were clearly labeled medical debt; 34 percent or about 8 cases out of 26 had 30 percent or more; and 19 percent or about 5 cases out of 26 had 40 percent or more of medical debt. Again, you have the numbers. If you're interested in the "may be," adding that percentage in, that's in the document I provided, but it obviously bumps it up. The interesting thing in Otoe County is the health insurance status. You see it's higher here. Half of those with clearly labeled medical debt did not have health insurance, so 13 cases out of 26. And, again, you see that more than 90 percent of the debt is being held by a local debtor within the borders of Nebraska. Lastly, looking at Red Willow County, far fewer filings, as you might expect in this county, 11 total in 2013. For the clearly labeled medical debt, 18 percent or about 2 cases had 30 percent or more, and 9 percent or 1 case out of 11 had 50 percent or more. Again, looking at health insurance, 2 out of 11 cases did not have health insurance and the debt...the vast majority of debt again more than 77 percent was held by local debtors. So the...looking...just looking at this overall through all three counties, more than one quarter of all the cases across the three counties had 20 percent of clearly labeled medical debt. Again, I think that that's pretty conservative in the way we approach this and likely there's a lot more. It's just very hard to determine just by looking at the filing. So for these cases, medical debt was a significant part of their total unsecured debt, a lack of health insurance is a clear theme running throughout, and the

majority of the debt is held by local businesses within the borders of Nebraska. And with that, I'd be happy to answer any questions if I can. [LR601]

SENATOR CAMPBELL: Senator Krist. [LR601]

SENATOR KRIST: Thank you, Mr. Goddard. You're always...when the professor comes, we listen. Thank you for coming. It's...we don't have time to get into the detail of the difference between a state plan and a state waiver, but suffice to say that we have the capability to change our state plan much easier than we would a waiver process. And what I look at are those silos of people like vets, like kids, that are affected that we could correct by a simple state change and the application of those dollars in the system, which is not Medicaid expansion, but it is using more Medicaid dollars to help those silos of folks. What's interesting about this data though and I think...you know, I would ask you to extract if you could is what ages pushed us, or what categories pushed us to that? If it's a family, are we talking about kids that aren't covered because they're tweeners? Are we talking about vets that aren't covered because they're tweeners, in-between different programs are not eligible? And then the chronology. With those bankruptcies, was the final straw a catastrophic illness that could have been covered in different areas which caused mom or pop to stop working or needed to work or vice versa? Is it possible to extract that data given a little bit more time? [LR601]

JAMES GODDARD: I think it may be possible to try and determine what the characteristics of the debtor may be: family, married, children. I think you can figure...I think you could sort those things out. Your second question is, it's less clear to me whether you could really parse that apart because it doesn't...you don't get to that level of detail in the filing on exactly...you see that who holds the debt and the amount and so you can make some assumptions that, well, look at the amount, look at who is holding the debt, that seems like a catastrophic illness. It would be hard to say with 100 percent certainty. And, I mean, some folks are...I think one thing that's fair that we heard already is that when you get to this level of actually declaring, you've already done everything

you can to try and deal with all those costs. So, I think some of the characteristics you could determine, but I don't know that you could say cause and effect with the illness aspect. You could certainly fairly assume, you know, some of that, I think. [LR601]

SENATOR KRIST: And that's just the Freedom of Information Act application. If we could dig down past that point, we probably could see those silos and try to effect them, but your data is not going to be able to give us that real quick. [LR601]

JAMES GODDARD: Yeah, all of this data is publicly available on the U.S. court system and is...you know, it doesn't just disclose some of the things that I think you'd be interested in finding, but it does, I think, have some of that. [LR601]

SENATOR KRIST: Okay. Thank you very much. [LR601]

JAMES GODDARD: Thank you. [LR601]

SENATOR CAMPBELL: Any other questions? Senator Gloor. [LR601]

SENATOR GLOOR: Thank you, Senator Campbell. And I think, James, when it comes to hard dollars involved here, it would be safe to assume that the healthcare providers have probably already discounted from their charges as part of the settlement that they're trying to get from whoever the individual is who isn't covered. In other words, if the cost for surgical procedure was $10,000, perhaps what they paid the insurer was going to be $5,000 and as they've sat down with that individual they may well have said, could you set up a payment system to pay for $3,000 or $4,000 of that original bill. So, I think the dollars and cents we're talking about are probably pretty deep discounted dollars I guess would be my point. [LR601]

JAMES GODDARD: I think that's accurate, Senator. I'm sure there are folks that are going to follow me that could tell you more about that, but that sounds accurate to me.

[LR601]

SENATOR GLOOR: I'm kind of teeing it up a little bit for them. Thank you. (Laughter) [LR601]

JAMES GODDARD: You're exactly...you're exactly right. [LR601]

SENATOR CAMPBELL: Any other questions? Thank you, Mr. Goddard. [LR601]

JAMES GODDARD: Thank you. [LR601]

SENATOR CAMPBELL: Our next testifier is Amanda Gershon, and we will start with the light system. It's good to see you again. [LR601]

AMANDA GERSHON: It's good to see you too. It's good to be here. My name is Amanda Gershon, A-m-a-n-d-a G-e-r-s-h-o-n. Some of you may remember me from last year. I have undiagnosed autoimmune disorders. One in 20 Americans have autoimmune. My own body is destroying itself. The damage autoimmune does is not reversible. There is no cure, but there are treatments that will slow the progress of destruction. If my body continues without treatment, it could affect my organs to the point that I couldn't take medications, sometimes even leading to death. I have no insurance and make less than poverty. I do not qualify for subsidies or Medicaid. The last year has been very hard. I never expected to get this sick so quickly--here I am. I've applied for disability, but I'm stuck waiting for everything to go through. And as we know, Medicaid isn't instantly granted with disability. I just have to wait and hope I don't get worse. I'm losing my hair in clumps. I've lost 20 percent of my body weight in three months and I don't know why and I have nowhere to go to find out. I had to go to the ER three times this year, twice because my heart is not beating correctly, and I hate going there but I have gone. And I have to file bankruptcy again. When I was 22, I filed bankruptcy on $60,000 in medical bills. I'm getting to that point again ten years later and

I can't keep doing this, I can't. The few years of my life that I had insurance, I had excellent credit, I had a home, I had vehicles, I had food on my table, I had no worries. I was out of debt and I recovered from the bankruptcy. But left with no insurance, I'm back to that starting point again. The worst part is, I'm not the only person that lives like this. Many people do across the country and in Nebraska, in Lincoln, in Omaha, in small towns. But the true cost of family to implement the expansion can't be measured in dollars. The true cost is the time lost being too sick to hang out with your friends, being too tired to celebrate holidays with your family, being too low to be able to help your neighbor in need, this is what makes us Nebraskans, and not being able to take care of yourself keeps you from being able to help others. Thank you. [LR601]

SENATOR CAMPBELL: Thank you, Amanda. It's always very difficult to tell a personal story and we appreciate you coming. Any questions from the senators? Senator Gloor. [LR601]

SENATOR GLOOR: Thank you, Senator Campbell. Amanda, can I ask where you live? [LR601]

AMANDA GERSHON: I live here in Lincoln. [LR601]

SENATOR GLOOR: And so, have you sought services at some of the community clinics, the federally qualified health center and whatnot? [LR601]

AMANDA GERSHON: I have done what I can. I mostly use the mission. They can help me with some of the smaller things when I get infections, things like that, but I still don't know what autoimmune I have and as you know, there are several to choose from. Each one has a different treatment, a different medication. I have been seeing two doctors in town that have drastically reduced their rates for me, but there's only so much they can do without a diagnosis. You know, we get into scary medicine and you can't just sit there and play games with scary medicine, so. [LR601]

SENATOR GLOOR: Can I...I don't want to put words in your mouth, but you've been able to get some care on an intermittent basis, but in terms of any sort of long-term consistent care for your chronic disease, that's the challenge that you're faced with. [LR601]

AMANDA GERSHON: Yeah. That's the challenge, it really is. [LR601]

SENATOR GLOOR: Okay. Thank you. [LR601]

AMANDA GERSHON: Thank you. [LR601]

SENATOR CAMPBELL: Thanks, Amanda, very much for coming. Our next testifier is Dr. Jim Stimpson. Dr. Stimpson is from the UNMC College of Public Health. Before we start, is anyone else going to use the screen or the PowerPoint? Thank you for the catch, Senator Krist. Good morning. [LR601]

JIM STIMPSON: Good morning. [LR601]

SENATOR CAMPBELL: Go right ahead, sir. [LR601]

JIM STIMPSON: (Exhibit 4) I'm Jim Stimpson, J-i-m S-t-i-m-p-s-o-n, director of the UNMC Center for Health Policy. I am here speaking for myself and in neutral position. I am not representing the University of Nebraska. The first step in understanding the impact of Medicaid expansion on Nebraska is to review the most recent estimates available for health insurance coverage of Nebraskans. I have provided a table summarizing health insurance coverage data for the total population in Nebraska. Keep in mind that these numbers come from a survey from the census and, therefore, they are not...they are estimates, not exact tallies, and may not sum due to rounding. However, what this table shows is there were...as of 2013, there were around 196,000

Nebraskans without health insurance in Nebraska. These recent numbers suggest that the number of uninsured has declined by at least 15,000 Nebraskans since 2011. The reduced number of uninsured can in part be attributed to the economy, which has improved, and also the federally run health insurance marketplace that opened in 2014. In a follow-up to table 1, I provided data that breaks out the uninsured population in Nebraska by poverty level. More than half of the uninsured population in Nebraska has a family income between zero to 138 percent of the federal poverty level, and about 89,000 persons within this poverty level range are between 19 to 64 years of age, which is the key demographic target of the Medicaid expansion program. However, the number of persons that would likely enroll in Medicaid expansion would be smaller than this number either due to their immigration status or failure to sign up for the program. So, around 104,000 persons are in the federal...are in that zero to 138 percent poverty range. In my published report from 2012 and prior testimony on this topic, I calculated that the estimated federal expenditures for Medicaid expansion, and the impact of returning federal dollars to the Nebraska economy, was estimated to be worth around $700 million in new economic activity every year at that time. Last year, at the request of Senator Crawford, I compared the estimated federal expenditures for Medicaid expansion in Nebraska to premium tax credits provided for persons between 100 to 138 percent of the federal poverty level. That analysis showed that the total cost to the federal government would be more than $200 million higher under the tax credit scenario compared to expanding Medicaid from 2014 to 2020. I've brought copies of the work I've carried out in the past that can be used in support of this interim study as needed. Thank you for this opportunity. [LR601]

SENATOR CAMPBELL: Thank you, Dr. Stimpson. Questions? It's always good to get a follow-up and important to note that the number that we have often talked about, 54,000, really is a number that has been projected in Ms. Hruska's and Mr. Bergquist's work. And as I always said to them throughout this whole process, you know, I'm going to bank on what our Legislative Fiscal Office puts forward because we all depend on them and they are a terrific staff. So, that's sometimes how the number is different from

what you might project to the number that we've utilized. Senator Krist. [LR601]

SENATOR KRIST: Doctor, just a quick question. Thank you for coming and for your follow-up. As Senator Campbell said, it's always useful. Why aren't you here speaking for the University of Nebraska? Did you not ask or did they tell you, you couldn't be here speaking for them, you had to speak as an individual, or...? Just out of curiosity. [LR601]

JIM STIMPSON: That's not my job to speak on behalf of them. [LR601]

SENATOR KRIST: Okay. All right. Thank you. [LR601]

SENATOR CAMPBELL: Any other questions? Thank you, Dr. Stimpson. Our next testifier is CEO Dan Griess from Alliance, Nebraska, and he is the CEO of the Box Butte General Hospital. Good morning and welcome. [LR601]

DANIEL GRIESS: (Exhibit 5) Good morning. Thank you. [LR601]

SENATOR CAMPBELL: Did I say that name correctly? [LR601]

DANIEL GRIESS: You did. Thank you. I was going to say, too, don't tell my staff about this light system because I could see them all chipping in for a Christmas present for me this year, actually. [LR601]

SENATOR CAMPBELL: (Laughter) There are many people that want this light system. [LR601]

DANIEL GRIESS: Yeah, absolutely. [LR601]

SENATOR KRIST: My wife has installed one in the house. (Laughter) [LR601]

SENATOR CAMPBELL: We're ready. You go ahead. [LR601]

DANIEL GRIESS: All right. Good morning, Senator Campbell and members of the Health and Human Services Committee. My name is Daniel Griess, D-a-n-i-e-l G-r-i-e-s-s, and I am the chief executive officer of Box Butte General Hospital, a 25-bed critical access hospital in Alliance. When the Patient Protection and Affordable Care Act was enacted in 2010, hospitals across the country were the first to come forward and to offer to take less reimbursement in the amount of $155 billion over a ten-year period. As our country moved in the direction to increase the number of individuals covered with health insurance and decrease the cost of healthcare, we were assured this new direction would significantly decrease hospital charity and bad debt. One key provision of the ACA was to increase the scope of the Medicaid program to include more than just vulnerable populations. States would now offer coverage by 2014 to adults with incomes up to 133 percent of the federal poverty level, whereas many states now cover adults with children only if their income is considerably lower or do not cover childless adults at all. In states that have not expanded Medicaid, the policy decision poses a double-whammy for hospitals. Not only do we miss out on having a greater number of paying patients, as a requirement of the ACA, we will begin to see phased-in cuts to disproportionate-share hospital payments, which helps to make up some of the reimbursement shortfall for delivering uncompensated care. The act increases federal funding to cover the states' costs in expanding the Medicaid program and I think that was discussed earlier in the testimonies previously. These individuals who would have the opportunity of health insurance coverage through the expansion of the Medicaid program are working Nebraskans who do not have access to health insurance. Many are working more than one job in an effort to provide for themselves and their families. Even though there are individuals who qualify for the Medicaid program who choose not to enroll, these Nebraskans are not our target audience. These individuals are now seeking emergent and nonemergent healthcare services in Nebraska hospitals through the emergency departments. The Emergency Medical Treatment and Active Labor Act,

EMTALA, requires a hospital to treat a patient without determining their ability to pay for services in advance of medical screenings. Through the expansion of the Medicaid program, these patients would have health insurance coverage and could access the healthcare system through a more appropriate manner, such as primary care clinics. Through regular screenings and prevention, significant healthcare events could be reduced thus further reducing healthcare costs which was the intent of the ACA from the beginning. In late 2013, two professors at the University of Nebraska-Kearney, one a professor of economics and the other in business management, completed a study for the Association of Healthcare Organizations in South Dakota. And I think a copy has been handed out to you. I'd like to bring your attention to this study and keeping in mind that Nebraska has more than twice the population of South Dakota, this data included within, therefore, will have twice the fiscal impact. Regardless, the identified principles are relevant to Nebraska in much the same way as they are in South Dakota. If you turn to page one, immediately following the Executive Summary, the analysts identified seven considerations. I will not list them all, but want to highlight those particularly relevant to healthcare in Nebraska. Of the seven listed effects of Medicaid issues are charity care, medical-related bankruptcy, and the resulting uncompensated care. According to this study's findings, expansion will mitigate these effects of healthcare reform with coverage of the currently uninsured. Reducing uncompensated care which results from a hospital's inability to obtain payment, and the mounting financial implications of charity care, will also impact cost shifting to those currently insured individuals. Insurance premiums will no longer need to inflate to make up for the uncovered costs of the uninsured--currently a silent tax for uncompensated care. In the same way, decreasing the likelihood of medical-related bankruptcies affects not only the healthcare industry, but other partners in the local economy as well. There's an important fourth consideration that should not go unmentioned: through expansion there will be a reduction in potential fines for employers with 50 or more employees. Again, the impact reaches beyond the healthcare environment. As elected officials representing the interests of Nebraskans, I urge you to expand the Medicaid program in an effort to provide health coverage for the uninsured while allowing our hospitals to

continue providing that care. Thank you for the opportunity to provide comments related to this important matter. Thank you. [LR601]

SENATOR CAMPBELL: Thank you for your testimony and for the report. Senator Gloor. [LR601]

SENATOR GLOOR: Thank you, Senator Campbell. Dan, thanks for coming down again. I know it's a long drive for you. [LR601]

DANIEL GRIESS: My pleasure. [LR601]

SENATOR GLOOR: It's a beautiful drive, especially that portion through Grand Island. (Laughter) [LR601]

DANIEL GRIESS: One of my favorites actually. [LR601]

SENATOR GLOOR: Nevertheless, it's a long drive. Are you a disproportionate share hospital? [LR601]

DANIEL GRIESS: We are. [LR601]

SENATOR GLOOR: Would you explain just for the record what disproportionate share means and what's happening to disproportionate share. I don't know whether you have any dollars that relate to your own hospital, but any numbers that you can put out there because this is for Nebraska hospitals, I know, a big issue. [LR601]

DANIEL GRIESS: It is. Disproportionate share hospital is funding that is to compensate us for serving a higher percentage of lower income-producing individuals. And so to compensate for that uncompensated care, they kind of...the federal government or Medicaid gives us additional monies. And I think our last fiscal year, that number was

approximately $50,000. Now... [LR601]

SENATOR GLOOR: And not all hospitals in the state of Nebraska necessarily meet the qualifications for that, is that correct? [LR601]

DANIEL GRIESS: That is correct. Yeah, if...I don't know what the percentage is to have for what they considered unusually high, but we have qualified. But we don't qualify for the amount as some other smaller hospitals and more difficult communities truthfully. [LR601]

SENATOR GLOOR: Okay. Thank you. [LR601]

DANIEL GRIESS: Sure. [LR601]

SENATOR CAMPBELL: Questions? Other questions? Senator Crawford. [LR601]

SENATOR CRAWFORD: Thank you, Senator Campbell, and thank you for this testimony and providing this report. This is very helpful. So, just again for the record as we're trying to make sure we have a record of costs of what we lose by not making that choice, again if we're just talking about this last year, if I understand from the table that you provided for us, the first year cost from uncompensated care, premium reduction, those kinds of costs that you just listed, for South Dakota it was $88 million, and so if you're estimating ours would be twice that, you'd be talking about a cost of the choice for just last...this year that we're in, of $176 million. Is that fair from your analysis and...? [LR601]

DANIEL GRIESS: Correct. I think that is fair. I think that the South Dakota report you can make a lot of great correlations because of the similarities between our two states. [LR601]

SENATOR CRAWFORD: Okay. And so this is...these are additional different costs than the ones we've already talked about in terms of the General Fund and loss of federal money. They are additional and different. If we're keeping a tally, we can add this to our tally, is that correct? [LR601]

DANIEL GRIESS: I would say yes. [LR601]

SENATOR CRAWFORD: Thank you. [LR601]

SENATOR CAMPBELL: Senator Gloor. [LR601]

SENATOR GLOOR: Yes. A follow-up clarification on disproportionate share, the federal government was eliminating disproportionate share under the assumption that all states originally were going to be a participant in Medicaid expansion. Has that happened yet? When is that supposed to happen? [LR601]

DANIEL GRIESS: I believe that starts sometime in 2015. [LR601]

SENATOR GLOOR: Okay. Thank you. [LR601]

DANIEL GRIESS: Yeah. [LR601]

SENATOR CAMPBELL: Thank you, Senator Gloor. Any other questions or comments? The South Dakota study is a very interesting study and one of the things that Senator Crawford touched on is the amount of money that comes back into the state and what that multiplier can be for the economic health in a sense of the state. Did you find...I mean, any comments about that part of it in terms of what's in this report? [LR601]

DANIEL GRIESS: I guess from my own perspective, I was...in reviewing the report, I was pretty impressed on some of the ripple effects that I had not intended or thought of

truthfully with regard to bringing in monies to the state. You know, not only the direct impact it has by having monies pushed in, but the indirect impact and then taking those monies and having them respent multiple times over and over again. I think that we as a state have been focused on the cost to the state, but really have spent less time really understanding the benefits. [LR601]

SENATOR CAMPBELL: I appreciate that. Thank you very much for coming. [LR601]

DANIEL GRIESS: Thank you. [LR601]

SENATOR CAMPBELL: Our next testifier is CEO Shannon Sorensen. Ms. Sorensen is the CEO of the Brown County Hospital in Ainsworth, Nebraska. Welcome. [LR601]

SHANNON SORENSEN: (Exhibit 6) Good morning. Thank you. [LR601]

SENATOR CAMPBELL: You go right ahead. [LR601]

SHANNON SORENSEN: Good morning, Senator Campbell and members of the Health and Human Services Committee. My name is Shannon Sorensen, S-h-a-n-n-o-n S-o-r-e-n-s-e-n, and I'm the chief executive officer of Brown County Hospital, a critical access hospital in Ainsworth. There's significant costs and benefits associated with the expansion of Medicaid eligibility pursuant to the Affordable Care Act. There have been many studies about the costs to Nebraska's General Fund. However, it seems less attention has been given to the benefits, possibly because the calculation of benefits is more complicated than the identification of costs. In previous testimony by Mr. Griess, he drew your attention to the economic impact study prepared by two professors from the University of Nebraska at Kearney for the South Dakota Association of Healthcare Organizations, which you have a copy of. In addition to the key points of that study discussed by Mr. Griess, there were more benefits evaluated by the UNK professors, and I've excerpted them both directly in the study. But I want to bring attention to a

couple really key points, mostly beginning on page 18 of that study. And number one there is cost shifting. Uncompensated care does not solely impact providers. Insurers pass the additional cost to families and businesses in the form of higher premiums. This silent tax, as it's known, was estimated to increase annual family premiums in 2008 by $1,017 in the state of South Dakota. I don't know how many communities and families within our communities would be able to sustain that and we're already beginning to see that in our community, higher premiums every year, which in turn is driving them away from the insurance. These are going to more catastrophic insurance, which becomes that higher deductible, which then becomes seeking less care. Additionally, the out-of-pocket healthcare cost for the poor and near-poor, because families tend to have limited savings, they're susceptible to unexpected economic and financial shocks as you've heard from a number of testifiers today on medical bankruptcy and the effects that these can have for these communities. But I mentioned in our community, largely agricultural, we see a lot of self-employed because of the agricultural economy and, therefore, high deductibles. So these high deductibles are turning into more catastrophic events which has been leading them away from that care and not giving us the opportunity to really increase health, which is the overall goal of that, so. Another key point there then is improved health and increased productivity for low-income workers. And really this is what it's all about, better health. And we know that from a number of different studies and things that have been put out there in the original intent of this study. But we have limited work forces to begin with in our rural communities and when we start to look at these increase...these productivity issues and how it can affect them, it becomes an economic crisis in our community as well. Next is the medical-related bankruptcy. I don't know that I need to comment to that too much more as you've heard about that by a number of other testifiers in great detail and they did an excellent job on that. But, obviously, it's a real issue for our communities, especially those rural communities. And we see that namely with assets so those that own land or other various types of assets that they have to liquidate just to be able to begin to pay the bills that exist. The next point there is businesses paying tax penalties stemming from the ACA. And economically we're trying to get more businesses to our rural communities,

but we're seeing a lot of them that are hiring employees less than 30 hours because then they don't have to meet these strict requirements and the penalties of what they may need to do if they have that, so has a huge economic impact in our rural community. Next there's protection against the possibility of credit downgrade. So, of course, hospitals rely on capital markets to finance expansions and facility upgrades. We're fortunate at Brown County Hospital to have some very new facilities that were funded through a tax bond back in 2008, but the reality of hospitals closing isn't far from us and namely, I say Tilden, which we're about 90 miles from, is a true reality. And we know that we can't continue to deliver care and provide services exactly the way we have and it's going to be this that's going to help us change the way that we can do that. So in conclusion, the expansion of Medicaid would bring additional federal money and many related benefits into South Dakota and the same would be true for Nebraska. Each benefit rebuilds in a total impact on the South Dakota economy in employment, labor income, value-added, and sector output for industries. State government also benefits significantly from increased tax revenues. These benefits include reduction in uncompensated care and cost shifting, better work health, fewer bankruptcies, less ACA penalties for business owners, shifting some of the state's direct costs to Medicaid, and the economic stimulus generated with the injection of billions of federal dollars, as Senator Crawford has noted. Thank you for the opportunity to provide comments related to this important matter. I'd be happy to answer any questions the committee may have. [LR601]

SENATOR CAMPBELL: Senator Krist. [LR601]

SENATOR KRIST: Thanks for coming. [LR601]

SHANNON SORENSEN: Yes, absolutely. [LR601]

SENATOR KRIST: How long have you been in your position? [LR601]

SHANNON SORENSEN: Four years. [LR601]

SENATOR KRIST: In the past few years, can you quantify the...has there been an increase in the use of the emergency room from when you started or from data that you can bring from Brown? [LR601]

SHANNON SORENSEN: We actually have seen a...I would...not an increase. We've maintained slightly 1 to 2 percent decrease. Our ER volumes are nothing compared to Mr. Griess' hospital and some of those relative things. What we see is the people coming into the ER more that say, well, I needed to come in because I can't afford it at the clinic. So we're trying to redirect in those instances. We have seen...we have been doing more follow up, discharge callbacks, those types of reaching out to those patients in ER to try and avoid a readmission to the ER specifically, making sure they're getting their medications or getting them scheduled. We've gone to now, any ER gets an automatic schedule in the clinic three days out to make sure that we can follow a little closer on medications that may have been ordered or what was going on. [LR601]

SENATOR KRIST: Do you think there has been an increase or can you tell if there's been an increase in certain groups: kids, vets, other folks? [LR601]

SHANNON SORENSEN: Specifically to the ER? [LR601]

SENATOR KRIST: Uh-huh. Are people using the ER more for their kids or they would have used the clinic because of whatever? [LR601]

SHANNON SORENSEN: I'm sorry, I don't have statistics on that. I would say in general, yes, we see that a little bit, but I don't have any supporting data for that. [LR601]

SENATOR KRIST: Okay. Thank you. [LR601]

SHANNON SORENSEN: Yeah, sure. [LR601]

SENATOR CAMPBELL: Any other questions? Senator Howard. [LR601]

SENATOR HOWARD: Thank you, Senator Campbell. I'm really curious about your cost shifting paragraph because we're hearing a lot of anecdotes right now about individuals whose premiums are going up in their insurance. In your opinion, can that be attributed to us not expanding Medicaid? Is that why the premiums are going up? [LR601]

SHANNON SORENSEN: Well, I think it's that as well as the taxes that have been put into place with the ACA. So there's a Cadillac tax and there's...I'm sure there's some insurance agents out there that would be able to help identify some of those even more, but the various taxes that go into that alone...and as those take effect in each year and then it also affects on businesses, so depending on the number of members that you have in your plan, certain taxes exist. So I think that's somewhat of a driver for that. We're seeing rates reduced from our insurance companies, our third-party payers though as well, so we have Medicaid, Medicare cuts. Obviously, sequestration significantly affects us, but we're also having Blue Cross and some of those insurance companies coming out decreasing reimbursement to us as well. [LR601]

SENATOR HOWARD: Thank you. [LR601]

SENATOR CAMPBELL: Senator Gloor. [LR601]

SENATOR GLOOR: Thank you, Senator Campbell. Thank you, Shannon, for coming down also. I've said for years that our job in the state of Nebraska is being the administrator of a small rural hospital. So you have my admiration and thanks. Other than running the Nebraska football team, I should say, that may...hardest job. (Laughter) [LR601]

SHANNON SORENSEN: I'll stick to this job. [LR601]

SENATOR GLOOR: Yeah, I'd recommend that. From what you've said, you must employ your...the physicians in the community must be employees of the hospital. [LR601]

SHANNON SORENSEN: We do now, yes. Just started that two years ago. [LR601]

SENATOR GLOOR: So, when people don't go to the clinic and go to the emergency room, they're just...they're just going to a higher cost option but in all cases...but in both cases, that's an expense that's borne by the hospital. [LR601]

SHANNON SORENSEN: Absolutely. [LR601]

SENATOR GLOOR: You're a hospital corporation. And unlike the limited opportunities Ms. Gorshon had for charity clinics and whatnot, you don't have anything...you are the charity clinic for Brown County and other nearby communities. [LR601]

SHANNON SORENSEN: Correct. Yeah. [LR601]

SENATOR GLOOR: Do you get any bleed-over from South Dakota? [LR601]

SHANNON SORENSEN: We have a little bit. You know, we're about 30 miles from the South Dakota border so we do see a little bit of that. Probably more than anything as our VA patients, there's a clinic in Winner, South Dakota, so patients that we can't see VA related may be seen in the Winner Clinic if they don't have to be transferred to one of the hospitals. We do try to put into place...you had mentioned earlier about discounted or deplete discounted rates. We try to put into place not only noncompensated care, financial assistance programs, sliding scales. You know, those were originally put into place for those without insurance, but now we're seeing those

with insurance and really high deductibles. So it's not changing it a whole lot. [LR601]

SENATOR GLOOR: It just adds to the overall bad debt expense for all. [LR601]

SHANNON SORENSEN: Yeah, absolutely. Yeah. I mean, we want to be able to provide additional resources in our community by expanding this that uncompensated care can get shifted into infrastructure, technology, resources, recruitment, those things that help us continue to survive in our small community. [LR601]

SENATOR GLOOR: And your emergency room isn't staffed by physicians. Do you have a PA or a nurse practitioner? [LR601]

SHANNON SORENSEN: All of our providers rotate through that so they're in the clinic, they're on call for the ER too, and they just rotate through each particular night. [LR601]

SENATOR GLOOR: But on call, they only come in as required. [LR601]

SHANNON SORENSEN: Correct. [LR601]

SENATOR GLOOR: Is the clinic attached to the hospital? [LR601]

SHANNON SORENSEN: It's a hundred yards next door, but not physically attached. [LR601]

SENATOR GLOOR: Okay. Thank you. [LR601]

SHANNON SORENSEN: Yeah, thank you. [LR601]

SENATOR CAMPBELL: We're going to have to note that when we're paying taxes and the taxes are going out, we're not bringing those dollars back. [LR601]

SHANNON SORENSEN: Absolutely, yeah. [LR601]

SENATOR CAMPBELL: Thank you very much for coming. [LR601]

SHANNON SORENSEN: Yes, thank you. [LR601]

SENATOR CAMPBELL: It's always good to hear from our rural hospitals. Our next testifier is Lt. Crystal Ditto and Lt. Ditto is a member of the U.S. Air Force stationed at Offutt Air Force Base in Nebraska, and we are very pleased to have you and thank you so much for your service to our country. [LR601]

CRYSTAL DITTO: Oh, thank you very much for having me. So my name is Crystal Ditto, C-r-y-s-t-a-l D-i-t-t-o. I've heard every joke possible for the last name. (Laughter) I'm, aside from being military, which I'm not representative of military via protocol, but I'm also a graduate student with the University of Nebraska-Omaha for military and social work, for a master of social work program. It's the old Boot Strap Program. I was prior enlisted so after completing school I go back active duty as a military social worker. So if Nebraska continues to not expand Medicaid, millions of our most vulnerable residents will be unable to gain health insurance. Contrary to belief, not all veterans are able to access services from the VA Hospital, unless they have a service-related injury or other strict qualifying factors. According to a 2013 urban institute study, 2,100 uninsured veterans and 800 veterans' spouses would fall into the healthcare gap if Nebraska does not implement the ACA Medicaid expansion. These numbers are truly concerning. As a future military social worker and a twelve and a half year Air Force veteran myself, I feel it's my ethical responsibility to seek the understanding of this vulnerable population. I firmly believe this group is facing a number of social problems which makes access to health and mental healthcare crucial. According to a 2013 Department of Defense VA report, 260,000 veterans are homeless or at risk for homelessness. And interestingly, while one in six civilian women are at risk

for sexual assault, the numbers rise to one in three for military women. And pending which data that you do reference, 18 to 22 veterans commit suicide daily. So, I do believe we are medically fragile. As for veterans' spouses, they stand among the invisible ranks and rarely qualify for any sort of VA services. In closing, Medicaid expansion can change lives by saving lives. I hope to raise public dialogue about this current limited access to VA healthcare and advocate for change on behalf of Nebraska veterans. I firmly believe that my brothers and sisters in Arms are not merely a statistic, and I hope this testimony has made a difference. [LR601]

SENATOR CAMPBELL: Thank you, Lieutenant. Questions or comments? Senator Crawford. [LR601]

SENATOR CRAWFORD: Thank you, Senator Campbell, and thank you for being here, Lt. Ditto. [LR601]

CRYSTAL DITTO: Thank you. [LR601]

SENATOR CRAWFORD: Could you just repeat the Nebraska numbers for us and then could...? [LR601]

CYRSTAL DITTO: For uninsured? [LR601]

SENATOR CRAWFORD: Correct. [LR601]

CRYSTAL DITTO: Sure. End of the reference was the 2013 Urban Institute Study, so for uninsured veterans it showed 2,100 veterans and that was 800 spouses, veteran spouses. [LR601]

SENATOR CRAWFORD: Okay. Thank you. In addition, or that number includes? [LR601]

CRYSTAL DITTO: In addition. [LR601]

SENATOR CRAWFORD: In addition, okay. Now can you just explain for the record why they would not be covered by, say, TRICARE? [LR601]

CRYSTAL DITTO: Whenever you transition out, a lot of people...even my husband on the drive here, I asked him, do you think you'd be eligible for VA benefits whenever you get out? And he goes, I really don't know. TRICARE is whenever you're predominantly in. [LR601]

SENATOR CRAWFORD: Okay. And VA...excuse me. [LR601]

CRYSTAL DITTO: And whenever you transition out of the military, yes, ma'am, then you're kind of in limbo. So unless you're picked up by a civilian employer or something of that sort, then you don't qualify. A good example is my father. He's had four years in the Air Force and then whenever he got out, he didn't have a service-related injury. He was at a time of peace, luckily. And it's still to this day--he's 56--so he's just waiting for the clock to tick down so he can get VA assistance because right now he makes too much money. And by too much money, I think it was $30 too much a month. So he's been paying about 60 percent of his civilian paycheck to cover insurance because TRICARE, VA, there's no options. You're literally in a gap. [LR601]

SENATOR CRAWFORD: So just to clarify, the VA doesn't cover him because of income restrictions? [LR601]

CRYSTAL DITTO: Yes, ma'am, for that specific thing. [LR601]

SENATOR CRAWFORD: Okay. Thank you. [LR601]

CRYSTAL DITTO: And he did not have a service-related injury. And kind of to piggyback on that, a lot of people don't report their injury whenever they're in the military, so that's why also we're more vulnerable whenever we transition over. If it's a sexual assault or any type of mental health condition that you come back, you don't want to be diagnosed because then you're going to get kicked out of the military. You lose your career, you have a stigma attached, so there's a lot of people who need help that don't have any access. [LR601]

SENATOR CRAWFORD: Okay. Thank you. [LR601]

SENATOR CAMPBELL: Senator Krist. [LR601]

SENATOR KRIST: Thanks for your service. [LR601]

CRYSTAL DITTO: Thank you. [LR601]

SENATOR KRIST: Talk to me about the unfortunate person who comes back who has the disability and what happens to their family. Do they get VA benefits? [LR601]

CRYSTAL DITTO: They don't. [LR601]

SENATOR KRIST: I kind of knew the answer to that. Tell us about that. I mean we have an incredible amount of folks that are coming back from the battlefield that are surviving that would have never survived in years past. And some of those are married with kids. [LR601]

CRYSTAL DITTO: Absolutely. [LR601]

SENATOR KRIST: And when they come back, the insurance that they're going to get, is there a VA eligibility for them, not for the service members' spouse and children.

[LR601]

CRYSTAL DITTO: Correct. Yes, sir. Which brings up another fact of the spouse and sometimes the children, they're serving as a role of the caregiver that they've never been trained to do. They have no idea how to handle the stress and there's no resources for them. We literally call them the invisible ranks, but they're the backbone to the family. They have no services either. So that's why I think it's so great that spouses are included because they're often overlooked. [LR601]

SENATOR KRIST: The last few years there's been a discussion about those 2,000-plus that would gain from this and then you have the 800 and then you add some of the kids, that's a different category. What we're talking about right now is the category of the people who come back with a disability, and all of the spouse and family that are related to that individual, which causes again an incredible strain and most times separation or divorce or try to find another... [LR601]

CRYSTAL DITTO: Or suicide. [LR601]

SENATOR KRIST: ...or suicide. And you talked about the lack of wanting to be diagnosed. And having served in the Air Force, I can tell you the last thing I want to do is ever go to a flight surgeon because I want to continue to fly. And you know, they always don't let you fly anymore. But in all seriousness, what that meant was, if I felt PTSD was in my life and I wanted to be treated, the last thing I want to do as an active-duty Air Force flyer is to go self-proclaim that I have a disability because now they're going to make me stop flying and I'm going to get that. And although that stigma is prevalent, the problem with that is that if you don't have that diagnosis, then you're not going to have the services on the outside. [LR601]

CRYSTAL DITTO: Absolutely. [LR601]

SENATOR KRIST: Would you like to comment to that? [LR601]

CRYSTAL DITTO: And I think that's a valid point because you have to have a diagnosis if you want to get any type of assistance; but if there's kind of a safety net or something to catch us, which would be very applicable in this situation, then they can seek services more so whenever they feel ready or at least have an opportunity instead of sitting in a dark room, having a flashback, and then doing the only thing they feel that they can. And I'm glad that you did share about your personal experience because for me whenever I first came in the military and experienced military sexual trauma, I did not disclose that to anybody until ten years in because I was a young Airman, and I knew nothing, and it's not on my record. So whenever it's time for me to transition out, hopefully at 20 years, if I don't get brave and put that on my record or have another injury, I'll have no help. I'll have nothing unless I do an official retirement. [LR601]

SENATOR KRIST: In that same vein, I'll remind my colleagues and my future colleagues, it hasn't been but a few years ago we extended mental or behavioral and PTSD care to our volunteer firefighters in an effort to try to treat them because as we know, treatment of that kind of disease, if you will, or affliction means that you can live a normal life. Leaving it untreated usually results in suicide or something akin to it. [LR601]

CRYSTAL DITTO: Absolutely. [LR601]

SENATOR KRIST: So thank you for your service and thanks for coming. [LR601]

CRYSTAL DITTO: Thank you for your service. [LR601]

SENATOR CAMPBELL: Thank you, Lieutenant. We very much appreciate hearing from you. [LR601]

CRYSTAL DITTO: Thank you. Appreciate it. [LR601]

SENATOR CAMPBELL: Best of luck on your studies. [LR601]

CRYSTAL DITTO: Thank you, ma'am. [LR601]

SENATOR CAMPBELL: Our next testifier is Bruce Beins, and I bet I'm not saying that right. And Mr. Beins represents the EMS Services. Nice segue. Good morning. [LR601]

BRUCE BEINS: (Exhibit 7) Good morning and thank you very much. My name is Bruce Beins. It's B-r-u-c-e B-e-i-n-s, and I'm here representing the Nebraska Emergency Medical Services Association. That is an association of about 2,200 emergency care providers, first responders, EMTs paramedics. Mostly volunteer, 80 percent of our EMS's is carried on by volunteers in Nebraska, mostly in the rural areas. So we are in a lot of cases the entry point into the healthcare system for a lot of Nebraskans. I've got some different data here and excuse me if I jump around a little bit. What you've just been handed is some information that comes from the Nebraska ENARSIS system. Now the ENARSIS system is an electronic data reporting that all services are required to report data to this system. There are required data points and there are unrequired data points. Unfortunately, insurance information is not a required data point. This was really for patient care information. So if I could just point out a couple of things on there. On the top table, which is the last table that they had complete year-end information for in 2012, there the note at the bottom where there was 61,830 records where a patient was transported but no payer information was indicated. Well, for...as someone who actually enters this data for my own service, I can tell you that a lot of times the reason there's no information entered is because there is no information because those people don't have insurance. Now, that's not always the case. There's also some services to where they have a different form that they fill out for their insurance information and so forth. So you could safely say though that out of that 61,000 a large percentage of them are also the uninsured. EMS in Nebraska, of course we don't pick and choose. When

911 is called, you expect somebody is going to come help you whether or not you're from Lincoln or Omaha or from the rural or very rural that most of my constituents come from. So we're going to respond no matter what. When I started in EMS about 30 years ago, EMS didn't think about getting paid and that was not a concern. We don't have a system of EMS in the state of Nebraska that was built by design. This system come about by evolution, generally coming down from the funeral homes, and so forth, that used to take care of ambulance services to volunteer fire departments or volunteer rescue services. So to start with, it was all just, we want to take care of our people. You know, it's our friends and neighbors and our family. Over the years...when we started, you would get donations so you'd get a check for $50 or a check for $100. And so over the years we kind of had to change our thinking. I mean, we're still out there as volunteers trying to take care of our friends and neighbors, but the costs of providing that service and maintaining that service for the future have gotten to such that ambulance services are charging for their service. Unfortunately, like you've heard with some of the testimony in hospitals and so forth, we do get a lot of patients that are uninsured or the underinsured. You've heard about the high deductibles now that a lot of people have with their insurance policies. So there is a large percentage of it that goes uncollected and is eventually, you know, wrote off from the rescue service. Some rough numbers that I can give you, I had a very interesting discussion with a billing service that bills about 90 percent of the EMS services in the state of Nebraska, along with doing nine other states around us that they also have customers. And she said about 60 percent of all EMS runs are Medicare, Medicaid runs. So, Medicare, Medicaid basically pays us our costs. So they don't pay what we'd like to get paid, they pay us what they tell us they're going to pay, which is basically cost. So that leaves us 40 percent. And out of that 40 percent, 30 percent of them are insured in some way, but most of them are a high deductible insurance. And then there's the 10 percent that are uninsured, and we're probably not going to get anything out of the 10 percent because they don't care whether or not we hurt their credit rating, whatever. The 30 percent is kind of interesting though because those are the high deductible people. Obviously, we've hauled them to a hospital, so they're going to have other medical debt, at least an

emergency room charge that goes along with that. About 25 percent of that gets collected. And what this biller told me, which I thought was very interesting is, is they are now holding those ambulance bills and they're holding them for 30 days or six weeks before they ever turn them into the insurance company. And the reason they're doing that is to shift that cost because they want people to...who have already burned through their deductible with hospital charges before they get that bill from the ambulance, that then the insurance will pay. Well, that kind of doesn't seem right in some way. One of my other hats is, is I'm the chairman of the board for the Harlan County Health System, which is a critical access hospital in south central Nebraska. So, I can see how that would work because in a hospital, we want to get our bills out because we don't want too many days in AR and we want, you know, everything to get filed like it's supposed to and...but some of that cost is getting shifted back to the hospitals. So, I thought that was kind of interesting in that aspect as far as the billing for it. In my other hat as a chairman of a hospital board, I did dig up some information that I was mostly concerned with the emergency side of things, so I pulled up some ER information. And from 2013, the uninsured in our critical access hospital, 88 percent of the charges from emergency room costs in 2013 are still uncollected today. So that's a year out. Now, these have probably not gone to a collection agency yet. They're probably still being worked through the system trying to get them to make payments, so forth. But a good argument would be that those uninsured would be some of the people we're talking about with Medicaid expansion. A lot of them are in that gap. So, a percentage of those or a large percentage of those with coverage would at least get us the reimbursement that we would get from Medicare, Medicaid, which would at least be our cost. And at least getting our cost is what's going to ensure that we can continue the service into the future. So, if there's any questions, I'd be glad to answer. [LR601]

SENATOR CAMPBELL: Any questions from the senators? Senator Gloor. [LR601]

SENATOR GLOOR: Thank you, Senator Campbell. Thanks, Bruce, for coming. Your quote was once upon a time EMS didn't think about being paid. Are there still rescue

squads in smaller communities that in fact exist just based upon volunteerism, capital expense for the rescue units get picked up by the city or county? Or does everybody bill in this day and age? [LR601]

BRUCE BEINS: By and large, I would have to say at this point, everybody bills. There are still probably a few. My service was one of the last ones that finally said, we just can't keep this going for the future. We're driving a 20-year-old ambulance, you know, and have no money in the fund to replace it. A good used ambulance is going to cost us $100,000. So, I think, pretty much everybody anymore has went to billing. And then how they collect some of their bills, you know, from the uninsured or underinsured, that's kind of a local decision on whether they're going to take people to collections or what they're going to do with them. [LR601]

SENATOR GLOOR: Knowing that there's always paperwork involved and a lot of paperwork involved, is it safe to say that perhaps you're selective in terms of what you charge for? In other words, if you make a run to pick up somebody on main street who has fallen, would that necessarily generate a bill as opposed to the transfer of somebody from community to... [LR601]

BRUCE BEINS: Yes, it would. Once you become a Medicare provider, you pretty much have to treat everybody the same. Now, there's different tiers of billing from a basic transport to a basic life support run to an advance life support run. I mean, there's different tiers of billing, but everybody gets billed. In fact, there's even a billing category for no transport. You go help somebody up that fell in their home, you know, and now they've refused to go to the hospital, there's a bill for it because you called the service out. And we want that service to be available for the next person that needs help up off the floor. [LR601]

SENATOR GLOOR: Okay. Thank you for the clarification. [LR601]

SENATOR CAMPBELL: Any other? Thank you very much for coming. [LR601]

BRUCE BEINS: Thank you. [LR601]

SENATOR CAMPBELL: We will now open the floor for testifiers. How many people in the room wish to provide testimony in addition? Okay. Go right ahead. Now, I can say good afternoon. [LR601]

LYNN REDDING: (Exhibit 8) Good afternoon. How are you today? [LR601]

SENATOR CAMPBELL: I'm fine, Lynn. [LR601]

LYNN REDDING: Good afternoon, Senator Campbell, and members of the Health and Human Services Committee. For the record, my name is Lynn Redding, L-y-n-n R-e-d-d-i-n-g, and I have travelled from Grand Island to comment on the impact of expanding Medicaid. As a person with a disability and a recipient of Medicaid, I wish to stress to you today how important healthcare is for people with disabilities and for those who cannot access health insurance through their employer or private market. For me, Medicaid is literally a life saver. My disability and other chronic health conditions require me to see several doctors and specialists, as well as taking a lot of medications. Without my Medicaid coverage, I would not be able to afford these visits or medications. My point is this: Access to healthcare is a crucial piece for not only people with disabilities and/or chronic health conditions, but also Medicaid is a good safety net for those who cannot access health coverage by other means. By expanding...but expanding Medicaid is not just about me. There are many people that you know, but for various reasons do not have private or employer-based healthcare. As a result, they have extremely limited access to healthcare, usually the emergency room. I know I'd rather see my doctors in their offices than go anywhere near the ER. Expanding Medicaid presents an opportunity for people who end up stuck in the coverage gap between 101 percent and 133 percent of federal poverty level to get healthcare. People

who are currently uninsured should have options than being forced to go to the ER at a very expensive price or go without. Everyone deserves access to healthcare regardless of their health, social, economic, or disability status. Medicaid expansion--it could be a life or death situation for someone you know. Thank you. [LR601]

SENATOR CAMPBELL: Thank you, Lynn. It's always good to see you and have your testimony. Are there any questions from the senators? The next testifier, and I believe our last testifier for the day...oh, I'm sorry. I missed...okay, so, Mark, are you the last? [LR601]

MARK INTERMILL: I think so. [LR601]

SENATOR CAMPBELL: Okay. [LR601]

BRAD MEURRENS: (Exhibit 9) Good afternoon, Senator Campbell and members of the committee. For the record, my name is Brad Meurrens, B-r-a-d M-e-u-r-r-e-n-s, and I'm the public policy specialist at Disability Rights Nebraska, the designated protection and advocacy system for persons with disabilities in Nebraska. As an organization premised on advancing public policy and protecting the rights of Nebraskans with disabilities, we fully support the effort to extend Medicaid coverage. Extending Medicaid would increase access to needed healthcare for many Nebraskans with disabilities. The overlap between poverty and disability, as well as uninsured status and disability, is significant. Thousands of Nebraskans with disabilities live in poverty and lack health insurance. According to the American Community Survey, 16.8 percent of Nebraskans with disabilities, age 21 to 64, were uninsured in 2011; 24 percent of Nebraskans with disabilities, age 21 to 64, were living below the poverty line in 2011. It is false to assume that all Nebraskans with disabilities are currently using Medicaid-funded services or would be covered under traditional Medicaid. Not all people with disabilities meet the financial, family size, or disability-specific eligibility limits. Thus, many people with disabilities would be left in the gap between current Medicaid eligibility and the

insurance exchanges under the Affordable Care Act. In fact, the National Association of State Mental Health Program directors notes that, "Many people recognize Medicaid as a program that provides coverage to the poor, but few know that millions of working adults, mainly childless, do not currently qualify for Medicaid even if they have little income. And about 25 percent of this population has serious and moderate behavioral health conditions. The Medicaid expansion will significantly increase access to health insurance which is the passkey to receiving high-quality care." Simply put, extending Medicaid would provide affordable coverage for a wide range of people with disabilities; people with disabilities who are ineligible due to excess income or assets; people with disabilities who are in the two-year waiting period for Medicare; people with disabilities who are eligible for traditional Medicaid with a spend-down; people whose disabilities are not considered severe enough; people who do not know, do not admit that they have a disability, or whose disabilities are not diagnosed; people with disabilities who churn off and on Medicaid; low-wage workers who become ineligible for Medicaid when they are employed; and people whose disabilities improve when they have a consistent source of healthcare and/or treatment. For those individuals with disabilities who would not qualify for current Medicaid and would not qualify to enter the exchange, they would literally have no place to turn for affordable healthcare, except the emergency room. In summation: Extending Medicaid would create an incentive for people with disabilities to work and make the lives of those who are employed a lot easier. Current financial eligibility for Medicaid significantly restricts the employment options and wages for employees with disabilities. Extending Medicaid would allow employees with disabilities to earn more without the ever present threat of losing their vital Medicaid coverage because they received a raise, worked overtime, or got a better job offer. Extending Medicaid would help to break the forced dependency that employees and many other people with disabilities in Nebraska currently face and would create more opportunities for individual achievement, financial and social independence, and healthcare access for thousands of vulnerable Nebraskans both with and without disabilities. I'd be happy to answer any questions the committee may have. [LR601]

SENATOR CAMPBELL: Are there any questions? Thank you, Brad. [LR601]

BRAD MEURRENS: You're welcome. Thank you. [LR601]

SENATOR CAMPBELL: Our next testifier. [LR601]

MARK INTERMILL: (Exhibits 10 and 11) Good afternoon, Senator Campbell and members of the Health and Human Services Committee. My name is Mark Intermill, M-a-r-k I-n-t-e-r-m-i-l-l, and I will be brief. You're getting a couple of documents that are coming around. One is a report that AARP's Public Policy Institute has developed which really is the crux of AARP's interest in this issue and that's the healthcare coverage of Americans between the ages of 50 and 64, those individuals who are not yet eligible for Medicare and are still trying to get their coverage in the private marketplace. But I want to focus on the second one-page document which is an array of the cost of coverage through the federally facilitated marketplace for a 59-year-old nonsmoker from Lancaster County. Now, I am a 59-year-old nonsmoker from Lancaster County, (laughter) which this resonated with me. What I think this chart shows is that there is a certain logic to the coverage offered through the Affordable Care Act until you get to the bottom line, right now. You can see a person...if this person had a $48,000 income, they would pay a premium of $514, which is the full premium for an individual who is a 59-year-old nonsmoker in Lancaster County. They would have a deductible of $2,000 and out-of-pocket limit of $4,500. Maximum cost for covered services through the plans are $10,668 or 22 percent of that individual's $48,000 income. As we move down the chart, you can see that percentage reduces so the lower your income, the less of your income you have to pay for healthcare costs that are covered by the plans, until you get to the bottom. Until you get, you know, from $12,000 to $11,000, at $12,000 you're paying 4 percent of your income for those covered services, assuming you met the full out-of-pocket limit, you drop down $1,000, it's 97 percent of your income that you pay for covered services, the same as the person with $48,000 in income. We saw from the fiscal note that Liz Hruska talked about that by not participating in Medicaid expansion,

we're deferring something in the order of $276 million, the federal support that would help that group get access to coverage. And since the...kind of the purpose of this hearing was to look at what is the impact of not participating in Medicaid, that's an obvious one. But one of the things that the South Dakota report that was prepared by the professors at UNK identified was that there's a revenue impact of not participating in Medicaid. And what they indicated was that in many government programs there is...you have benefits on one side but offsets on the other side. There are taxes or something that come out of the economy as a result, but not in this situation because the taxes are paid up-front. We're paying those costs of providing these benefits already. So we're essentially just deferring $276 million into our economy. And if you track General Fund revenue over the past 10 or 20 years, it typically runs at about 4 percent of the state's gross domestic product is what we realize in General Fund revenue. So when you look at that $276 million and assume without any multipliers, that 4 percent would come back in the form of revenues to the state, that's about $11 million. And when you go out to the 2020 estimate, we're getting up into the $14-15 million of revenue without any multipliers. So, I think my case is that this isn't right what's happening to that bottom group of individuals. There's an opportunity to fix it that will help...there are offsets in terms of the costs that might come about as a result of doing that. So thank you very much, and I'd be happy to try to answer any questions. [LR601]

SENATOR CAMPBELL: Questions? Okay. Thank you very much. Senator Davis, do you wish to make any final remarks? Okay. [LR601]

SENATOR DAVIS: First of all, I just want to thank the committee for being here and listening and asking great questions, and thank the people that have put a lot of time into the committee work this summer trying to come up with a plan for today, and for the testifiers who participated here today. I wanted to touch base a little bit and respond to some of the things that have been said. When in question with the EMS that someone asked about the billing which, you know, I happen to have several volunteer services in my district, I know they all bill for their services. If they don't get paid, that's the end of

the line for most of them. They don't pursue that because the people are residents of their community and so, a lot of those EMS volunteers in the rural parts of the state are still having bake sales and car washes and those kind of things to buy the new ambulance. So that is the way that works. This would obviously help those volunteers who really give a lot of their own personal time, which is personal, but many of those people take time away from their business to do their work so it's a little more than just personal, it can affect their livelihood too. Senator Watermeier and Senator Schumacher and I have been serving on a committee this summer to look at how tax exemptions are put in place to develop business and industry in the state of Nebraska. And a lot of the jobs that are being generated through those projects, we're just not evaluating them, but we're looking at how they're done. A lot of those jobs that are generated are not significant jobs in terms of revenue. I'm glad that that's going on. My point being, though, that the state has moved in a very orderly and planned way to try to stimulate economic activity within the state by giving exemptions to businesses who are employing people who aren't making a whole lot more than 133 percent. We have the ability by accessing federal funds to put a big block of revenue into the state when you heard Mr. Intermill talk about that revenue generator, which will generate revenue for the state, and for every one of these communities out there. I come from a district that is very...has very serious problems with depopulation, elderly people, poverty, uninsured, hospitals that are working really hard and doing a great job, but struggle to meet their everyday needs. If you want to do something really good for rural Nebraska that will really help the economic activity in rural Nebraska, I think Medicaid expansion is the thing that will probably do more good than anything. So with that said, I again thank you for the time and look forward to the discussion on the floor. [LR601]

SENATOR CAMPBELL: Excellent. And with those comments, we will close the public hearing on LR601 and everyone have a great rest of the day. [LR601]

SENATOR DAVIS: Thank you. [LR601]

SENATOR CAMPBELL: Thank you for coming. [LR601]