[LB472 LB650]

The Committee on Health and Human Services met at 1:30 p.m. on Wednesday, February 25, 2015, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB650 and LB472. Senators present: Kathy Campbell, Chairperson; Sara Howard, Vice Chairperson; Roy Baker; Tanya Cook; Sue Crawford; Mark Kolterman; and Merv Riepe. Senators absent: None.

SENATOR CAMPBELL: Good afternoon and welcome to the hearings of the Health and Human Services Committee. I'm Kathy Campbell, and I serve as Chair of the committee. I represent District 25 in Lincoln. As is our practice here, we're going to do self-introductions. So I'll start on my far right. Senator.

SENATOR KOLTERMAN: I'm Senator Kolterman from the 24th District, Seward, York, and Polk Counties.

SENATOR BAKER: Senator Roy Baker from Gage County...District 30, Gage County, part of southern Lancaster County

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

JOSELYN LUEDTKE: Joselyn Luedtke. I serve as the legal counsel for the committee.

SENATOR COOK: I'm Senator Tanya Cook. I represent the 13th Legislative District in Omaha and Douglas County.

SENATOR RIEPE: I'm Merv Riepe. I'm the state legislative senator from District 12 which is...represents the good people of Omaha, Millard, and Ralston.

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

SENATOR CAMPBELL: And we have two pages today. Brook...is Brook over there? Oh, okay. Brook is from Omaha and she is at UNL majoring in marketing, advertising, and political science. And Jay is over here. Jay is from Dalton, Nebraska, at UNL majoring in ag economics. I'm going to quickly go through the procedures because we'll no doubt have a long afternoon here. If you are testifying today, we would like to have any...a copy of any of the materials you bring. We'd like 15 copies. If you do not have that number, you can visit with the clerk and the

pages. As you come forward, we need you to complete one of the orange sheets. Write as legibly as you can. And when you bring that forward, if you have items that you want distributed and the orange sheet just give to the clerk and the pages will take care of that for you. I would like to advise you that if you own a device that makes noise--a phone, an iPad or whatever--please turn it off or turn it to silent. It's very disconcerting to hear something ringing while you're trying to testify. As you come forward and sit down in the chair where Senator Nordquist is, we would ask that you first state your name for the record and spell it. That's so that the people who listen, the transcribers, can clearly know how to spell your name. We use the light system here in the committee. And you'll have five minutes. Green will be there for a fairly long time. And that will be four minutes. It will go to yellow which tells you, you have one minute. And it will go to red and then I'll be trying to get your attention. And then we'll follow up with any questions that the senators might have. So I think that takes care of all the introductions. We will start this afternoon and open the hearing on LB650, Senator Nordquist's bill to encourage hospitals to offer vaccinations. Welcome, Senator Nordquist.

SENATOR NORDQUIST: Thank you, Chairwoman Campbell and members of the esteemed Health and Human Services Committee. My name is Senator Jeremy Nordquist from District 7 in downtown and south Omaha. And I'm here today to introduce LB650. And I'm certainly heartened by the level of civic engagement and concern over "Tdap-ing" immunizations I see in the room today. (Laughter) The bill I'm here to introduce is one that affects the health of all Nebraskans but most importantly the youngest Nebraskans. LB650 would encourage hospitals to offer all maternity parents or new parents on-site Tdap immunizations for them and their babies. As this committee is aware, vaccines are highly effective means of preventing infectious diseases. Federal and professional guidelines recommend childhood and adolescent immunizations to protect against a wide range of viral and bacterial infections including pertussis, otherwise known as the P in the Tdap immunization. Pertussis, commonly known as whooping cough, is a highly contagious respiratory disease that is potentially fatal to infants. Nebraska health data shows that in 2014 we had more than 395 confirmed or probable cases and already confirmed or probable in January 2015, 215 cases. In 2012 the CDC reported over 48,000 cases in the U.S., but it also notes that estimates likely only represent a small percentage of actual cases. Tragically, infants, especially those too young to be vaccinated, are at especially high risk of contracting the diseases. Babies often catch pertussis from the people who they love the most. The CDC has found that up to 80 percent of infected babies caught the disease from family members. Unvaccinated adults and adolescents can contract and spread the disease without realizing it, and it's highly contagious during the first weeks of infection. And a sneeze, cough, or talking up close to an infant can all lead to exposure. This exposure certainly is helped by someone receiving the vaccine. When parents get vaccinated, they are not only protecting their own health but the health of the infant as well. I would note that as we talked about drafting this bill--and I brought it on behalf of the March of Dimes--we wanted to stay away from any kind of mandates on our healthcare providers. And I know that there are some concerns about

how the patient or the parent--especially those that aren't admitted to the hospital, mainly the father--how they can be immunized by a hospital. I think we need to discuss those components and see if there is a possible pathway forward but certainly just the effort to raise awareness about the need for vaccinations is something that we all need, to...the Tdap vaccination for new parents is something that we all need to be aware of. There will be individuals testifying after me on behalf of the March of Dimes, and I'd appreciate your consideration of this bill. [LB650]

SENATOR CAMPBELL: Thank you, Senator Nordquist. Any questions, Senators? Okay. Oh, Senator Riepe. [LB650]

SENATOR RIEPE: Thank you, Senator Campbell. Senator Nordquist, thank you for being here. [LB650]

SENATOR NORDQUIST: Yeah. [LB650]

SENATOR RIEPE: It's...the reading I have is that Nebraska is the number two state of all states in terms of level of vaccines. And the other question that I have is that, or maybe statement in here a little bit too, is that most of the vaccines will be through routine physician office visits. That's why I was a little bit surprised with the hospital piece. [LB650]

SENATOR NORDQUIST: Yeah. Right. [LB650]

SENATOR RIEPE: It's a little late usually by that time. [LB650]

SENATOR NORDQUIST: Well, I think before we send them home, I think that...with a newborn, I think that's certainly is a good point. [LB650]

SENATOR RIEPE: Oh, I see, newborn. [LB650]

SENATOR NORDQUIST: Yeah, so, you know, as a new dad...but I'll say that, you know, I have the four-month-old at home. When we went in for one of our first prenatal visits, the...our physician--my wife's physician--said, dad, you need to get a Tdap shot. And that was easy for me. It's a preventative service now under the Affordable Care Act, so there's no insurance copay. I just went to Walgreens and got the shot with no cost at all to me. So there are avenues. But we think, and the March of Dimes thinks, that, you know, that last stop before the baby goes home might be a good opportunity to make sure everyone who thinks it's important gets it. [LB650]

SENATOR RIEPE: Well, thank you. That's a good explanation. [LB650]

SENATOR NORDQUIST: Yeah. [LB650]

SENATOR RIEPE: That makes sense, yeah. [LB650]

SENATOR CAMPBELL: Any other questions? Senator Nordquist, will you be staying? [LB650]

SENATOR NORDQUIST: I won't. I have the next bill up in Revenue, so I probably should head over there and make sure I'm ready to go. Thank you. [LB650]

SENATOR CAMPBELL: Thank you very much. [LB650]

SENATOR NORDQUIST: Yeah. [LB650]

SENATOR CAMPBELL: We should indicate that senators will be coming and going this afternoon because they have bills in other committees. And so they're going to open on those bills and that's where Senator Crawford is and she will be joining us when she is finished. Okay. How many people wish to give testimony in favor of the bill? Okay. Those opposed to the bill? Okay. And those in a neutral position? All right. Our first proponent? In the committee, we go proponents, opponents, and neutral. So we will have our first proponent. Good afternoon. [LB650]

MARK BRISSO: (Exhibit 1) Good afternoon. Hi. My name is Dr. Mark Brisso. I currently sit on the state board of directors... [LB650]

SENATOR CAMPBELL: Oh, sorry, sir, Doctor, you will have to spell it for us so the transcribers can hear you. [LB650]

MARK BRISSO: Oh, okay. B-r-i-s-s-o. [LB650]

SENATOR CAMPBELL: Go right ahead. [LB650]

MARK BRISSO: As I said, I'm currently one of the state board of directors for the March of Dimes as well as being a neonatologist here in the city of Lincoln. As a neonatologist, I am responsible for the care of the premature and acutely ill infant shortly after delivery. I would like to thank all of you for this opportunity to present testimony today on behalf of the March of

Dimes in support of this legislation that encourages hospitals to offer parents of the newborn an immunization for pertussis. As I'm sure many of you will recall, March of Dimes was founded to fight polio and fund the research that ultimately produced vaccines which eliminated that dreaded disease in the United States and almost every other nation on earth. Over the past decades, the United States has seen the virtual elimination of many feared diseases largely due to the development and effective administration of vaccines. Public awareness about the dangers of these diseases and the benefit of vaccines has been the key to their elimination to this point. However, a recent surge in pertussis outbreaks across the country has raised alarms within the health community. As stated before, pertussis, commonly known as whooping cough, is characterized by a long and uncontrollable coughing fit that in children can cause severe difficulty in breathing, them to have vomiting spells or even pass out. However, in the group of infants I care for, as well as otherwise healthy term neonates, this disease is far more than a nuisance cough or even just a breathing disorder. This is often a significant pneumonia and, before the onset of the vaccine and thereby herd immunity, often meant certain death in these infants. These infants are at the most risk and have the least ability to fight off this disease. After the introduction of the pertussis vaccine, rates dropped dramatically. However, as stated earlier, pertussis cases have surged in the recent years. As recent as 2012, greater than 48,000 cases of pertussis were reported in the United States, but many more were unreported or underdiagnosed as just a simple cold. These cases unfortunately included 20 deaths, most of which occurred tragically in infants less than three months of age. Again in Nebraska in 2014, there were nearly 400 confirmed cases of probable whooping cough not all diagnosed with the rapid test. However, in January of 2015, there have been greater than 200 cases already diagnosed, and I know in speaking with the pediatricians in town they are no longer even swabbing for it. They're just diagnosing the infants as such and treating them. The recommended pertussis vaccine in the United States for infants is called DTaP, a combination vaccine that protects against pertussis, diphtheria, and tetanus. DTaP comes in a series of five vaccines recommended for all infants at 2, 4, and 6 months, and then booster shots between 15 to 18 months and then again at the beginning of school age a 4 to 6 years. The infants are not considered to be fully protected until the pertussis has been given three different times usually by six months of age. Because the immunity induced by this childhood vaccine fades over time, adults are recommended to receive the booster vaccine known as Tdap with tetanus once in their lifetime by the Centers of Disease Control and Prevention. The Tdap vaccine protects against the whooping cough and usually lasts anywhere from 10 to 15 years and is effective in eight out of ten people. One major challenge in identifying and controlling pertussis outbreak stems from the fact that other respiratory disorders cause very similar symptoms and they are often just diagnosed as a bad cold. According to the CDC, when the source of pertussis can be identified, mothers tend to be that source in 30 to 40 percent of the cases and family members with close contact in up to 80 percent of those cases. As a result, it is critically important that the adults that have regular contact with these infants be immunized. Nebraska cannot afford to allow parents to be ignorant about this serious disease or the measures that they can do to protect their own newborn. The pending legislation of LB650

would encourage hospitals to offer provider parents an opportunity to be immunized while mom is still in the hospital. Thank you. [LB650]

SENATOR CAMPBELL: Okay. Are there questions? Thank you very much. Oh, sorry, Senator Riepe. [LB650]

SENATOR RIEPE: Yeah, I'm sorry, Senator. I have a question. It talks in here in the bill, in which it says require all hospitals and employees to be vaccinated against influenza, tetanus, pertussis. Is it...in your case, is there an opt out for any of the employees or...and second--I'll double down on this one--is are they required, if they don't have direct contact with infants, you know, like they're working in engineering or boiler or, you know... [LB650]

MARK BRISSO: Yes, there is an opt out, Senator. They can opt out for a number of reasons including health and religious reasons. They are required to take specialized precautions if they do opt out. [LB650]

SENATOR RIEPE: Okay. You might reassign them or something, too. [LB650]

MARK BRISSO: Correct. [LB650]

SENATOR RIEPE: Okay. Thank you. [LB650]

SENATOR CAMPBELL: Any other questions, Senator? Thank you, Doctor, for coming today. [LB650]

MARK BRISSO: Thank you. [LB650]

SENATOR CAMPBELL: Our next proponent? Good afternoon. [LB650]

BERNARD BRUCE: (Exhibit 2) Good afternoon. Good afternoon, Chairwoman Campbell and members of the Health and Human Services Committee. My name is Bernard, B-e-r-n-a-r-d, Bruce, B-r-u-c-e. I'm a retired firefighter from both Omaha and Papillion Fire Departments, and I'm here to speak in support of LB650. My daughter had two premature boys. We lost the first one--his name was Will--and Patrick, who is now six years old. During the fall of 2012, Jennifer, my daughter, was pregnant with their third son when I was working with the Papillion Fire Department. I became very ill during this time. I was coughing so hard at times I could not breathe. I lost my breathing drive for 10/15 seconds where I couldn't suck air in and even lost

consciousness on three or four occasions where I just woke up in a chair, you know, coughing so hard. I was put on antibiotics, but after a week it didn't get any better. I was then tested for pertussis. With the diagnosis and treatment of antibiotics, I took those to make sure...during this time to stay clear of my daughter and her family to make sure we didn't spread it. One thing not on here is with Papillion I was working on the fire department. And you're living with the guys 24 hours a day. There's probably about three other guys whose wives were pregnant. So then that was on my conscience also. Did I infect them? And could they take that home? I don't know how I was exposed to it, to pertussis, but part of my job as fire department was speaking to school children about fire safety. After receiving treatment for pertussis and knowing I wanted to be with my new grandson, I received the DTaP immunization. Infants, especially those under 12 months of age, are at high risk for severe disease and death. I did not want to expose the new family member to that. Immunization is one of the most effective ways of protecting the population from disease. However, many infants in the United States are catching pertussis, a vaccine-preventable disease, from the people who love them most, their parents. Because protection from the childhood vaccine fades over time, adults unknowingly spread the potential life-threatening disease to their newborns. Unvaccinated adults can contract and spread this serious disease without realizing it. Vaccinated adults protect infants and children from illnesses. Very young children cannot be vaccinated for many reasons and rely on the immunity of those around them to protect them. Approximately half the infants less than one year of age who contract pertussis are hospitalized, so the immunization of family members can prevent babies' exposures while they are too young to be vaccinated themselves. The March of Dimes is asking Nebraska lawmakers to encourage hospitals to offer parents of newborns the pertussis immunization. Immunization makes the difference between life and death for their baby. Thank you for your time and your service to Nebraska. [LB650]

SENATOR CAMPBELL: Thank you, Mr. Bruce. Are there questions from the senators? And everybody is now doing fine? [LB650]

BERNARD BRUCE: Pretty much. We just had a new one and, like I said, my number three--I number my daughters (laughter)--the number three daughter, she just had a baby in December. And once again, we always try to make sure we all have the flu shots whenever this happens. But this year, I don't know if you know about pertussis. And CDC and Douglas County Health contacted me and Sarpy County Health because Papillion is in Sarpy County, because they were trying to track it down. This is in the year 2012. And they were...they told me that we all thought we were immunized when we were younger. Well, it doesn't last. You need a booster. And they didn't actually add the booster. This is what they told me, is they didn't add the booster to the...your tetanus shot until 2005. So before that, you know, I've been cut and I've been...always got tetanus shots. But up to...after that I hadn't gotten one, you know, so then, you know, in the last seven years luckily I haven't had stitches where I needed a tetanus shot. And the bad part is, that opened me up to pertussis. And just having it realizes that for the old and the young, it can

be devastating for you, because I like to think I'm in somewhat good shape. And there was times I didn't think I was going to make it. [LB650]

SENATOR CAMPBELL: Wow. Well, we will all be checking with our physicians at the next... (Laughter) [LB650]

BERNARD BRUCE: Yeah, make sure you have it. [LB650]

SENATOR CAMPBELL: We'll be saying, could you look at the file and make sure? Thank you so much for your personal story. [LB650]

BERNARD BRUCE: Thank you. [LB650]

SENATOR CAMPBELL: (See also Exhibit 3) It's very helpful. Anyone else in the hearing room who wishes to testify in favor of the bill? Okay. We'll take those who are opposed to LB650. Sir, are you opposed to LB650? I thought you had raised your hand. No? Okay. Anyone else in the room? Anyone in a neutral position? Okay. That will close the public hearing on LB650. And are there any people who are leaving who came just for LB650? Okay. I'm assuming that the trooper and the Red Coat are watching the numbers in the room. So we'll take just a minute to change seats. [LB650]

SENATOR HOWARD: With that, we will open the hearing for LB472, Senator Campbell's bill to adopt the Medicaid Redesign Act. Senator Campbell, when you're ready. [LB472]

SENATOR CAMPBELL: (Exhibit 1) Okay. Senator Howard and members of the committee, I am Kathy Campbell, K-a-t-h-y C-a-m-p-b-e-l-l, and I represent District 25. Colleagues, LB472 represents several years and months of work to understand the Affordable Care Act and the possibility it creates for Nebraskans and our economy. First I want to provide some historical background on Medicaid. Then I'll explain how we crafted LB472 with a goal of utilizing the federal dollars available to states as a strategic investment in our healthcare. I want to touch on the personal stories--and I have one at the end--but a great number of personal stories have come, I'm sure, and to some of you, of people who would be in the gap and would, I would say, touch one to understand what it is like to be at 100 percent of the federal poverty level and below and not have health insurance. In the early 2000s, the Legislature created the Medicaid Reform Council to look at ways to bend the curving climb of Medicaid costs. That group did great work and began to find ways to save the state money in Medicaid spending. I should add that that bill was first put forward by Senator Erdman and then there were a great number of stakeholder groups across Nebraska and a number of providers--great number--came forward with great

suggestions. It is necessary to effect such savings without inadvertently shifting the burden to other areas of our economy such as uncompensated care in hospitals for medical or medical bankruptcy. Then in 2010, the Affordable Care Act was passed by Congress which has made inroads to changing our traditional views of healthcare, especially for the low-income population who has traditionally gone without health insurance and healthcare. Whether you like Obamacare or not, our healthcare system was and still is in need of reform. According to the Organization for Economic Cooperation and Development, the United States spends 2.5 times the average in per capital average total health expenditures and 17 percent of our GDP. At the same time, we all know Americans are sicker. Our life expectancy is actually decreasing, meaning we are not getting better care for the money we are spending. The mantra in my time with this committee has been to increase accessibility to healthcare and insurance coverage to decrease costs. Discussion ensued on how Nebraska would participate or opt out of such changes. One option was whether or not to close the coverage gap for individuals at or below 100 percent of the federal poverty level. Above that amount, the federal government would provide federal subsidies for people purchasing insurance on the private exchanges. But Congress wanted to incentivize states to cover a group of individuals not traditionally covered, sometimes referred to as the childless adults, the working poor. Traditionally, Medicaid in Nebraska is only available to those who meet eligibility in four specific categories: children with family incomes below 200 percent of poverty; their parents below 50 percent of poverty; pregnant women below 185 percent of poverty; or the aged, blind, and disabled. Just to be clear, childless adults are not currently eligible for Medicaid no matter how low their income. In 2013 I introduced LB577 to amend eligibility for Medicaid to include low-income adults age 19-64 and close the coverage gap. During debate, I listened and learned that my colleagues were concerned about the federal government's promise to cover the newly eligible at or above 90 percent of the state's costs. Over the interim, we regrouped, studied what other states have been doing, and were successful at and reintroduced the idea as LB887, the Wellness in Nebraska Act. That bill included more specifics on demonstration waivers; created a WIN marketplace of qualified health plans; addressed employer contributions, administrative costs; and was heavily focused on the insurance market. The bill did not have enough votes to overcome a cloture motion. Michelle Chaffee, our former committee counsel, and I have spent much of the summer again taking in the feedback from our last two attempts, have engaged experts and stakeholders to come up with a plan that addresses the lack of healthcare for low-income adults and the economic costs now being realized by our hospitals, our businesses, our schools, really every facet of this state. LB472 creates the Medicaid Redesign Act. The goal of LB472 is to reduce the number of uninsured, low-income Nebraskans, increase access to healthcare services, leverage available funding to redesign Medicaid to work better for Nebraskans. What we had not looked at, colleagues, in the last two bills was a specific plan and way to look at our current Medicaid plan as it would fit into the newly eligible population. LB472 creates the Medicaid Redesign Task Force to look at innovative and more efficient models of healthcare delivery. I believe that if there are sources of funding available now to allow us to examine our system and come up with

better ways of doing business, we should take advantage of those funds. It was very intentional that we drafted the bill to give the Governor and the department flexibility in designing a Medicaid program that improves the health of Nebraskans and cares for those in need. In other words, we want a Nebraska plan. LB472 also expands coverage to nondisabled individuals ages 19-64 who earn between the 100 and 133 percent of the federal poverty level, allows premiums up to the 2 percent of the individual's income to ensure they have "skin in the game" and allows for copays for necessary emergency room visits. LB472 also incentivizes cost-saving wellness behavior such as preventative screenings and annual checkups. The premium contribution also helps individuals budget for when they move back into the private marketplace and are responsible for their own premiums. Currently, the federal government pays about 52 cents for every dollar spent in Nebraska on Medicaid. That's what's known as the FMAP. When LB472 is passed, the federal government will pay 100 percent of the cost for providing healthcare to the newly enrolled at no cost to the state through 2016 with a step-down to no less than 90 percent after 2020 under the Affordable Care Act. These are dollars Nebraskans are paying to the federal government in taxes and not getting back. To address the concerns of if the federal government discontinues the match originally set out in Section 13 of LB472 includes a termination provision for the state. And this is a specific request of a number of senators in the last two sessions, that it would include a termination provision for the state to discontinue Medicaid coverage for nearly eligibles if the federal match ever falls below 90 percent. I want to make a note or make a comment about the fiscal note here. I've mentioned to the committee before the fiscal note does not consider cost savings. Any fiscal note does not. Currently, thousands of Nebraskans are living without health insurance not caring for their health, not getting preventative screenings and care, and missing work for long periods of time which reduces their productive years in the work force, burdens our hospitals who are caring for sicker people free of charge with no reimbursement, not to mention the added stress that people with unmanaged chronic health conditions puts on people. In 2014, over 3,000 people filed for medical bankruptcy in Nebraska. The costs we all pay for the treatment of those without health insurance is a hidden tax and one that LB472 can reduce. The first testifiers this afternoon--and I've asked for a bit of leeway on their time, and I've talked to Senator Howard today--are from the University of Nebraska at Kearney to give a preview of their study on the effects to the Nebraska economy. But I invite you to consider using common sense. If more people are eligible for health insurance, more people will see a doctor earlier, and receive preventative treatment to keep themselves healthy and working and able with a healthy population. I do want to indicate that this Sunday morning when I opened the paper, the Lincoln paper, I saw a letter from a woman here in Lincoln. And in that letter she talked about the fact that her daughter would be one of those people who falls in the Medicaid gap, "My daughter with Asperger's syndrome, an autism spectrum disorder, is in her 30s and able to work part time as a substitute paraeducator with the Lincoln Public Schools, but her job does not provide health benefits, and her total salary for the year is less than $7,000. Both my husband and I are retired and, thus, have limited resources to continue helping pay our daughter's private insurance policy, which went up again, to $269 per

month. The policy has a high deductible and doesn't even cover the cost of her seeing" her psychologist and other healthcare providers. "These treatments help her greatly, but add another 40 percent to her monthly health care costs." She concludes that obviously passing LB472 would help her daughter. If we were only to look at the fiscal impact, we would miss the human impact that is being made to the state of Nebraska for a number of our neighbors, the people who we work with, or see in our communities. Nebraska is known for helping our neighbors, watching out for each other. This is one case where we really do need to watch out for each other and try to help them have access to healthcare. So with that, Madam Chair, I'm going to distribute to the committee a piece that was--thank you, Jay--that was given to me from Nebraska Appleseed that kind of summarizes and gives you some of the information in the bill. I would like you, if possible, if you don't mind, to hold your questions until the end because we have so many people that want to testify and I'd rather just start with the two professors from Kearney. [LB472]

SENATOR HOWARD: Thank you, Senator Campbell. Brennen, are there items for the record? [LB472]

BRENNEN MILLER: (See also LB650 Exhibit 3) On LB650, before this bill, was a letter from the Nebraska Medical Association. Would you also like me to do LB472? [LB472 LB650]

SENATOR HOWARD: Certainly. Why not? [LB472]

BRENNEN MILLER: (Exhibits 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27) It will take just a moment. Letters of support from: the Holland Children's Movement; Nebraska Association of Behavioral Health Organizations; Nebraska Psychological Association; Nebraska Speech-Language-Hearing Association; Brain Injury Association of Nebraska; Dr. John Walburn; Nebraska Association of Home and Community Health Agencies; Health Center Association of Nebraska; Nebraska Occupational Therapy Association; Nebraska Rural Health Association; Public Health Association of Nebraska; Nebraska Association of Service Providers; National Multiple Sclerosis Society; The Arc of Nebraska; Nebraska AIDS Project; Carol Windrum; Children and Families (sic) Coalition of Nebraska; City of Lincoln; Voices for Children in Nebraska; American Heart Association; American Cancer Society Cancer Action Network; State of Nebraska Planning Council on Developmental Disabilities; Nebraska State Education Association; Dr. Rowen Zetterman; March of Dimes. In opposition, a letter from Nancy Carr. Thank you, Senator. [LB472]

SENATOR HOWARD: Thank you, Brennen. Good afternoon, Professor. [LB472]

ALLAN JENKINS: (Exhibit 28) Good afternoon. Senator Campbell, members of the committee, it's a privilege to be here today, and might I add it's a pleasure to be inside today? (Laughter) So

we may run a little long, like till springtime. My name is Allan Jenkins, A-l-l-a-n J-e-n-k-i-n-s. I'm an economics professor at the University of Nebraska at Kearney. I am not speaking as a representative of the university. I am speaking today in favor of Medicaid expansion through LB472 on the basis of a preliminary study that I am engaged in with my college, Dr. Ron Konecny. He's going to follow me. Our work is being sponsored by the Nebraska Hospital Association and AARP. When Ronald Reagan became President in 1981, he was quite concerned about the impact of governmental policies on the economy. And he quickly realized that even though he was the boss, he had very few management tools to actually control the behavior of the agencies. Now, I didn't see Speaker Hadley today, but I suspect that Dean Hadley would have liked to have had a few more management tools in his time with us at Kearney. So, sorry about that, Galen. (Laughter) But unlike the dean, President Reagan could do something about it, and he quickly did. Within one month of being in office, he signed Executive Order 12291, which directed all federal agencies to engage in cost-benefit analysis before they moved forward with any type of new regulatory process. In the 34 years since that time, cost-benefit analysis is now a widely recognized tool of public policy. One of the issues that tends to arise in cost-benefit analysis is that the short-term costs are often much more obvious than the long-term benefits. This is an example I used for my students: When you go to buy a new car, by the time you leave the lot, you have a pretty good idea what the cost of that car is going to be. You know, they give you a little hint with that window sticker, don't they? The long-term benefits of having the car--increased reliability, safety, better fuel economy, and all those things--those benefits are not as immediately obvious and there's no little sticker to help you, but those benefits are just as real as the cost. So as we look at the landscape of Nebraska today, many of the actions which shaped modern Nebraska have come at a substantial public cost. You know, if your predecessors in this building and in the capitol in Washington had only thought about the cost without thinking about the benefit, would I have enjoyed that drive on I-80 last night? The interstate didn't build itself. It...government making a decision to spend money. The other little example I--once again--I like to use in my class...I understand you're not students. This is just a little bit of a different setting. I normally face a hostile audience (laughter) so I don't know, but I guess they'll let me know if they're unhappy with me. One of the examples I like to use is rural electrification. You know, prior to the Rural Electrification Act of 1936, only about 10 percent of Nebraska's farmers actually were hooked to the grid. Individual farmers couldn't cover the cost of putting up the lines and putting in the generating stations. That only happened because the federal government and the state government pumped hundreds of millions of dollars into rural America. The government decided the benefits outweighed the costs, and I think that the success of today's agricultural sector would indicate that that was money well spent. Of course you have to consider the cost of everything. You are stewards of the public purse. You know, as a taxpayer, I'm glad you're paying attention to costs. But what we have found in our study is that the benefits are real and they...the benefits need to get into the equation here. So we began our study by looking at seven different benefits that we could identify. I don't have time to talk about all of those, but let me just talk about one of them. And that's the expansion of discretionary income

for low-income workers. We know from Census Bureau data that low-income people tend to spend about 7.5 percent of their income on healthcare. It works out to about $1,628 per person. If we expand Medicaid so that some of that healthcare cost is shifted away from the individual, that will free up roughly $1,100 per person. Well, once again, we know a lot about the expenditures of low-income families. If we suddenly increase their family income a bit, we know they will spend it--most of it--and they will spend most of it locally. Now, for main street, this is good news, because increasing healthcare costs over the last 40 years have crowded out other kinds of discretionary spending. We see that in all kinds of study. I used an example I included in the document that you received saying that the Bureau of Labor Statistics recently found that spending on apparel had decreased about 25 percent for low-income workers. Obviously, the demand, you know, the need for tennis shoes and shirts and clothes didn't go away. It's just, again, they simply lack the funds. So we do a fair amount of arithmetic in our study. And some of that's pretty straightforward. So if I want to think about the impact of giving low-income people a little bit more money, I'm going to sort of figure out how many people are going to be impacted and, once again, how much the increase would be. Now, in our study, because we're talking about benefits, we back away and soften our estimate. So for example, where 54,000 is typically the number that's used here for early enrollment, we backed away to 48,500. When we do the arithmetic then that still generates about $53 million in additional spending. Now, once we have that number, we have a wonderful tool called IMPLAN, and some of you may have bumped into it in previous studies. IMPLAN is a widely recognized management tool that can trace the impact of an initial economic injection. Because there are patterns within the economy, IMPLAN can track and trace the magnitude of the changes. And once again, the beautiful thing about IMPLAN is that it is tailored to Nebraska itself. The IMPLAN we use is tailored to Nebraska. So as money is injected into the low-income spending sector, the IMPLAN model then will trace the changes to the overall economy. And once again, when we do that little arithmetic, once again the IMPLAN knows that, you know, Nebraska is not New Jersey. We have a particular expenditures pattern here. We have our own tax systems. Once again, IMPLAN tracks that out. So what we find, if you allow $53 million in spending not on healthcare, you're going to generate another $20 million from that effort that's going to also generate about $3 million in state and local taxes and it's going to support about 480 jobs. So this is why we think it's important to talk about the benefits when we're thinking about these impacts. And I've provided a little sample of all those benefits. And once again my colleague, Dr. Konecny is going to talk a little bit more about some of the structural issues that we used here. I'd like to use the remainder of my time just to make a couple of points. One is that it's not business as usual in the healthcare industry. The cuts that are coming into Nebraska's hospitals and provider networks, those cuts are real. And they will have an impact. The benefit of financially stabilizing the healthcare sector cannot be overlooked. Healthcare is an infrastructure issue. Healthcare is not a luxury good. It's an infrastructure issue. If you do not have access to adequate healthcare, you have no chance for economic development. So we need to recognize that benefit. My second point is that what we see today is a systemic problem created by the substantial erosion of

employment-related healthcare benefits. It's not an issue of individual effort. I'm a strong supporter of individual responsibility. When I find that two students have turned in exactly the same paper (laughter), I don't know, that doesn't work, does it? I think you probably should do your own work. You ought to do your own work. But the reality is, only about 15 percent of low-wage jobs now have health benefits available, so it seems a little unfair to blame the workers for lack of that insurance. We have effectively created a giant game of musical chairs where there's only one chair for every six workers. And my final point, 28 states have now expanded Medicaid, so we have a much better idea of the benefits than we had even one year ago. Early in this process, some had recommended that Nebraska wait to see what has happened. Well, we've waited, and now we know it's a mistake to wait any longer. My colleague, Dr. Konecny, will now explain in more detail how we carried out our study. I believe our plan was, we would both give our testimony and then answer any questions jointly. Thank you. [LB472]

SENATOR HOWARD: Thank you, Professor. Go ahead when you're ready. [LB472]

RON KONECNY: (Exhibit 29) Okay. Good afternoon, Senator Campbell and committee members. My name is Ron Konecny, R-o-n K-o-n-e-c-n-y. I am a management professor at the University of Nebraska. I'm not speaking as representing of the university. I am speaking today in favor of the Medicaid Redesign Act, LB472. My statements build on previous comments from Dr. Jenkins. In particular, I want to share with the committee how we organized the project to accurately and honestly portray the flow of funds that result from Medicaid expansion. I want to explain how we modeled the eventual effects and benefits. First, I'd like you to examine our summary table. It's on the first page after the...my comments. It's titled "Fiscal Benefit of LB472 by Fiscal Year." We used cost estimates provided by the Legislative Fiscal Office. But the research summarized in this table closes the loop by presenting the financial benefits to the state's economy. For example, a look at fiscal year 2019-20 shows the passage of the Medicaid Redesign Act will result in direct funds through the economy in a way that supports--with the previous numbers from the Fiscal Office--7,857 jobs with an associated $346 million in labor income is the benefit. The flow of funds through the economy eventually return $31 million of money to a variety of tax jurisdictions. Because the federal medication system's percentage changes, fiscal year 2019-20 is the best examination of long-term consequences of expansion. Our research, again, uses the Fiscal Office cost values. Now, I'd like you to direct your attention to the next page. It's the flow of funds diagram. It's the one that looks like the wiring diagram of my home audio system. (Laughter) It's a great inspiration there. I'd like you to...walk you through the diagram. While I created a diagram for each year, I'm using fiscal year 2018-19 in this example. The diagram is slightly difficult from year to year. We did not use or model potential cost offsets associated with mental or behavioral health. The relative size of each component identified in the flow of funds diagram will adjust over time as the FMAP and the number of participants change. The gray boxes represent the relative scale of each program or activity in the study. The colored lines represent the flow of dollars from one program or fund to

another. Once again, the size of lines represent the relative scale of the flow. The diagram helps us because it reinforces the fundamental reality that every dollar has a purpose, that no dollar is forgotten, and that no dollar can be used or counted twice. Dr. Jenkins and I took great effort to assure that no activity or expenditure was double counted in this cost-benefit analysis. The diagram also reinforces the reality that benefits flow through recipients to providers. The gray box, the gray bar in the left middle of the diagram, represents the total cost of Medicaid expansion. It receives funds from the funding sources on the far left and directs funds to activities on its immediate right. The values to the left are taken from the earlier-mentioned fiscal note. Our analysis focuses on flows on the right of the large gray bar. To cut to the chase, the box on the top left, Nebraska General Fund, and the box on the top right, state and local receipts, are the two of most interest to most people in this room. After accounting for all the flows in fiscal year 2019-20...or '18-19 in your diagram, the net cost to Nebraska General Fund...an expected gain of a few million dollars. That's how much we expect to gain. Because the margin of error in both cost estimates and benefits...benefit estimates, we do not really know if there is a net gain or a net loss. We do know that the difference, a gain or a loss, is about the cost of one good cup of coffee for each person in Nebraska. Our full report, titled "Nebraska Medicaid Expansion" details the rationale and methods summarized by these tables and charts. The method used is--that Dr. Jenkins mentioned earlier--was IMPLAN. And so both of us are open to answer any questions that you have. Senator Campbell and committee, thank you for the privilege of sharing our research with you this morning. [LB472]

SENATOR HOWARD: Thank you, Professor. Professor Jenkins, would you like to come back up? Are there any questions for the professors? From the professor, Senator Crawford. (Laughter) [LB472]

SENATOR CRAWFORD: I just wanted to clarify your last point. You were saying that once you count in the, you know, the possibility of the margin, we don't know for sure if it's a gain or a loss, you mean that the margin of error there... [LB472]

RON KONECNY: The margin of error, yeah. Did I forget to say error? [LB472]

SENATOR CRAWFORD: So it's not statistically significant positive or statistically significant negative. It is that range. [LB472]

RON KONECNY: Exactly, exactly. The data has enough fog in it just from the estimates that when you say, oh, there's a net gain of $1 million or a net loss of $1 million, it's, really? Prove it. Well, you can't. And, like you said, it's not statistically evident that it will incur any cost. We... [LB472]

SENATOR CRAWFORD: But just to be clear, that does mean that there's...it is...that does mean that we know it's not going to be a major loss. We know that... [LB472]

RON KONECNY: Exactly. Exactly. On the outside, when I was looking at it, it would cost about one cup of coffee, good cup of coffee, per citizen in the state. [LB472]

SENATOR CRAWFORD: And that's like the worst-case estimate given these... [LB472]

RON KONECNY: No, worst case is way out there. [LB472]

SENATOR CRAWFORD: No, no, no, I mean, given the flow that you have, wouldn't it...that's the... [LB472]

RON KONECNY: But yeah, we're within the confidence interval of from what...it's not a confidence interval I calculated directly, because I did not know all the standard errors from the costs. But looking at the information I have and from other studies, that is a reasonable estimate of the...essentially... [LB472]

SENATOR CRAWFORD: A reasonable low estimate is a small loss. [LB472]

RON KONECNY: Yeah, what you would consider the low, low cost. Right. [LB472]

SENATOR CRAWFORD: Thank you. [LB472]

SENATOR HOWARD: Are there...Senator Baker. [LB472]

SENATOR BAKER: Thank you, gentlemen, for testifying here today. Did you factor in at all people who don't have insurance now and who maybe go to the emergency room and are unable to pay, therefore, the rural hospitals are eating it? [LB472]

ALLAN JENKINS: Absolutely, we do. And once again, because this topic has received a lot of information, we know that everyone who's not insured ends up inflicting about $1,700 a year of financial damage to someone. Now, as it parses out, some of that cost falls onto the federal government, and so that's your taxes that are covering part of that. Part of that is covered by state and local government, part of it by a little subsidy from private insurance holders, and part of it is simply eaten by the hospital. And that's one of the reasons that one-third of our critical access hospitals right now are under some substantial financial stress. [LB472]

SENATOR BAKER: So my question, does that appear in your model here in any fashion? [LB472]

ALLAN JENKINS: It actually does. The two little bottom...the very bottom little leg of the...where it says charity care bad debt. Okay, it does appear in the model. [LB472]

SENATOR BAKER: Gotcha. Thank you. [LB472]

SENATOR HOWARD: Are there other questions for the professors? And I would say, as you switch back and forth, would you say your name for the...you don't have to spell it again. [LB472]

ALLAN JENKINS: Okay. I thought I was going to give a bad answer, so I thought I would, you know, let there be some confusion on the record there. (Laughter) [LB472]

SENATOR HOWARD: All right. Senator Riepe. [LB472]

SENATOR RIEPE: Would you like me to spell my name? No. (Laughter) Just teasing. It sounded like, as you presented this, it's a significant stimulus program for the state. I'm not sure about that. One of the questions that I have is, with the expanded Medicaid as this proposes, have you looked at the availability of providers, because we're talking about 54,000 additional people? You're going to have some that...employers that will drop it. So you're going to be potentially crowding out what I call good money with less than good money. You're going to be...private payers are going to have to go away. But when Medicaid comes in, hospitals will tell you right now, they can't. My other issues is this with critical access hospitals--and Bruce is here, he can tell us too--is that it was my understanding--correct me if I'm wrong--but those are cost-plus. So if you're in a cost-plus market, you got no worries. [LB472]

ALLAN JENKINS: Okay. This is Dr. Jenkins. I teach healthcare economics. Ron teaches statistics. So I'm going to take this one. On the issue of, will the system suddenly have to deal with a sudden influx of massive numbers of new patients, there will be a little bump up as some people who have gone without insurance will seek to catch up with some preexisting conditions. But let's be clear here: every person in Nebraska right now has access to healthcare through the emergency room. There's no difference in the total number of patients. There may be a difference in how people access care. We want them to access care more reasonably and more efficiently than they are doing it right now. The other part of that is that we don't consume healthcare like other products. I'm 61 years old. I've had healthcare for 58 of those years. I don't go to the doctor because I have healthcare. I go to the doctor because I need care. And I've lucked out. And most

years, even though I have insurance, I don't go to the doctor. So if people are reasonably healthy...once again, there's some evidence of people who choose to be uninsured are healthier than normal. Right? They're gambling a little bit. So I don't think that the system is going to be overrun. But the other thing that's happening then...I know this is a long answer, but that's a great question. Great questions get long answers. (Laughter) That's the way that goes. The cost containment pressures now in healthcare has ratcheted down average stay in the hospital for example. It's...the average stay in a hospital now is down under five days. So we have a lot of capacity out there that in fact is not operating at total capacity, but we also need to have...we need to have some excess capacity, just like in...for NPPD, if the power lines go down, we want them fixed right away. So we need some excess capacity so if there's a tragedy--a traffic accident or something--we need to be able to respond to that. But that also means that we have some room for additional patients. [LB472]

SENATOR RIEPE: May I continue? [LB472]

SENATOR HOWARD: Certainly. [LB472]

SENATOR RIEPE: Thank you. In the real world, many of these physicians will not take Medicaid patients at Medicaid reimbursement, you know, 10 percent of their practice. I know firsthand from running a pediatric group, we have patients from Lincoln that had to drive to Omaha to see a pediatrician because they would not be...Medicaid would not be accepted. So unless you're going to mandate that all of these providers must participate, you're going to have a hard time. The other question I have before we go on is, I'm very much interested if you took a look at, or did you study expanded Medicaid as it was presented to you, or did you look at options, because I feel--and I'm going to continue on a little bit--you know, there are two approaches to this? You either get a government-run or you get a consumer-based, market-driven kinds of systems. And my sense is, we're going down the road of consumer driven, because that's what we want to say. And given a little bit more time, and if I don't get called out from our committee, I want to read a statement by President Obama in relationship to expanded Medicaid. [LB472]

SENATOR HOWARD: Are there other questions for the professors? Was that a question, Senator Riepe, or were you looking to share a comment? [LB472]

SENATOR RIEPE: Well, may I just read it in? I'll turn it into a question. (Laughter) Do you agree? President Obama argued, and I quote: It is not sufficient for us to simply to add more people to Medicare or Medicaid to increase the rolls to increase coverage in the absence of cost controls and reform. We cannot simply put more people into a broken system that doesn't work. My contention is, we have a broken system. We need to look at new ideas. And I'm all for

covering people. You know, I spent a lot of years in healthcare. I'm concerned about that. [LB472]

ALLAN JENKINS: Dr. Jenkins. Once again, it's one of those...we're not here defending the Affordable Care Act. We're not here saying that there's only one way to bring the best possible healthcare system, you know, into being. But, you know, the reality is we have to do something. Once again, if I fall back on my teaching training, you know, when the Sherman Anti-Trust Act was passed in 1890, it wasn't very successful. Symbolically, it was important to say, let's start talking about this idea. But it had to be augmented then with, like, the Clayton Act of 1914. So I think I would never say that what we have now is even...is certainly not perfect or even desirable. It's up to our elected officials to craft the best possible system. Our role as academics is to, if you ask a question that can be answered with numbers, we will make the numbers dance. So, but as far as which is the philosophically more palatable approach, I'm an economist. I'm not equipped to speak to that. [LB472]

SENATOR RIEPE: Thank you. [LB472]

SENATOR HOWARD: Are there other questions for the professors? Seeing none, thank you for your time today. [LB472]

ALLAN JENKINS: Thank you very much. [LB472]

RON KONECNY: Thank you. [LB472]

SENATOR HOWARD: We'll take the next proponent for LB472. [LB472]

SENATOR BAKER: Senator Howard, may I ask that, you know, I assume there's going to be an awful lot of people testifying today for it and later against it, and that...I want to hear what everybody has to say. But if it's a matter of something has already been said before, we can scan your prepared document and skip over those parts that have already been said, and just say, I'm for this, rather than repeating everything that someone has already said. [LB472]

SENATOR HOWARD: Certainly. We also want to make sure every testifier gets their five minutes. [LB472]

SENATOR BAKER: Absolutely. [LB472]

SENATOR HOWARD: And so with that, it's nice to see you again. [LB472]

MARTY FATTIG: (Exhibits 30, 31) Nice to see you again, Senator Howard. I also have a written statement here from Catholic Health Initiatives, Cliff Robertson, that I would like to submit into the record. Good afternoon, Chairman Campbell and members of the Health and Human Services Committee. My name is Marty Fattig, M-a-r-t-y F-a-t-t-i-g, and I'm the chief executive officer of Nemaha County Hospital in Auburn, Nebraska, testifying on behalf of the Nebraska Hospital Association and its 89 member hospitals in support of LB472, the Medicaid Redesign Act. When the Affordable Care Act was enacted in 2010, Nebraska's hospitals were forced to surrender 6 percent of their Medicare revenues in exchange for gains expected from people with health insurance and Medicaid coverage. Since 2010, reimbursements have been reduced by another 2 percent as Congress wrestles with the national fiscal debt and an additional 10 percent in reductions is currently under consideration. Medicaid expansion is intended to provide greater health insurance coverage nationally. As of February 2, 2015, 28 states and the District of Columbia are moving forward with the Medicaid expansion. If Nebraska expands Medicaid to 133 percent of the federal poverty level, many more adults across the state will gain coverage, coverage that is especially important for working adults across the state...excuse me, for working people in areas where employer-provided health insurance is less common and poverty is more prevalent. It appears to me that a great deal of thought has gone into the development of this bill. LB472 incorporates many innovative approaches from around the country and tailors them to meet the needs of Nebraska. It maximizes enhanced federal funding, strengthens private marketplaces, supports employer-sponsored insurance, and enhances stakeholder engagement. Through a Medicaid Redesign Task Force, LB472 provides the groundwork for much-needed reform that includes a primary care focus through patient centered medical homes and integrated care for chronic conditions. It incorporates wellness incentives, personal responsibility, and will reduce inappropriate use of the emergency room. LB472 is a patient centered, comprehensive plan to deliver quality care at a cost-conscious manner. Aside from providing coverage for more people, strengthening the provider network, and reducing the demand for ER services, creating a stronger and healthier work force, and helping children be more capable of learning, it is unconscionable for Nebraska to turn its back on this federal assistance. Without question, there is a gross cost to the state if we expand Medicaid. However, it is imperative that all offsets be taken into consideration to determine the net cost versus benefit. Currently, there are several direct expenditures made by the state that would be replaced with enhanced federal Medicaid dollars such as payments for behavioral health, disability, AIDS drugs, and healthcare for inmates. There is also a direct cost to the state if we do not provide coverage to this population. Failure to expand will leave billions of federal dollars on the table, billions of tax dollars paid by Nebraskans that could have been used to provide care for thousands of working poor and others living in poverty. Estimates vary, however a conservative estimate of the money left on the table is more than $2 billion through 2020. The economic activity stirred by the infusion of $2 billion over five years alone would more than offset the gross costs. Medicaid Redesign Act

incorporates a circuit breaker that terminates the state's participation in the expansion when the federal funding falls below 90 percent. It creates incentives for providers to redirect more individuals to preventive care through patient centered medical homes, accountable care organizations, and federally qualified health centers and other providers that are much lest costly. Those efforts will reshape Nebraska's healthcare delivery system to one focused on reducing costs and producing higher-quality outcomes while meeting the growing demands, a system that can accommodate existing and newly eligible individuals. Without the Medicaid Redesign Act, the healthcare provider network as we know it today will be stretched possibly to the breaking point. Communities will be left without critical pieces of healthcare foundation. Residents will be left without institutions to attend to their healthcare needs, and communities will lose jobs and economic activity. NHA supports the Medicaid Redesign Act and urges this committee to advance this proposal to General File. And thank you for the opportunity to address you today. [LB472]

SENATOR HOWARD: Thank you, Mr. Fattig. Are there questions? Senator Riepe. [LB472]

SENATOR RIEPE: Thank you, Senator Howard. Thank you for being here. You're a hospital CEO, is that correct? [LB472]

MARTY FATTIG: Yes, I am. [LB472]

SENATOR RIEPE: How much of your revenue percentagewise is due to uninsured? [LB472]

MARTY FATTIG: Uninsured runs approximately 10 percent. [LB472]

SENATOR RIEPE: So would you be willing to reduce your fees by 10 percent to avoid that uninsured population? [LB472]

MARTY FATTIG: Ten percent we generally do. What we do is... [LB472]

SENATOR RIEPE: Well, you're passing it over now, but... [LB472]

MARTY FATTIG: No, no, many times this uninsured population we actually offer a financial assistance package and do reduce the cost of that care to help the person pay for it. [LB472]

SENATOR RIEPE: That money has to come from somewhere. I'm just trying to figure out where. [LB472]

MARTY FATTIG: Well, it has to come from being really careful on operations and other places. [LB472]

SENATOR RIEPE: Would the hospitals and the physicians be willing to participate in the cost, because it's a cost on this tag...is really high? Would they be willing to...I know Medicare has talked about a--for physicians--talked about a 25 percent decrease in fees. Would hospitals match that and take a 25 percent decrease in fees? [LB472]

MARTY FATTIG: No. We cannot. [LB472]

SENATOR RIEPE: I see. Okay. [LB472]

MARTY FATTIG: We've taken a number of cuts already. That was...when we went into the Affordable Care Act, because we thought the whole thing would happen as a package. The Supreme Court saw otherwise. And so we have a different paradigm today to deal with. [LB472]

SENATOR RIEPE: Are you a critical access hospital? [LB472]

MARTY FATTIG: Yes, we are. [LB472]

SENATOR RIEPE: Are you based on a cost-plus basis? [LB472]

MARTY FATTIG: It's not cost-plus. It's listed as 101 percent of allowable cost. Sequestration by the federal government reduced that to 99 percent of allowable cost. It's somewhere between 90 and 92 percent of cost that we're being paid for right now. [LB472]

SENATOR RIEPE: Okay. Thanks for coming in. [LB472]

MARTY FATTIG: Certainly. [LB472]

SENATOR HOWARD: Senator Kolterman. [LB472]

SENATOR KOLTERMAN: Thank you, Senator Howard. Mr. Fattig, can you tell me...I see you're representing Nebraska Hospital Association today. Is that correct? [LB472]

MARTY FATTIG: That is correct. [LB472]

SENATOR KOLTERMAN: Will you tell me how many critical access hospitals we have in the state in Nebraska? [LB472]

MARTY FATTIG: Yes, I can. There are 64. [LB472]

SENATOR KOLTERMAN: Sixty-four critical access? [LB472]

MARTY FATTIG: One closed last year. [LB472]

SENATOR KOLTERMAN: Okay. And you already asked if he was a critical access, so I don't need to ask that again. Thank you. [LB472]

SENATOR HOWARD: Senator Crawford. [LB472]

SENATOR CRAWFORD: Thank you. And thank you for being here. [LB472]

MARTY FATTIG: Hi, Senator Crawford. [LB472]

SENATOR CRAWFORD: So I wondered if in your capacity and leadership in the Nebraska Hospital Association or in your leadership in rural healthcare if you'd had a chance to talk to hospital CEOs from other states that have expanded Medicaid and if you from that discussion have heard from them about increased revenues and savings that they have seen in their states? [LB472]

MARTY FATTIG: I have had the opportunity from a number of people. I do sit on some national boards and whatnot. And, yes, I've had the opportunity to talk with some. It...you see when you look at critical access hospitals across the nation, the average operating margin is about 0.7 percent on critical access hospitals. Forty-one percent lose money every year. So if you can add another $200,000 or $300,000 to the bottom line from no pay to Medicaid, it's significant to these folks. [LB472]

SENATOR CRAWFORD: Thank you. [LB472]

SENATOR HOWARD: Senator Kolterman. [LB472]

SENATOR KOLTERMAN: Just another question or two: Are you familiar with the Arkansas model? [LB472]

MARTY FATTIG: Not to the point where I could talk about it intelligently. I have read about it. It is a public/private partnership, you know, that has received a waiver. And I'm not sure we have enough data to know how well it's working yet, but it sounds like it has potential. [LB472]

SENATOR KOLTERMAN: Okay. I'll wait and see if I can find somebody that is more familiar... [LB472]

MARTY FATTIG: I hope you can. I'd like to talk to them, too. [LB472]

SENATOR KOLTERMAN: ...because I'm not hearing very positive vibes about it after a year of service. [LB472]

MARTY FATTIG: Okay. Oh, okay. [LB472]

SENATOR KOLTERMAN: But I was just curious. Thank you. [LB472]

SENATOR HOWARD: Other questions for Mr. Fattig? Before you go, I was surprised that you didn't mention anything about DSH payments, Disproportionate Share Hospital payments, and what the status is of those. [LB472]

MARTY FATTIG: Currently they've been...they're still in place. They are at risk here in the next few months as those pieces of legislation come before the federal government. Disproportionate Share Hospital payments are significant to the medium-sized hospitals. And by medium-sized, I'm talking about the North Plattes, the Kearneys, the Grand Islands, and those types of places. So they are significant. You know, it's all part of the puzzle, Senator Howard, and those hospitals are probably in the most precarious position of all of our hospitals. They're not the great big guys that can do everything for all people, and they're not like, frankly, like critical access that gets some help. They have to stand on their own on a very tricky footing and it's very difficult for them. [LB472]

SENATOR HOWARD: Senator Cook. [LB472]

SENATOR COOK: Thank you, Madam Chair, and thank you, Doctor, for coming today. The second to last paragraph of your testimony says that without this act, the provider network will be stretched. [LB472]

MARTY FATTIG: Yes. [LB472]

SENATOR COOK: So can you expound upon that somewhat? It seems like we're darned if we, darned if we don't. And if you are also--part b, if you'll indulge me--what other...if you're aware of any other aspects of ACA that address the anticipated provider shortages. [LB472]

MARTY FATTIG: Excellent questions, Senator Cook. First of all, the stretching, as I...in the area that I'm aware of is on rural hospitals. [LB472]

SENATOR COOK: All right. Thank you. [LB472]

MARTY FATTIG: Their margins are so tight already. There have been more rural hospitals in the nation closed in the last year than in the previous ten. And a lot of that has to do with various issues involved with the ACA. The problem with providers is one that I, frankly, don't know how we're going to resolve other than creating a new paradigm for the delivery of healthcare. We are looking at...it used to be that we were competing with every other rural hospital in the state for primary care providers. We are now competing not only with the rurals but with all of the metropolitan areas in the nation as well, because under the ACA, these are the gatekeepers of the ACOs, the patient centered medical homes, and so forth. [LB472]

SENATOR COOK: Thank you. [LB472]

MARTY FATTIG: Certainly. [LB472]

SENATOR HOWARD: Senator Kolterman. [LB472]

SENATOR KOLTERMAN: I hate to keep asking questions, but... [LB472]

MARTY FATTIG: Not a problem. [LB472]

SENATOR KOLTERMAN: Has...you come from a small hospital. And have you looked at the patient centered medical home type of arrangements for the current...your current constituents or your current patients? [LB472]

MARTY FATTIG: We have. And in fact, frankly, the model that we have in Auburn is not real conducive to implementation of a patient centered medical home. Where it really works well is when the physicians are employed by the hospital so that you're working with one bucket of money. Our physicians in Auburn are independent. [LB472]

SENATOR KOLTERMAN: So they're still standalone clinics? [LB472]

MARTY FATTIG: Standalone clinic. [LB472]

SENATOR KOLTERMAN: Okay. [LB472]

MARTY FATTIG: But if they...but we still try and get into the homes of our most...those most fragile patients, those that have the chances of really going bad on you in a hurry. We try to get into those homes as quickly as we can after admission. We make follow-up phone calls. We actually put telehealth equipment in those homes where we can monitor weights and glucoses and blood pressures and things like that in their home and then have that data transmitted to the hospital where we can examine it. And we can see when a patient is starting to head south instead of waiting till they end up in our emergency room to take care of them in that manner. [LB472]

SENATOR KOLTERMAN: And you're doing that now as a hospital? [LB472]

MARTY FATTIG: Yes. [LB472]

SENATOR KOLTERMAN: And then a follow-up question, because you're... [LB472]

MARTY FATTIG: At no reimbursement, by the way. [LB472]

SENATOR KOLTERMAN: At no reimbursement? [LB472]

MARTY FATTIG: It's just the right thing to do. [LB472]

SENATOR KOLTERMAN: As a Nebraska Hospital Association, you've got to be somewhat familiar of how many hospitals have employed physician networks. As an example, in Seward the...Seward County, I think there's ten physicians and three PAs and they're all employed by the hospital. So that's a different model than what you have in Nemaha County or in Auburn. [LB472]

MARTY FATTIG: Right. Right. It is. [LB472]

SENATOR KOLTERMAN: Do you know what the breakdown...because you're right, that is more conducive to patient centered... [LB472]

MARTY FATTIG: I can't give you exact numbers, but there are more and more employed physicians in the state in rural communities every year than now. And it would be my belief that over half of the physicians in rural communities today are employed. [LB472]

SENATOR KOLTERMAN: By the local hospital? [LB472]

MARTY FATTIG: By the hospital. [LB472]

SENATOR KOLTERMAN: All right. Thank you very much. [LB472]

SENATOR HOWARD: Senator Cook. [LB472]

SENATOR COOK: Thank you. Doctor, you've identified telemedicine as perhaps an answer to expanded need for providers. Would you agree with that statement... [LB472]

MARTY FATTIG: Yes, I would. [LB472]

SENATOR COOK: ...that it is one possible way to shift the paradigm? [LB472]

MARTY FATTIG: Absolutely. Absolutely. [LB472]

SENATOR COOK: All right. Thank you. [LB472]

MARTY FATTIG: Certainly. [LB472]

SENATOR HOWARD: Any other questions for Mr. Fattig? Seeing none, thank you for your testimony today. [LB472]

MARTY FATTIG: Thank you, Senator Howard. [LB472]

SENATOR HOWARD: And in deference to Senator Baker's comment, while every citizen is afforded five minutes, we do appreciate brevity as a committee. (Laughter) [LB472]

SENATOR BAKER: Thank you, Senator Howard. [LB472]

SENATOR HOWARD: You're welcome. Good afternoon. [LB472]

VIRGINIA WRIGHT: (Exhibits 32, 33) Good afternoon. My name is Virginia Wright or Ginny Wright. And I am representing the more than 100 members of the Lincoln Council of MoveOn.org. [LB472]

SENATOR HOWARD: I'm sorry, Ms. Wright, could you spell your name for us? [LB472]

VIRGINIA WRIGHT: And I sat there and listened to everybody be reminded. (Laughter) V-i-r-g-i-n-i-a W-r-i-g-h-t. MoveOn is a genuine grass-roots group of 8 million members. We have no PAC, corporate, or business support. Donations average $3 to $10 per person with a maximum of $5,000 a year per person. Today I am presenting the latest petition in support of Medicaid expansion in Nebraska. And the staff has three petitions, two from October...one from July of 2012, one from October of 2014, and one that was started last Friday and as of 8:00 a.m. this morning had 336 signatures. Nebraskans care a lot about this subject and respond very quickly. In July 2012, we presented Governor Heineman with a petition, rationale, and comments from over 2,000 Nebraskans in support of the proposed Medicaid expansion at that time...which Senator Campbell did a very good job of describing the subsequent efforts also. The color map which staff, I think, have, or I can pass this one. This color map shows the locations of the signers on that 2012. And every time we've done this, it is the same story. North, south, east, west, all over our state, people want healthcare. They care about the citizens who are unable to get it. One dot may represent only one person in the more frontier areas. In the more populous area, a dot may represent multiple people. We did not calculate that. We're showing the widespread support. That was 2012. The other petitions showing up today is an October 2014 petition that garnered over 1,000 signatures in two weeks. And the incredible depth and diversity of Nebraskan support for Medicaid expansion is shown by the compiled list, which I believe I've attached for you, of 158 Nebraska towns in the comments. And some of the signatures are from out of state. And from their comments, you can see that they were from Nebraska or they have some connection to Nebraska. You have heard the benefits of expanded Medicaid. Knowledgeable people see the benefits of reducing healthcare costs over the long run. Routine healthcare keeps people healthier, prevents illness and more serious or expensive conditions. The expansion supports and creates thousands of good jobs and supports rural hospitals. Nebraskans see the connections between health, wellbeing, productivity, and economic benefit and additional tax revenues, not to mention that the job of government is to serve the public interests. Those who oppose expanding Medicaid have yet to present factual and relevant explanations for their position. For example, a paragraph from Governor Pete Ricketts' letter to me, dated January 28, 2015 is illustrative, "As I have publicly stated, I do not support the expansion of Medicaid as proposed under President Barack Obama's controversial health care law. The federal government has a history of reneging on its promise as it did when it stopped covering 40 percent of the cost of states' special education program. I cannot trust that the federal government will honor its promise to help fund this costly expansion, which would come at the expense of Nebraska's schools and roads." Most of us believe healthcare is a basic human right. All but the US among

the developed countries have universal healthcare at half our cost and twice the rate of desirable outcomes. In our health insurance system, LB472 is a major step in the right direction. The Washington Post published the Plum Line blog commentary by Paul Waldman February 13, 2015, "New evidence shows that Medicaid expansion has major benefits. Will conservative states listen?" which describes a study by Deloitte Consulting and the University of Louisville about the Kentucky results as it enthusiastically accepted all of the ACA expanded Medicaid and developed its own insurance exchange, Kynect, made sure it worked well, and aggressively marketed it. [LB472]

SENATOR HOWARD: Ms. Wright, your red light is on. Would you mind summarizing? [LB472]

VIRGINIA WRIGHT: I see that, and I have three more paragraphs. May I finish? [LB472]

SENATOR HOWARD: If you wouldn't mind summarizing them for us. [LB472]

VIRGINIA WRIGHT: Well, this is new. It's not been testified to before. [LB472]

SENATOR HOWARD: Certainly. [LB472]

VIRGINIA WRIGHT: Thank you, Senator. They made sure it worked well and aggressively marketed it. Within this article is the big question for conservative states which have rejected expanded Medicaid: Could a huge economic benefit to a state, thousands of jobs, and millions or even billions of dollars in additional tax revenues be enough to convince them? For a lot of them, the answer is no. Many conservatives believe that it's better for a poor person to be uninsured than to get Medicaid, that it's actually a moral evil to help them improve their lives in that way, because it makes them takers and deprives them of the bracing encouragement to improve themselves that suffering will bring. "While you will often hear Republicans say that their state 'can't afford' to accept the expansion because of its (sic) 10 percent they'll have to contribute, the Kentucky study and others demonstrate that this is just false: expanding Medicaid saves states money" and it's the right thing to do. "It would be nice if the holdout states would admit that their reluctance to expand Medicaid has nothing to do with (the) alleged practical costs. It's because they've made a particular moral judgment about government and poor Americans." So the elephant in the room is now visible. Kudos to all the senators and organizations who have worked with Senator Kathy Campbell to craft a meaningful bill to achieve access, affordability, and quality of care that the Affordable Care Act intended. We've lost millions of dollars as you have already heard. Nebraskans care. The thousands of MoveOn.org members ask you to support LB472, move it out of committee and to full debate and to...you have the full article that I was quoting from. That's the Kentucky model and all reports it's very successful. Two of the concerns

about arguments against Medicaid expansion is that there are false equivalencies being made comparing healthcare and humans and their service needs to typical industrial financial analysis and sentient beings are very different. [LB472]

SENATOR HOWARD: Ms. Wright, I'm going to stop you right there to make sure we have time for questions. Senator Riepe. [LB472]

VIRGINIA WRIGHT: Sure. [LB472]

SENATOR RIEPE: Senator Howard, thank you. I notice your organization is called MoveOn.org. Is this part of the George Soros... [LB472]

VIRGINIA WRIGHT: No. [LB472]

SENATOR RIEPE: Okay, it's a different MoveOn, huh? Okay I just...curiosity. I didn't know how broad your base was. [LB472]

VIRGINIA WRIGHT: No, there are no...no individual can make more than $5,000 a year to us. [LB472]

SENATOR RIEPE: George Soros makes more than that. [LB472]

VIRGINIA WRIGHT: Yeah, I'm aware of that. But we are not beholden to anyone. The members actually decide.... [LB472]

SENATOR RIEPE: It's a local group. [LB472]

VIRGINIA WRIGHT: We are the local in Lincoln, but there are thousands across Nebraska and 8 million in the country, and we decide which issues to take civic action on and what position to take. [LB472]

SENATOR RIEPE: Okay. Thank you. [LB472]

VIRGINIA WRIGHT: Thank you. [LB472]

SENATOR HOWARD: Other questions? Seeing none, thank you for your testimony today. [LB472]

VIRGINIA WRIGHT: Thank you, everyone. [LB472]

SENATOR HOWARD: Our next proponent? Good afternoon. [LB472]

SHERRY MORROW: (Exhibit 34) Good afternoon. Thank you. For the record, my name is Sherry Morrow, S-h-e-r-r-y M-o-r-r-o-w, and I'm from Kearney. I'm a Buffalo County commissioner. And I'm appearing on behalf of NACO, the Nebraska Association of County Officials, today as their president. The Nebraska Association of County Officials' platform urges local and state federal government agencies to be responsible partners in providing adequate and equitable health and human services. LB472 is a step in the right direction to acknowledge such a partnership. Furthermore, the bill would assist in improving the health and healthcare coverage of uninsured, low-income adults in both rural and urban counties across our state. Based on a study of counties of those who responded in 2014, the counties paid the following amounts for general assistance, and just a sample of a few of those: Sarpy County, $145,000; Dakota County, $37,400; Otoe County, $7,000; Hamilton, $30,000; Dawes, $35,000; Buffalo, $13,000; and Douglas, $1,831,187. Extending coverage to this highly vulnerable population would result in significant cost savings for states and counties with increased quality of life benefits to millions of individuals who have been left out of the reliable access to healthcare and stronger social structures for the communities in which they live. In addition, the population that would be potentially assisted would be individuals who are being held in our county jails. Again, according to the same study, the projected savings regarding medical services for individuals in jails or detention facilities would potentially be as much as $50,000 to Red Willow County; $250,000 to $300,000 to Sarpy County; $60,000 to Buffalo County. Due to the vulnerable population that this legislation would impact and the increased cost counties face related to general assistance and inmate populations, I encourage you to advance LB472 to General File. Thank you. [LB472]

SENATOR HOWARD: Thank you, Commissioner Morrow. Are there questions? Senator Baker. [LB472]

SENATOR BAKER: Thank you. Ms. Morrow, do you happen to have the Lancaster County number? [LB472]

SHERRY MORROW: Yeah, I do. They're going to testify next so I didn't pass that on. (Laughter) [LB472]

SENATOR BAKER: Thank you. [LB472]

SENATOR HOWARD: Other questions for the commissioner? Seeing none, thank you for your testimony today. [LB472]

SHERRY MORROW: Thank you very much. [LB472]

SENATOR HOWARD: Good afternoon. [LB472]

DEB SCHORR: (Exhibit 35) Good afternoon, Senator Howard and members of the Health and Human Services Committee. My name is Deb Schorr, D-e-b S-c-h-o-r-r. I am here on behalf of the Lancaster County Board of Commissioners to express our strong support for LB472. The last four fiscal years, Lancaster County spent approximately $10 million on the medical needs of our general assistance clients. Adopting the Medicaid Redesign Act would virtually eliminate all general assistance medical costs for Lancaster County, a potential annual savings of $2.5 million for our taxpayers. Additionally, the Medicaid Redesign Act will greatly improve the quality and effectiveness of healthcare for our low-income citizens as well as assisting the Lincoln/Lancaster County community in meeting its goal of integrating primary healthcare and behavioral health. The results of the study conducted by the Tax Modernization Committee in 2013 indicate there is too much reliance and pressure on real property tax. The citizens of our state have sent the message loud and clear that their number one concern is high property taxes. Reforming Medicaid provides an opportunity to help lower property taxes by maximizing the use of federal funds. Opponents of LB472 argue we cannot afford the Medicaid Redesign Act. The truth is that we cannot afford to miss this opportunity. Thank you and I'd be happy to answer any questions you may have. [LB472]

SENATOR HOWARD: Are there any questions? Senator Crawford. [LB472]

SENATOR CRAWFORD: Thank you, Commissioner. [LB472]

DEB SCHORR: Thank you, Senator. [LB472]

SENATOR CRAWFORD: Thank you. Thank you, Commissioner. So this is your general assistance medical costs. So there would be additional savings...would there be additional savings in terms of costs for the healthcare that was mentioned earlier in terms of jail costs? [LB472]

DEB SCHORR: I will break down just for our general assistance numbers for you a little bit more specifically. In 2014, our hospital charges for general assistance clients were $300,000; pharmacy, $400,000; physician costs, $650,000; and then nursing support through our local health department, approximately $400,000. [LB472]

SENATOR CRAWFORD: And those are all the general assistance? [LB472]

DEB SCHORR: Those are all general assistance costs. [LB472]

SENATOR CRAWFORD: Thank you. [LB472]

SENATOR HOWARD: Senator Kolterman. [LB472]

SENATOR KOLTERMAN: Yeah, thank you for coming to testify. Can you tell me, because I'm not familiar with how counties can do this, but if you have somebody that's in a county jail and they've got their own insurance, do you use that or is the county responsible for paying for their care when they're in their care and custody? [LB472]

DEB SCHORR: We do have an obligation to pay for care for those who have no other support. And we do have a contract with Bryan to provide coverage to our inmates, both our adult facility and our juvenile facility and those in police custody, at Medicaid rates. [LB472]

SENATOR KOLTERMAN: But do...but my question is, if they have health insurance then do you...are you the source of last payer, so to speak? [LB472]

DEB SCHORR: Are you speaking specifically with regards to the jail? With regards to our general assistance clients, yes. They have no other means of support. [LB472]

SENATOR KOLTERMAN: Okay. So would the jail fall into that category, do you know? [LB472]

DEB SCHORR: Yes. [LB472]

SENATOR KOLTERMAN: Okay. Thank you. [LB472]

DEB SCHORR: There could be certain situations where private insurance may kick in. I'm not prepared to address that specifically. [LB472]

SENATOR KOLTERMAN: Okay. Thank you. [LB472]

SENATOR HOWARD: Senator Riepe. [LB472]

SENATOR RIEPE: Thank you. I understand that you're not in front of us today to talk about or represent all of the county boards. [LB472]

DEB SCHORR: Correct. [LB472]

SENATOR RIEPE: But I can safely assume that you would represent the feelings of Douglas County and every other county because it's fundamentally a transfer of your cost to the state. [LB472]

DEB SCHORR: Correct. And also, there was a comment made earlier that DSH payments were important to mid-size hospitals. I would say that they are important to all size hospitals. [LB472]

SENATOR HOWARD: Are there other questions for the testifier? Seeing none, thank you for your testimony today. [LB472]

DEB SCHORR: Thank you. [LB472]

SENATOR HOWARD: Good afternoon. [LB472]

SHELLY SEDLAK: Good afternoon, Senators and members of the Health and Human Services Committee. Thank you for hearing my testimony. My name is Shelly Sedlak, S-h-e-l-l-y S-e-d-l-a-k, and I live in Seward, Nebraska, and it's Senator Kolterman's district. All my life I've known and appreciated what it means to work. In 1978 I enrolled in the National Guard and was a member of the 167th Infantry Brigade as a member of the military police, where I served for several years. Until recently, I was the store manager in Seward, Nebraska, where I found great purpose in helping my neighbors in my community find the items that they needed. I loved my job. It gave me a great sense of self-worth, pride especially. But now that is gone. A little over five years ago I suffered a brain aneurism and which caused a stroke. That turned my life upside down. I am able to afford medications through Medicare, but there are other tests and treatments I cannot afford that maybe could help me go back to work one day and regain the pride I used to feel. The disability payments I receive help me get by but I was told I don't qualify for Medicaid because the payments from disability are too much and I'm too young. I fell through the crack. If LB472 was passed I could afford an MRI and the physical therapy that would help me to improve to the point that I may, able to be go back to work someday and live a more normal life.

If LB472 is not passed, I can't afford the care the doctors would like me to have. I have to choose between going to physical therapy or going into debt. Lots of Nebraskans are like me. We want to be useful and contribute to our towns, but first we need to get medical treatment. We didn't ask to become sick or injured. I certainly didn't ask to have that stroke. All I can ask is for you to give me my best chance of a normal life again. Before I had my accident, I had a promising career--finally. I used to get so tickled if I could help my customers. That was the hardest thing for me since the stroke, not having the human contact of my valued customers. I don't think it's right that I have to fight so hard to get the care I need. If I had the right care maybe I could get back to work again and feel like I was useful to my friends, family, and neighbors. I want to say especially thanks to my mother, Arlene and my twin sister Sheri King for all their help since--I call it--my accident. They've always been there in my corner. And when I got released from UNMC my mother and sister paid for all my medications; I'm on a lot of them. I'm asking you to please send LB472 to the floor and support the bill so Nebraskans like me can have our fair shake and try to get back on our feet. [LB472]

SENATOR HOWARD: Thank you, Ms. Sedlak. Are there questions? Senator Riepe. [LB472]

SENATOR RIEPE: I have a quick question. First of all, we appreciate your coming in. And any person with a mother named Arlene stands by good with me. Thank you, Mother. My question is this: Did you...and I'm sure maybe you have Social Security and disability, was that not an option? [LB472]

SHELLY SEDLAK: I'm on Social Security disability. [LB472]

SENATOR RIEPE: Disability. Okay. [LB472]

SHELLY SEDLAK: But Medicaid said I didn't qualify because... [LB472]

SENATOR RIEPE: You couldn't get on Medicare because of that. [LB472]

SHELLY SEDLAK: Yes. No, I couldn't get Medicare because...Medicaid because I'm getting Medicare. I wanted the Medicaid for my supplemental insurance and because Medicare only pays 80 percent. Right now I'm having the difficulty of paying that 20 percent. It's just like, a week from today I have to go back to Omaha for them to do an MRI on my brain to check the stent in my brain to make sure it's not leaking. And that can be catastrophic if there's a problem. I'm holding my breath. I'm in fear. I don't want my sister or mother to have to foot my bills. But I contributed to the state of Nebraska all the years I worked. I don't really have anything more to say, Senator. [LB472]

SENATOR RIEPE: Thank you very much. [LB472]

SENATOR HOWARD: Senator Kolterman. [LB472]

SENATOR KOLTERMAN: Thanks for coming today. We go back a long ways, don't we? [LB472]

SHELLY SEDLAK: Yes, we do. [LB472]

SENATOR KOLTERMAN: Can you tell me--and I don't remember--are you...I know you're on Medicare because we've worked with you on that. Are you eligible for a Medicare Part D prescription, because you're under the age? [LB472]

SHELLY SEDLAK: I've got the prescription but not the full thing because of the age. [LB472]

SENATOR KOLTERMAN: Because you can't get a supplement in the state of Nebraska. Now if we had Medicaid Advantage in Seward, which you're aware of, we had you covered there for a while. But that's not eligible anymore. [LB472]

SHELLY SEDLAK: I'm not eligible for that. [LB472]

SENATOR KOLTERMAN: Right. Just wanted to make sure that I was thinking through you (recorder malfunction) correctly. Thank you, Shelly. [LB472]

SENATOR HOWARD: Any other questions? Thank you, Ms. Sedlak, we really appreciate personal stories. [LB472]

SHELLY SEDLAK: Thank you, Senators. You all have a wonderful day. [LB472]

SENATOR HOWARD: Thank you. Good afternoon. [LB472]

AMANDA McKINNEY: (Exhibit 36) Good afternoon, Senators. My name is Dr. Amanda, A-m-a-n-d-a, McKinney, M-c-K-i-n-n-e-y, and I'm here to testify on behalf of Nebraska Medical Association in support of LB472 Medicaid Redesign Act. I'm a practicing obstetrician/gynecologist in Beatrice and we provide obstetric and/or gynecologic services to women living in the Nebraska counties of Gage, Jefferson, Saline, Nemaha, Johnson, Thayer, Fillmore, and Pawnee, and the Kansas counties of Washington and Marshall. I support the expansion of

Medicaid for several reasons which I will outline later. However, I want to clear up a commonly held misconception first. There have been many statements made by current lawmakers opposed to this expansion claiming that many providers don't accept Medicaid patients because of low reimbursements. While there may be some physicians declining to see Medicaid patients, most do accept these patients, particularly providers in rural areas of the state. Currently, almost 30 percent of the patients I see in my clinic are covered by Medicaid. We will always continue to see those patients. We also provide a significant amount of uncompensated care, approximately 7 percent to 8 percent of our charges, for individuals that would be covered by Medicaid if it were expanded. Nearly two-thirds of the uninsured live in rural areas. This places an undue burden of uncompensated care on rural clinics and hospitals. Without Medicaid expansion to cover some of those uninsured, many communities will lose their hospitals and healthcare providers. Hospitals will close. It's already happened in other states where Medicaid was not expanded, like Missouri. People will lose their jobs and the economies of these communities will perish. Our hospital employs over 400 people. People will die. It happened in North Carolina. Six days after a small, rural hospital closed, a 48-year-old woman died of a heart attack in a school parking lot waiting for a helicopter to transport her to the nearest healthcare facility 84 miles away. There is no question that Medicaid is, at times, abused by its recipients and there is always a risk that the federal government would pull its matching funds. It is also true that physicians need to find better ways to manage the care of patients in ways that provide improved outcomes in conjunction with cost savings. This bill addresses all those issues. Therefore, it would be fiscally and ethically irresponsible not to proceed with expansion. As a physician, sometimes my patients die. And it is devastating whenever it happens but I can live with myself, knowing that I did everything that I could to save that individual. That's my job as a doctor. That's why I'm here today. The job of this Legislature is to make difficult decisions that affect the lives of your constituents. So please consider the facts carefully and then vote "yes" for LB472, Medicaid Redesign Act. And on a personal note, I know how politically difficult some of these decisions are. My grandfather, Clair Callan, served in the 89th Congress and he voted for Medicare and Medicaid. And of all of the votes that he took, he was most proud of that one. And it was a politically difficult vote for him to take. He waited until the last; they didn't need his vote. And they told him...Senator Exon at the time said, don't vote for this because you're committing political suicide. And he said, I'm going to do it because it's the right thing to do. And he did, and he committed political suicide. But that was the most...he was most proud of that vote. So thank you for your time. [LB472]

SENATOR HOWARD: Thank you, Doctor. Are there questions? Seeing none, thank you for your testimony today. Good afternoon. [LB472]

AMANDA GERSHON: Good afternoon. My name is Amanda Gershon, A-m-a-n-d-a G-e-r-s-h-o-n. I am stuck in the Medicaid gap. I have undiagnosed health issues that I can't get help for. I don't earn enough money to get subsidies for insurance. And as a childless adult I don't qualify

for Medicaid, regardless of my income amount. I've worked since I was 16. I've often worked two jobs and long hours to cover medical expenses. Being uninsured creates a cycle of poverty. My medical expenses fluctuate and the price of prescriptions vary, so it's difficult to create a budget. Often money that was intended for bills has had to pay for unexpected expenses, which leads to late fees, reconnection fees, often vehicle maintenance must be postponed which can cause a huge hardship. I filed bankruptcy on $60,000 in medical bills when I was 19, I'm sorry, when I was 22 and I need to file again. Every medical issue becomes a major decision. I must always ask myself, can I afford to be seen? Can I afford the medications? Should I wait and see if this becomes tolerable? Lack of medical care complicates simple issues leading to longer absences from work, changes in productivity, and even loss of jobs. I used to be a reliable employee, but now I don't always make it to my one five-hour shift a week. I don't earn enough to take care of myself without the medical costs. And without access to proper medical care, I will just keep getting worse. In Nebraska, disability doesn't even guaranty Medicaid. If Medicaid expansion was passed last year or the year before I would still be working. I would have been diagnosed and given proper treatment. Instead, I just progress with no way to stop it. Many people from different backgrounds fall into the same Medicaid gap, some of whom are college students, young families, the self-employed, farmers, single parents, veterans, our family, and friends. They all need healthcare because they have no safety net if they get sick or injured. It leaves them vulnerable to the cycle of poverty. Their lives, as well as mine, would have a positive change with expansion. We've had the opportunity to see how other states have benefited. We've observed mistakes and successes. As Nebraskans, we can do this right. We can help some of our most vulnerable neighbors and friends live better, healthier lives. We have excellent healthcare here in Nebraska. We have award winning hospitals that have done amazing things in various fields of medicine. It's time all Nebraskans have access to the care that can give them a better quality of life. Thank you. [LB472]

SENATOR HOWARD: Thank you, Ms. Gershon. Gershen (phonetically). Did I say it right? [LB472]

AMANDA GERSHON: Either/or. [LB472]

SENATOR HOWARD: Are there any questions for the testifier? Seeing none, I remember you from last year. You look a little bit better, I will say. [LB472]

AMANDA GERSHON: A little bit, getting there. Thank you. [LB472]

SENATOR HOWARD: A little bit. Thank you. Good afternoon. [LB472]

MERLIN FRIESEN: Thank you very much for the opportunity to testify. My name is Dr. Merlin Friesen, M-e-r-l-i-n F-r-i-e-s-e-n. And having said that, a personal greeting to my senator from District 30 who I've communicated with earlier this week. I'd like to speak on behalf of Nebraska Farmers Union and as a physician in support of LB472. I am currently the president of the Gage County and Jefferson County chapter of Nebraska Farmers Union. I spend full-time on a very small farm and I'm also a practicing emergency room physician at the Beatrice Hospital part-time. I think it goes without saying that an organization like Nebraska Farmers Union would support anything that can enhance the healthcare of its members. Farmers in Nebraska are some of the more vulnerable people, financially, to healthcare costs. And it has been a major priority of Farmers Union, both in our state and on a national level, to increase access to healthcare, insurance in particular. As a physician, I've spent 30 years watching the impact of declining health insurance or increasing uninsured numbers and the health impacts of that. We rank near the bottom among industrialized countries in healthcare outcomes and a large part of that is due to the fact that we leave so many people outside of the system. I spent a decade, almost a decade developing a low-cost clinic specifically for uninsured people because I saw the impact of watching them go without primary healthcare. I did that on a near-volunteer basis. My LPN and I made the same amount of income off that clinic. And I funded that, obviously, with doing...continuing to do emergency room work. I've seen up close the desperate consequences of people trying to access healthcare. I could provide the primary care. I couldn't get them in the door for the high-cost items. This year Nebraska Farmers Union added to it's ongoing support of universal access to health insurance by passing a special order of business at our convention two months ago. And one item on that special order of business was the specific request that the state move ahead with the federally funded Medicaid expansion. This is an opportunity for us to improve care. If we're ever to chip away at our poor health outcomes in this country, we need to do a better job of putting everybody into the system. The emergency room is a fallback for urgent items but it does nothing to address primary healthcare and therefore does very little to affect long-term healthcare outcomes. And I see that every day. I see people who I can address their urgent concern which was basically neglected for lack of primary care. But where do I send them for the follow up? Emergency room care does not substitute for that. And unfortunately, if you're uninsured, that's oftentimes your point of fallback for some level of healthcare. It's a moral obligation to our citizens and I know other people have talked about it. I'd like to phrase it in another way. To me, as a physician, it's heartbreaking to see people struggling with the impact of a major illness only to have to deal with, at the same time, the issue of what are they going to do? Is this going to bankrupt them? Is it going to give them bills that they're going to be hounded for because they have no way to earn the money to pay those bills? That's a moral obligation. And fiscally we've all talked about and I would highlight, that hospitals in rural Nebraska are some of the most major employers and they are at risk. The "almost" cost reimbursement of Medicare at this point only applies to Medicare. Hospitals still have to negotiate discounts from insurance, they have to accept reduced reimbursement from Medicaid, and most critically, they have to accept no reimbursement other than what an uninsured patient can scrape up from next to

nothing. Many of us providers are more than willing to provide care to this group of people. Some of us have done it at almost no reimbursement. We could well use the empowerment to provide more of these people with healthcare. And many of us are more than willing to step up to the plate to make that happen. I thank you very much for the opportunity to address you and any questions? [LB472]

SENATOR HOWARD: Thank you, Doctor. Senator Riepe. [LB472]

SENATOR RIEPE: Doctor, thank you for being here. Now, are you an employee of the hospital? [LB472]

MERLIN FRIESEN: Yes, I am. [LB472]

SENATOR RIEPE: So actually, the financial sacrifice is with the hospital as opposed to your personal sacrifice financially? [LB472]

MERLIN FRIESEN: What I was referring to was the ten years that I spent taking personal responsibility for providing care to these people when I was doing it on my own. And that was not...that was in primary care, not in the emergency room. [LB472]

SENATOR RIEPE: The other comment or question, I guess question I would ask is, physicians as a collective group, I'm not saying in Beatrice, but we hear the numbers. The 1 percent of income and physicians, as a collective group, are in that 1 percent. Do you think physicians would be prepared to step forward and help us make this financially viable? [LB472]

MERLIN FRIESEN: Some of us would do it voluntarily, others of us will do it by edict. Society has a right to expect that of us. [LB472]

SENATOR RIEPE: Okay. Thank you. [LB472]

SENATOR HOWARD: Senator Crawford. [LB472]

SENATOR CRAWFORD: Thank you, Doctor. Thank you, Senator Howard. And thank you, Dr. Friesen, for being here. I just want to thank you for your commitment to your patients in terms of being willing to step up and provide that kind of care and work with your community. I wonder if you could...you mentioned the general concept of, you know, the emergency room is for critical care, but it's not a place where you can really get the ongoing care that a patient needs. So

I wonder if you might just give, say, two examples just to clarify what that means in terms of the kinds of health conditions you are likely to see in the emergency room. And this is what you can do but what is the gap there, because people often say, well, everybody can go to the emergency room. So just help us understand that, maybe with one or two examples of what you can do and then what the gap is that's left. [LB472]

MERLIN FRIESEN: Okay. A person might come into the emergency room with what they think is a bad chest cold and it turns out they have a full-blown pneumonia. We initiate the treatment. The next step is for them to get careful follow-up in the next couple of days with their primary care physician. What do I do when they say, I have no primary physician? I haven't been able to pay my bills. Most of the clinics in town won't accept me back. I don't know the answer to that question. And I guess maybe that could be true for any other number of conditions, speaking specifically to the uninsured folks that don't have good primary care. Many of them make the choice not to get primary care because they realize that the financial hurdle at the front end is too high. So I guess I will quit if that's enough, that one example. [LB472]

SENATOR CRAWFORD: That's helpful. All right, thank you very much. I appreciate that. [LB472]

SENATOR HOWARD: Are there other questions for Dr. Friesen? Seeing none, thank you for your testimony today. [LB472]

MERLIN FRIESEN: Thank you very much. [LB472]

SENATOR HOWARD: Our next proponent. Good afternoon. [LB472]

BEATTY BRASCH: (Exhibit 37) Good afternoon. My name is Beatty Brasch, B-e-a-t-t-y B-r-a-s-c-h. I'm director for the Center for People in Need. On behalf of the center and the people we serve, I'm here to ask you to support LB472. At the Center for People in Need we serve those in Lincoln who make under 150 percent of poverty...of the federal poverty line. There are many working families we see or who seek services such as in our weekly food program or holiday toy drive program that fail to qualify for Medicaid, yet are making too little to qualify for subsidies to the Health Insurance Exchange Act. To give you one story, Angie recently got into an auto accident and had no health insurance through her work. She has exhausted her savings completely but is ineligible for premium tax credits through the Health Insurance Exchange because she has no income. She requires surgery in order to get back to work. Another example is Gloria, who works two jobs providing for her daughter on her own, but neither job offers health insurance. She makes too much to qualify for tax credits through the exchange. We also see the coverage grant in AmeriCorps members we employ at the center. Elias, a former U.S.

interpreter in Iraq, moved to our country with a visa he obtained for helping the Army. Unfortunately, his AmeriCorps income makes him ineligible for Medicaid and he cannot afford health insurance through the exchange because he only receives $1,000 a month. He and his wife are now barely able to afford medication and food for the family. Without addressing these situations and that of all Nebraskans in the coverage gap, their future is bleak as a health crisis could mean bankruptcy. Unfortunately, stories are all too common and illustrate the real problems accessing healthcare that we see every day at the center. We surveyed 1,206 client families of the center for our poverty report last year. Forty percent of them did not have health insurance, the same percentage reporting having gone to the emergency room because they could not afford a doctor's visit. Over 40 percent said they took less than the prescribed amount of medication, and also to make it last longer. These are decisions that no family should ever have to make to get routine help because there's simply not enough money for that option. One argument has been used that they are opposed to Medicaid expansion is that the federal funding is unreliable. However, the reason is not used for many other instances of federal funding in agriculture, education, or roads. We cannot refuse funding to help those individuals like Angie, Gloria, or Elias, and some of the poorest people in our state when we accept funding for so many other programs is not assured for years to come. You've undoubtedly heard today many economic arguments for expansion of Medicaid: Its injection of taxpayer dollars into Nebraska; the necessity of expansion for rural hospitals; and efficiency of the program dollar-for-dollar. Most important though is, let's not forget that this is really about investing in human potential of the people of Nebraska. If we can put individuals like Angie, Gloria, and Elias back on the track to lead to a healthy and productive life, we will all benefit from it in the long term. We need to make a smart investment in the people of our state. Please vote to advance LB472. [LB472]

SENATOR HOWARD: Thank you, Ms. Brasch. Are there questions? Seeing none, thank you for your testimony today. [LB472]

BEATTY BRASCH: Thank you. [LB472]

SENATOR HOWARD: Good afternoon. [LB472]

LYNN REDDING: (Exhibit 38) Good afternoon, Senators. For the record, my name is Lynn, L-y-n-n, Redding, R-e-d-d-i-n-g, and I have traveled from Wood River to offer my support for LB472. As a person with a disability and a recipient of Medicaid I wish to stress to you today how important access to healthcare is for people with disabilities. My Medicaid is literally a lifesaver. My current 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. As a single, childless adult, if it were not for my disability, I would not qualify for Medicaid. For me this is a grave situation. But it's not about me. There are many

people that you guys know, for various reasons, who are caught in the health insurance gap that do not qualify for Medicaid and are ineligible for insurance through the marketplace. As a result, they have extremely limited healthcare choices, go without, go to the ER, or go bankrupt. I know for a fact that I'd rather see my doctors in their offices and not in the ER and I'm confident that I'm not alone in that. I would not be able to afford my doctor's visits, let alone my life-sustaining medications without Medicaid. And I know I'm not alone in that. I am fortunate that I have already qualified for Medicaid. LB472 presents the opportunity for people who get stuck in the coverage gap to get healthcare. Everyone deserves access to healthcare. Please advance LB472. It can be a life or death situation for someone you know. Thank you. [LB472]

SENATOR HOWARD: Thank you, Ms. Redding. Are there questions? Seeing none, it's always nice to see you. [LB472]

LYNN REDDING: Thank you. [LB472]

SENATOR HOWARD: Our next testifier? Good afternoon. [LB472]

GWENDOLEN HINES: Good afternoon. My name is Gwendolen Hines, it's G-w-e-n-d-o-l-e-n, and my last name is Hines, H-i-n-e-s. I'm here on behalf of the Unitarian Church of Lincoln. Medicaid is not available in Nebraska for nondisabled, childless adults and is only available for parents of dependent children if their household income is under 57 percent of the poverty level. That's $13,594 for a family of four. So imagine being a parent of a family of four and making $15,000. How would you cover healthcare? There's no way you would be able to do that. Expanding Medicaid would make it available to residents with an income of 138 percent of the poverty level, which would be $33,000 for a family of four. This would cover approximately 54,000 new Nebraskans. The way it is now, people have to wait until their situation is really bad and then go to the emergency room. They can't pay the hospital bills and so they set it up on the taxpayers and the hospitals. And the way it is now, our taxpayers...our tax dollars are going to other states to fund Medicaid expansion. There's no reason not to expand Medicaid. The federal government has not reneged on any expansion in any states, so there should be no fear of that. I looked up to see what experience some other states had with Medicaid expansion. Colorado expanded Medicaid and covered 225,066 new people. They say that by the year 2025 they will have created 22,388 more jobs in the health industry because of the increase in money that people have to spend on healthcare. The state will save $133.8 million and in addition to that it will receive $128 million more in tax revenue in 2025. In the state of Kentucky, Medicaid expansion brought coverage to 308,000 dollars (sic) and created 17,000 new jobs. Expansion will save the state $802.4 million and plus tens of millions of dollars in revenue from the new jobs. In March 2011, early Medicaid expansion brought improved coverage to 84,000 people in Minnesota. Further expansion in 2014 will cover 57,000 more Minnesotans. The combination is

claimed to have saved the state $1 billion from 2011 to 2015. So that's all I have to say. Thank you for you hearing me. [LB472]

SENATOR HOWARD: Thank you, Ms. Hines. Are there questions for the testifier? Seeing none, thank you for your testimony today. [LB472]

GWENDOLEN HINES: Thank you. [LB472]

SENATOR HOWARD: Good afternoon. [LB472]

CLIFTON McEVOY: Good afternoon. Good afternoon, Senators. My name is Clifton McEvoy, that's spelled C-l-i-f-t-o-n M-c-E-v-o-y, I'm here today because I served in the Air Force from 2004 to 2010. I am now a veteran, one of many who volunteered to serve our country. What does that mean to have served? Well, a veteran much smarter than me said it best. He said volunteering to serve in the military means you, in essence, write your country a blank check for the ultimate sacrifice, your life. I currently work for a nonprofit organization in Omaha, however, today I'm here representing only myself as a veteran. I know that Nebraska is a place that respects veterans of the United States Armed Forces. Our state is proud to be home to veterans and to treat us with a humbling degree of pride and dignity. For that I am very grateful. However, part of the respect that should be afforded to many...to my brothers and sisters who served is making sure their physical and mental health needs are being met after their service has been completed. In Nebraska right now, there are more than 2,000 low-income veterans who fall into the coverage gap that LB472 would close, according to the Urban Institute. Additionally, there are also 800 spouses of veterans who are also in the coverage gap. These Nebraska families have made great sacrifices to serve our country but in many cases cannot get the medical care they need. This is because, contrary to common belief, many veterans cannot get care through the Department of Veterans Affairs hospitals. While the VA does an admirable job to care for veterans, you can only qualify for VA care in specific circumstances: You must be seeking care for a service-related injury or illness; you must have been a combat veteran for at least five years; or you must have an income so low, you are very deep in poverty. Families of veterans are not able to get VA treatment at this time. For many Nebraska veterans and their family members this leaves them unable to afford health treatments they badly need. They can't afford private health insurance but still are not deep enough into poverty to qualify to use the VA. Further, many veterans leave the military with health conditions that don't appear right away, sometimes several years in the future. Veterans suffer from hypertension and diabetes at higher rates than the general population and are much more likely to have suffered a concussion. Then there is the matter of the hidden trauma of mental health. The RAND Center for Military Health Policy Research estimates that 20 percent of veterans, including a lot of my friends, of the Iraq and Afghanistan conflicts are affected by PTSD or major depression. This has major impacts on their

family and professional lives once they are out of the service. Nebraska can and should do a better job for veterans and their families by ensuring they have access to healthcare by closing this coverage gap. Passing LB472 would be a true commitment to their well-being and would ensure the healthcare needs of those who have served are not forgotten by their state. Nebraska is a stronger place when veterans and their families can get the healthcare they need. We happily wrote our country that blank check for our life. And even if it was never cashed, we still signed it. We served our country and continue to serve our community and we humbly ask you for your continued support. As veterans, we are often thanked for our service. Let's turn those thank-yous into actions with the passing of this bill. I thank you for allowing me to speak to you today and I respectfully ask you to advance this bill to the floor with the committee's full support. [LB472]

SENATOR HOWARD: Thank you, Mr. McEvoy. Are there questions for the testifier? Seeing none, nice to see you again. [LB472]

CLIFTON McEVOY: Thanks. [LB472]

SENATOR HOWARD: Our next testifier? [LB472]

BRAD MEURRENS: (Exhibit 39) Well, I see Mark wants to go here, so I'll be brief in my comments. Good afternoon, Senator Howard and members of the committee. For the record, my name is Brad, B-r-a-d, Meurrens, M-e-u-r-r-e-n-s, and I am the public policy specialist with Disability Rights Nebraska, the designated protection and advocacy organization for persons with disabilities in Nebraska. I am here today to offer support for LB472. This bill provides an opportunity for individuals who have traditionally been locked out of healthcare access to have a real chance at getting healthcare coverage. LB472 increases access to vital healthcare coverage for thousands of Nebraskans who would traditionally find it impossible or difficult to obtain healthcare coverage otherwise. For many people with disabilities who are not able to access either traditional Medicaid or the insurance exchange, this is a real opportunity to maintain or improve their health status. Access to healthcare should not be relegated to those who are affluent, have employer sponsored insurance, or are fortunate enough to have a health condition, assuming that they meet the other criteria for eligibility, that they could potentially qualify for Medicaid. We applaud the focus on those Nebraskans with disabilities and/or significant health conditions in this bill. It is false to assume that all Nebraskans with disabilities or who have exceptional medical conditions are currently covered or would be covered by traditional Medicaid. Not all people with disabilities meet the eligibility criteria and limits for traditional Medicaid. The National Association of State Mental Health Program Directors notes that 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. This bill presents Nebraska with the opportunity to provide real

opportunity for individuals with disabilities to go to work or to return to work and earn more money, get a new or better job, or even take a simple pay raise without the constant fear of losing their Medicaid eligibility due to even marginal increased earnings. It provides those Nebraskans with disabilities in the coverage gap a real opportunity to access healthcare in a timely, planned, and comprehensive manner, not in costly environments or when the situation reaches a crisis. In conclusion, we recommend that this committee make a slight change in the composition of the Medicaid Redesign Task Force. We would suggest that the task force also be required to have representation from an individual with a disability, an individual who would have exceptional medical conditions, and an individual who has or currently utilizes Medicaid to help the task force get a sense of how potential changes to Medicaid would affect individuals and families on the ground. Ultimately, we recommend this bill be passed out of committee. I'd be happy to answer any questions that you may have. [LB472]

SENATOR HOWARD: Thank you, Mr. Meurrens. Are there questions for the testifier? Seeing none, thank you for your testimony today. [LB472]

BRAD MEURRENS: Thank you. [LB472]

SENATOR HOWARD: Good afternoon. [LB472]

MARK INTERMILL: (Exhibit 40) Good afternoon, Senator Howard 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'm here today on behalf of AARP. Two things that I want to do today: First of all, is to express AARP's support for LB472. We...LB472 will address individuals in the coverage gap between the ages of 19 and 64. That includes a significant portion of our membership, those between the ages of 50 and 64, many of whom are of the age that if they are in the private market they will be paying some of the higher premium prices that we have. The second thing I wanted to do is just to provide some information about the scope of the issue. You've heard excellent testimony from Ms. Sedlak, Ms. Gershon, and Mr. McEvoy about the reality of being in the coverage gap. But I also wanted to provide you with some information about how many people there are that fall into that category. I've got just some estimates of new Nebraska enrollees that might be based on the experience in other states. We have looked at reports that have been provided by the Centers for Medicaid Services to provide information about those states that have expanded Medicaid and what the growth in the Medicaid population was in those states and also a report that includes the growth in the non-Medicaid expansion states. What we found was about 23 percent growth was the average amount. We've looked at the profiles of those states to try to identify one that comes closest to Nebraska in terms of the numbers of people who are...who did not have healthcare coverage. And what we found was the aggregate was about the best profile. So based on that, we see a 23 percent increase, possibly, in the numbers of individuals that would be covered by

Medicaid or about 54,000 individuals who might avail themselves of the expanded Medicaid coverage that would be authorized by LB472. The second page also is just some census information that I have identified in terms of how many people there are based on their age and their health insurance coverage status. The shaded areas are those individuals who might be likely to receive enhanced coverage through the...as a result of LB472, those people who are directly purchasing health insurance coverage but have incomes below 138 percent of poverty and then those who are uninsured. I included the margin of error just for full disclosure. So the range is somewhere between about 90,000 and 116,000 people who fall into this category. The last thing I would point out is just on the first page up in the upper left corner where we have Nebraska's Medicaid and CHIP enrollment as of the quarter before the Medicaid...the ACA was implemented stood at 244,600 individuals. The latest report we have is from November of 2014 and we've actually dropped about 10,000; we're at 234,857. We have...that's the largest...there are only two states that had declines and we're the largest. So this leads me to believe that we won't see an exceptionally large increase in the numbers of individuals. I think the 54,000 number is...that the national experience has been is probably a fairly good estimate of what we would be looking at. So with that, I will close and respond to any questions that you may have. [LB472]

SENATOR HOWARD: Are there any questions for Mr. Intermill? Senator Crawford. [LB472]

SENATOR CRAWFORD: Thank you, Senator Howard. Thank you, Mr. Intermill, for these numbers. I appreciate that very much. So I'm just trying to understand, from your numbers, understanding some of the estimates we've gotten in other places about the number of people that we might be covering. [LB472]

MARK INTERMILL: Correct. [LB472]

SENATOR CRAWFORD: So going to your table, that's the different numbers of people in these categories. So do I understand correctly that that's the number of people who are uninsured right now who might be eligible? Right? [LB472]

MARK INTERMILL: This is...yeah, this is...yeah. [LB472]

SENATOR CRAWFORD: Okay. So then the lowest estimate is 89,000 the high estimate is 116,000, so just to make the math simple if we would just say 100,000. [LB472]

MARK INTERMILL: Okay. Yeah. [LB472]

SENATOR CRAWFORD: I need simple math. I still cheated and used my phone anyway. So 100,000, okay. So what was used in one of the fiscal note estimates was 80 percent of that and that gets you up to a number that's 80,000. And that seems much higher than what you have...what your other estimates show you, which should be much lower than that, closer to 54,000 as opposed to that 80,000. How do you account for that? [LB472]

MARK INTERMILL: Yeah. Two things I would...even though these are individuals who have incomes below the prescribed income level and they either don't have coverage or they're paying out of pocket for it, not all of them would qualify. [LB472]

SENATOR CRAWFORD: Okay. [LB472]

MARK INTERMILL: There may be some individuals in this number who are parents under 57 percent of poverty who would be eligible for the existing Medicaid program. It may be a fairly small number. I think the other question was, what percentage is likely to enroll is probably the more crucial question. In the fourth page of the handout is where I think we had the information about the experience of states that have expanded Medicaid and this be through 13 months. It starts out that...Arizona is the first one on that particular page, not Alabama. You can see what the change in eligibility has been in those states. The highest one was 76.89 percent, which was Kentucky. So that was...even at that high level it would still be less than 80 percent. Kentucky did an extraordinary job of outreach throughout their state. And that's, I guess I would say, based on our experience in terms of Medicaid enrollment I don't see that...I would be surprised if we had that same level of outreach. So I think that's what I would base it on, more the average number...average growth in the states as opposed to some of the more extraordinary. [LB472]

SENATOR CRAWFORD: So the 23 percent increase you have on this first page is based on similar states, similar expectations? [LB472]

MARK INTERMILL: When I tried to find a comparative state and looked at...one of the things I tried to look at is what was the proportion of the people who weren't covered entering the expansion base. The best comparator...I looked at Iowa, I looked at North Dakota, similar states in terms of their geography, their demography, their economy. But both of them had lower rates of uninsured going into the program. So what seemed to be the best comparator was just the aggregate nationwide number. And so that was also included, the 23.28 percent which produced the 54,675 number. [LB472]

SENATOR CRAWFORD: Thank you. [LB472]

SENATOR HOWARD: Are there other questions for Mr. Intermill? Seeing none, thank you for your testimony today. [LB472]

MARK INTERMILL: Thank you. [LB472]

SENATOR HOWARD: Our next proponent. Good afternoon. [LB472]

BOB RAUNER: Hello. Dr. Bob, B-o-b, Rauner, R-a-u-n-e-r, I'm testifying in behalf of the Nebraska Academy of Family Physicians in support of LB472. We're a representative organization that represents about 90 percent of Nebraska's family physicians, over 700 active members. The board of directors voted unanimously to support LB472. I'll skip what was said previously and address, for example, Senator Riepe's and Kolterman's examples about will doctors accept Medicaid. And I think it's important to look at why some do and some don't. The majority do, some don't, but they usually don't for very specific reasons. Five to ten years ago there was kind of a crisis in Lincoln and that had almost as much to do with translation services as anything else and also a managed...Medicare managed care company that was very difficult to work with. My day job I work with 12 independent family physician offices spread from Bellevue to McCook, include York, in your district. All of them are independent, all of them are patient-centered medical homes. We all accept Medicaid. We do not work with one of our particular managed care companies because they won't work with us on patient-centered medical home but will take the other product that's in Omaha and Lincoln because of that, because the other product does work with us. You said, well, we set a bar of cost reductions. And I would say, yes. And you said, 10 percent. I'd also say, yes, and I would say confidently, yes, because we've already done it. Our nine clinics that were on Aetna's Medicare managed care product, we have our 2014 results with our medical home pilot we did with them and our cost reductions happen to be 10 percent less. It's because our ER utilization was 47 percent less and our hospitalizations were 9 percent less. And I think what often gets missed in this is, well, will we just take a pay cut. Well, that's doing things the way we've been doing it for ten years and it's not working. You need to pay differently. So the fact that this is the Redesign Act is what's key. If you pay patients in a medical home to pay for the right things, you'll spend a lot less someplace else. What often happens with the uninsured is they go to the ER after it's too late. And a stroke could cost hundreds of thousands of dollars. The blood pressure medicine and a couple of visits to control that could be a couple hundred. And if you get them in at the right place, you save a lot of money. And that's essentially how patient-centered medical home works. Medicaid actually pays us a little more, not less, but we use that money to hire care coordinators and expand our office hours so people can get in. If we get them in and under control, whether it be their asthma, their blood pressure, whatever, then they don't end up in the emergency room getting things that are very costly and that would have been prevented. And so if we redesign Medicaid appropriately, yes, we can do it and we can serve the same number of people and probably for the same amount of money or even less money if we do it right. I think every

country in the world, they spend less than us but do better. Well, it's partly because we don't...the way our fee for service system is designed is inherently not conductive (sic) to taking care of chronic diseases and prevention. And if we could change Medicaid in the manner that would do this, we could do this. And most of what is in the redesign portions of the Medicaid Design Act are exactly what we've been doing for the last three years. So with that, I'll answer any questions. [LB472]

SENATOR HOWARD: Are there questions for Dr. Rauner? Senator Kolterman. [LB472]

SENATOR KOLTERMAN: Yeah. Thanks for coming. I know you've been a regular here over the last 30 days. Question that I have, the current Medicaid program, you're familiar with that? [LB472]

BOB RAUNER: Yeah. [LB472]

SENATOR KOLTERMAN: Is this a pilot project where you've had medical homes? Have you used that in the current Medicaid? [LB472]

BOB RAUNER: Yeah, it's been a...well, it started in 2009 with a bill that Senator Gloor introduced. And we had two clinics, a clinic in Kearney and clinic in Lexington. The Lexington clinic is one of our 12 clinics now. They did a pilot phase to try outpatients in a medical home, define what it is, run some numbers, and it worked. Then the current...the Medicaid director at the time, Vivianne Chaumont, added in that the new round would...that new managed care contracts would have to (inaudible) medical home. We also did a joint agreement with...under another kind of voluntary committee that Senators Gloor and Wightman ran over the last couple of years. And in that voluntary agreement every major insurer in the state would do at least ten pilots per year. Most of the insurers, except for one, followed through on that; that's the one we don't work with. And so we've done medical home contracts with several of our insurers: Arbor, Aetna Medicaid, Blue Cross Blue Shield. All of them are working out well. Some are too early to get full numbers but Aetna Medicaid was one of our first ones we started working with. And so that's why we have full 2014 year numbers to show that it's actually worked. [LB472]

SENATOR KOLTERMAN: Where I'm going with this is, is there any...do you know, is there anything that would prevent us from continuing to expand that in just our current Medicaid population? [LB472]

BOB RAUNER: Yeah, but it wouldn't work as well because what some people don't realize is the transientness of people on Medicaid. They're on Medicaid for six months sometimes and then

they're back off to noninsured again, then they're back onto Medicaid. It actually impairs our ability to do quality improvement because if they're on and off, we get them, they're controlled and they go off and they don't come in. And then they go back on and that may be when their complication happens. And so if people are constantly transitioning on and off, that's part of the problem. Part of this whole problem is you've got this big gap between the exchanges and Medicaid. And these people in the gap, those are the ones who are going to have these complications. And when they have those complications, then they're going to the ER. Then the hospital is going to get stuck (inaudible) care. And if they do get on Medicaid, then Medicaid is going to have to pay more for those people. So not included that uninsured, that's one of our biggest problems with our system. I...my personal opinion is, we need an all private system but we need one that covers everybody so we don't have this gap because that's when things get out of control and complications happen. [LB472]

SENATOR KOLTERMAN: And do you know if the exchange program, the federal exchange and our state exchange, which is a federal, is there any...has there been any pilot programs utilizing patient-centered medical homes on the exchange with any of the companies that are there,... [LB472]

BOB RAUNER: Right now it's left... [LB472]

SENATOR KOLTERMAN: ...because we have Blue Cross, Aetna? [LB472]

BOB RAUNER: Yeah, I think it's left up to the insurance product for the most part because of the exchange themself doesn't say that you have to do this. I think this bill though would make them do that. And so people, at least on Medicaid, would have to do that. I think we should expand that and go beyond just Medicaid because if it works for Medicaid it probably works even better for Blue Cross, for example, or UnitedHealthcare. The biggest problem we have in the clinic is the fact that right now we can't get everybody to participate. So it's hard to do things one way for half your patients, another way for the other half of your patients. And so what we need to get is a patient-centered home to be multipayer and more broad. I think that's the main solution. [LB472]

SENATOR KOLTERMAN: Okay. Thank you. [LB472]

SENATOR HOWARD: Senator Crawford. [LB472]

SENATOR CRAWFORD: Thank you for being here and thank you for your work on the pilot and for coming back and showing us those results so we can see...those are very powerful in

terms of seeing how that worked to figure out what it might look like if we expanded it. So I wasn't typing fast enough. [LB472]

BOB RAUNER: Okay, sorry. [LB472]

SENATOR CRAWFORD: So I wondered if you would repeat the cost savings and the ER change for me. [LB472]

BOB RAUNER: Yeah. And you could probably verify this with Carol LaCroix, she's our medical director at Aetna Medicaid right now or Deb Esser, who at the time helped design this, but she's now moved over to Blue Cross. It's 10 percent lower costs compared to our peers and it was the nine clinics that were part of this for the entire years, so it's those nine versus everybody else in the state. And the main reason is that our hospitalizations were 9 percent lower and the ER visits were 47 percent lower. There's broader stuff. They haven't given us approval to say everything because it's part proprietary but those are the things they've said we can say publicly. [LB472]

SENATOR CRAWFORD: Okay. Thank you. [LB472]

BOB RAUNER: I'd like to say more, actually, but we're limited. [LB472]

SENATOR CRAWFORD: Thank you. Thank you. This, and more. [LB472]

BOB RAUNER: Okay. Yeah. [LB472]

SENATOR CRAWFORD: Thank you. [LB472]

BOB RAUNER: Yeah. [LB472]

SENATOR HOWARD: Other questions for Dr. Rauner? Oh, Senator Kolterman. [LB472]

SENATOR KOLTERMAN: I've just got one other question. These nine clinics that you are working with, were they part of...were they private clinics or were they owned by the hospitals or...? [LB472]

BOB RAUNER: All 12 were private. [LB472]

SENATOR KOLTERMAN: Okay. [LB472]

BOB RAUNER: However, there's not a distinction between private and public or hospital owned. So Crete, for example, the clinic there is owned by Bryan Health System. They were one of the first level 3 patient-centered medical homes in the state and they're hospital owned. There's nothing about hospital owned versus independent that prevents you from being a patient-centered medical home so I think that's a false distinction. We actually are working now with trying to find ways to get small hospitals that have employed physicians. And there's also a misconception...the independent employed...there's a "U" shape in Nebraska, meaning most urban and in Omaha they're a majority employed. Lincoln is about 50-50. If you get medium-size towns like Columbus, York, most are independent. And you get the most small, again, then you start getting more employed again. But it works in all four environments and there are medical home programs in all four environments. [LB472]

SENATOR KOLTERMAN: Thank you. [LB472]

SENATOR HOWARD: Any other questions for Dr. Rauner? Seeing none, thank you for your testimony today. [LB472]

BOB RAUNER: Thanks. [LB472]

SENATOR HOWARD: For a show of hands, how many more proponent testifiers do we have? I see four. After proponents, we'll take a five-minute break. [LB472]

JIM OTTO: (Exhibits 41, 42) Good afternoon, Senator Howard, members of the committee. My name is Jim Otto, that's J-i-m O-t-t-o, I am a registered lobbyist for the Nebraska Restaurant Association and the Nebraska Retail Federation. And I'm here today on behalf of both associations in full support of LB472. Many Nebraska businesses will benefit from the passage of LB472. Most importantly, this bill will lead to healthier employees which will, in turn, make for a healthier and more productive work force. As we have heard today, it provides affordable healthcare coverage for Nebraskans that are at or below 133 percent of the federal poverty limit. I'd like to call your attention to the first handout that I sent out or is being passed out right now. And it just lists the various employers...industries in Nebraska that would benefit, that actually have employees that fall into this category. And obviously, restaurants are at the top of the list. But it's kind of surprising all of the other businesses that are on the list, including, if you go down the list, banking, colleges and universities, elementary and secondary schools, construction. It's just kind of surprising how many different businesses or industries have...it gives you the number of employees that would qualify. These numbers come from the U.S. Census Bureau through the American Community Survey. And LB472 provides for better

solutions for preventative healthcare. And this preventative healthcare, along with the affordability of health insurance for these employees will make for healthier work environments. This just gives you some perspective of the importance of passing of the bill related to employees and their health. It's also our opinion that passage of LB472 just makes basic economic sense for Nebraska businesses. Rejecting federal dollars hurts the Nebraska economy and has a negative effect on the business climate in our state. When Nebraska fails to draw down federal dollars to increase coverage through Medicaid some low-income workers will access premium subsidies on the exchange, thereby exposing Nebraska employers to greater penalties under the Affordable Care Act's shared responsibility provisions. A recent Jackson Hewitt study concluded that the federal tax penalties to employers could total nearly $1.5 billion each year in the states that have not yet expanded Medicaid for adults. The study also concluded that the annual penalties for employers in Nebraska would range from $11 million to $16 million. The last point I'd like to make is that the surrounding states of Iowa and Colorado have passed Medicaid expansion as provided by the Affordable Care Act. It's important for Nebraska to stay competitive and provide the most business friendly climate we can. We don't want employees to be forced to search for jobs and ultimately move to Iowa or Colorado just so that they can have affordable healthcare. I'd just like to thank you and the committee for your time. The second handout summarizes in bullet points many of the points that have been made. And I'd urge you to move LB472 to General File. Thank you. [LB472]

SENATOR HOWARD: Thank you, Mr. Otto. Senator Riepe. [LB472]

SENATOR RIEPE: Mr. Otto, thank you. My question would be, is it the underlying motive of the restaurant industry to be able to exit the business of being an employer who provides health benefits to its employees so that you're then able to pass that off onto the taxpayers of the state? [LB472]

JIM OTTO: Any employer, if they look at the numbers...I don't know if this a direct answer to your question, Senator. You know the healthcare industry much better than I do. But if an employer actually looks at the numbers and looks at the bottom line and what is offered by Medicaid expansion and makes their decision based on profit, they would be in favor of it. [LB472]

SENATOR RIEPE: I appreciate your candor. Thank you. [LB472]

SENATOR HOWARD: Other questions for Mr. Otto? [LB472]

SENATOR COOK: I guess I want to clarify it. When you say be in favor of it... [LB472]

JIM OTTO: In favor of Medicaid expansion. [LB472]

SENATOR COOK: In favor of Medicaid expansion and not socializing the risk, per se, of providing healthcare? [LB472]

JIM OTTO: Well, I would...I guess I think the senator would say that it is socializing the risk, so. [LB472]

SENATOR COOK: Oh, okay. I just wanted to clarify that any business that you were talking about "it," the expansion of Medicaid. Thank you. [LB472]

SENATOR HOWARD: Thank you, Mr. Otto. [LB472]

JIM OTTO: Thank you. [LB472]

SENATOR HOWARD: Good afternoon. [LB472]

JON BAILEY: (Exhibit 43) Good afternoon. Good afternoon, Senator Campbell, Senator Howard, members of the committee. My name is Jon Bailey, that's J-o-n B-a-i-l-e-y, I'm the director of the rural public policy program at the Center for Rural Affairs in Lyons, Nebraska. And today we provide you testimony in support of LB472. We support LB472 as we did LB887 in 2014 and LB577 in 2013 for the same reasons we supported both of those bills and for all of the supporting reasons you heard today. LB472 is critical to rural Nebraska for the thousands of rural Nebraskans that are in need of affordable healthcare, for our healthcare infrastructure, and for all of...treating all of the healthcare disparities that are apparent in all rural communities. But today we come before you in support of LB472 for another reason. And it's a reason connecting LB472 to another major issue that you all are facing this year and that is the Corrections issue. Today in conjunction with Nebraska Appleseed we released a report entitled "LB472 and Leveraging Federal Dollars to Reform Corrections", a report showing the benefits of a redesigned Medicaid program to our Corrections program, our Corrections population, and the state's taxpayers. A copy of that report is attached to my testimony that you received. Basically to summarize this report, we used Nebraska Corrections data, findings from other states, findings from research on connections between Medicaid and health insurance coverage, necessary treatments, and the criminal justice system and criminal justice outcomes. In summary, our report shows four basic things: Number one, a lack of mental health services and substance abuse treatment is a primary cause of reoffending and recidivism and a return to jail or prison. A redesigned Nebraska Medicaid program such as proposed in LB472 would help, in our estimate, nearly 400 people per year from returning to prison. That reduction in the number of people

reoffending and returning to prison would save the state, by our calculation using the average figure per offender from the Department of Corrections, would save the state of Nebraska gross about $11 million in one year. A redesigned Nebraska Medicaid program could save additional state and county dollars that have already been invested or will be invested in Corrections reform. We did not go into the local jail population--you heard that earlier from the county commissions--but you can add that on top of this of savings to the state prison, state Corrections program. Obviously, LB472 will not solve all of the issues you will be facing this year on Corrections. It's a small piece of the Corrections problem, but it's an important piece. It's an important piece for a population that is in need of very specific treatment, very specific...the lack of those treatments affect their ability to stay out of the Corrections population, to stay out of prison. Reducing the numbers of people in jail, reducing the recidivism rate for prison is critical. And you all know that. And it's one of the reasons we have now the problem that we're facing in our Corrections system. Obviously, the research we used in the report...and I lead you to all of that research in the report. Research clearly shows recidivism can come from a lack of health coverage. There's a consensus among national and Nebraska research and analysis that mental health and substance abuse treatment are what many in the Corrections population need. Examples from national research and from other states clearly show linking people to coverage and necessary treatments work in reducing criminal offenses and recidivism. Since traditional Medicaid is unavailable to most of the correctional population and health insurance is unavailable to most, Nebraska needs LB472 to make these necessary connections. Nebraska taxpayers, public safety, as well as those in the Corrections population will be the beneficiaries. I think one of the interesting parts of our report, we outline some of the steps you have already taken in past years to provide these treatments yet you haven't taken the path to get most of the people who need these treatments to get the treatments and to stay out of the Corrections populations. So for all those reasons offered, we support LB472, ask the committee to advance it to the full Legislature. I'd like to thank Senator Campbell and all the other sponsors of LB472 for keeping up the good fight on this critical issue to so many Nebraskans. So thank you. [LB472]

SENATOR HOWARD: Thank you, Mr. Bailey. Are there questions? Seeing none, thank you for your testimony. [LB472]

JON BAILEY: Thank you. [LB472]

SENATOR HOWARD: Our next proponent? Good afternoon, Father. [LB472]

KEITH NELSON: (Exhibit 44) Good afternoon. Good afternoon, Senator Campbell and my own Senator Cook, who's from my district, and all the members of the Health and Human Services Committee. It's a privilege for me to be here and it's the first time I've ever had a opportunity to participate at this level of the democratic process. And so my comments today will, hopefully,

reflect my participation in the democratic process as well as my membership in the faith community. The first thing I want to... [LB472]

SENATOR HOWARD: I'm sorry. Will you state your name and spell it for the record? [LB472]

KEITH NELSON: Oh, give you my name and...that's right. My name is Keith Nelson, K-e-i-t-h N-e-l-s-o-n, and I'm a retired Lutheran clergyman who is a member of Augustana Lutheran Church in Omaha. And I come today on behalf of OTOC, Omaha Together One Community, a faith-based organization that's a community organizing and works with a variety of different organizations in the greater Omaha area on issues of interest to the community. I guess what I want to do first is to ask you to support LB472, the Medicaid Redesign Act. So I'm here asking for your support. Secondly, I would like to ask a question for you to ponder yourselves. As a citizen of Nebraska, where we pride ourselves on being the good life state, is it just, is it helpful, is it fair to deny many low-income, working class citizens access to Medicaid or to insurance subsidies? Now the approach that I'm going to take for my comments are not reflected in the document that I have handed out. That actually is a guide of information that we will use as OTOC in our educational process, trying to inform other clergy, other religious, and other members of the faith community on the importance of LB472 and what it means and what the elements are that they need to know so that they can be supportive of their senators in this Legislature as the votes are taken, both in committee as well as on the floor, should this be advanced as I hope it will be. What I would like to do is to reflect on a story that some of you, if not all of you, may be familiar with. I don't make the assumption that you are, but I hope that many are. And that is the good Samaritan story in the New Testament. And I use that story because I really believe it's the story of the compassionate stranger. And the reason I'm choosing to use that story is because the compassionate stranger was really confronted by the same kinds of issues that you are confronted in working with the redesign of the Medicaid program. In other words, the stranger came along and he saw a person beside the road who was in need. In other words, he had the vision to see a need. And though he had no experience with it, he didn't know how best to solve this problem. It was complicated. There were no such things as hospitals, there were no such things as ERs, there were no such things as ambulances, there were no such things as emergency room doctors. What do I do, here is a person in need? Now two others had preceded him and not noticed or if they noticed, chose to disregard, walk by. Who cares? Not my problem. But the compassionate stranger did notice and he said, I'm going to deal with this issue. I'm going to see to it that this person is cared for. I'm going to see to it that there is a caregiver. I'm going to see that the caregiver is compensated for the care that they provide. And I'm going to take personal responsibility to see that a system is put into place, one that I have to be responsible for and held accountable for, to see to it that a person in need's needs are met. The redesign bill that is before you is one that gives you the capacity as legislators to work cooperatively with the new Governor to discover ways to address very real needs in this state, the answers to which are not only complicated but not necessarily clear. But you have heard lots of

statistics, you've got lots of information, and now the ball is, in effect, in your court. And you get to work with the Governor, should you choose to do so, to see to it that the needs of citizens of Nebraska are met. Thank you very much. [LB472]

SENATOR HOWARD: Thank you. Are there questions? Senator Riepe. [LB472]

SENATOR RIEPE: Father or pastor, whatever, I have a question. What's the role of the church? The church used to be very involved in actual delivery of a lot of care families is...and I'm reminded of a biblical quote as well that says: Give unto Caesar what is Caesar's and give unto God what is God's. And so, you know, we're talking about Caesar here being the state's money as opposed to maybe God's money or the church's money or whatever. There's a role...there's got to be some balance here. [LB472]

KEITH NELSON: Yep. I'll try to answer it very quickly and succinctly as I know how. Number one, isn't it ironic that Methodist Hospital is called Methodist, that Bergan Mercy is called Bergan, that Immanuel Hospital was called Immanuel, that Lutheran Hospital was called Lutheran. The church is involved, has been involved, and continues to be involved in seeing to meeting the needs of individuals in a variety of ways. And so we have a role that we cannot abandon in speaking out on behalf of the meeting of needs in a way that can be met. And the reason we now work with you as a government entity as we have now for many, many, many years is that the need is far greater than the nonprofit, not-for-profit faith community can address on its own. It is a shared responsibility as citizens that we understand we are members of a community, not just of the faith community, but of the greater community. [LB472]

SENATOR RIEPE: With all due respect, Pastor, I don't think that the Methodist or the Bergan Mercy or the Immanuel or any of those, the church is...and I was there a long time. I don't remember any checks coming from any one of them. They left their name on them from historical standpoints, but there was never any cash flow that came that way. [LB472]

KEITH NELSON: I have no knowledge. I do know, however, that it was the initiative of asking the right questions and having the right vision that saw to it that healthcare was being provided by the society to its members. [LB472]

SENATOR RIEPE: True. Thank you. [LB472]

SENATOR HOWARD: Other questions for the testifier? Seeing none, thank you for your testimony today. [LB472]

KEITH NELSON: Thank you so much. [LB472]

SENATOR HOWARD: Our next proponent? Good afternoon. [LB472]

JAMES GODDARD: (Exhibit 45) Good afternoon. My name is James Goddard, that's J-a-m-e-s G-o-d-d-a-r-d, and I'm director of the Health Care Access Program at Nebraska Appleseed, here today to testify in support of LB472. We have some written remarks that are being handed out but I'd rather spend my time with the committee today talking a little bit about fiscal implications and a few other questions or comments that have come up. Looking at the fiscal note, without analyzing any of its shortcomings, this is a good deal for our state. There's a savings in the biennium that's clear. And something that hasn't really come up today is the more than $2.1 billion, billion, according to the fiscal note, that would be returned to Nebraska only if we take up LB472. To be clear, these dollars are not being saved if we fail to pass this bill. The reason these dollars are flowing out is because of the structure of the Affordable Care Act and it paying for itself. So these are being taken out of our state, they're being taken out of our communities, and the only way to get them returned is by passing this bill and that will stimulate our economy and our communities. There are also several areas of savings in the note, the state disability program, prescription drug assistance, behavioral health funding, counties, and Corrections. So we know that we're going to see these savings and with our share that we have to put in, we would also cover thousands of people and close the coverage gap, folks who are locked out of our healthcare system if we don't do anything about it. That's taking the note for what it says. Looking a little closer, there are a few things that I think it's missing. We already heard from Jon Bailey about Corrections. The report that we put out today shows $11 million annually, potentially, in savings just from recidivism. Closing the coverage gap could be a key to paying for mental health and substance abuse treatment for those on parole and probation. And if we're serious about reforming the Corrections system and moving people out or preventing them from going in, we have to pay for those services. This is a way to get 90 percent of the cost paid for. That's not in the fiscal note. We also...or it's a very small amount, $750,000. We also don't see any savings for patient-centered medical homes or wellness activities. More importantly, I want to just draw your attention to the administrative costs in the note: $18 million dollars in year one; $21 million in year two. This is a little difficult for me to understand because now the current Medicaid staff, from top to bottom, is 482 individuals. This would add 435 additional people, effectively doubling the size of the Medicaid Department. That, to add, according to them, 77,000 individuals. There are only 235,000 individuals on the program now so it's a little hard to see that administrative costs could be even close to that range and, in fact, it was 30 percent less than administrative costs in LB887's fiscal note. So even considering some of the questions about the projects and the savings the note doesn't account for, we need to view this with common sense. And that is that this bill is a wise policy for Nebraska. I don't know if people have seen the Milliman report yet. I assume someone will come behind me and talk about that like we had last year, which was fun. But I want to talk a little bit about that report that was released yesterday at

around 4 p.m.; Milliman provided an additional update to their original 2010 report. And as we've seen with some of their prior reports, there's some serious flaws with some of their assumptions. The main one I want to draw your attention to is Milliman assumes that LB472 will provide premium support to help pay for the cost of employer-sponsored insurance and that that would cover 46,000 additional people by 2018. The problem is, there is no premium support for employer-sponsored insurance in the bill. It's not in there. It was in LB887 so it appears that Milliman is either looking at last year's bill or making assumptions about what is in that bill, but that language simply isn't there. There are other concerns about some of the assumptions, particularly around their projections for how many people would be medically frail or have a chronic condition. They estimate it's more than one in ten people would have that. And people with those conditions are drivers of cost. There's some issues with that. I'd love to talk to the committee more about that report when we have a little bit more time. In short, this 2015 iteration appears to have similar flaws as the other reports and I would read it, if at all, with a certain measure of skepticism. Quickly, we talked a little bit about provider adequacy today and we agree it's totally critical to have a sufficient provider network. But we're already paying for the care for many of these folks, just in inefficient ways. LB472 reorients our system using innovation and also would rely on the private market where people can go see non-Medicaid providers if they're between 100 percent and 138 percent of poverty. Moreover, LR22 and LR422 are resolutions from the past two years that are working to transform our healthcare system over the next 15 years to ensure, in part, that we have an adequate provider network. So ultimately, it does nothing for our provider network to simply shut thousands of people out of the system. I can see that I'm almost out of time. The last thing I would say is, Senator Kolterman, you asked a question about the Arkansas model. I know a little bit about that. It uses premium assistance for everyone in the new population and LB472 has a similar component to using premium assistance, it's just split up a little bit differently. The outcomes I know so far are good. There's been 11 percent reduction in uninsured in Arkansas after this was put into place. So in conclusion, LB472 is a wise policy. It would bring back billions of dollars to our state, it would explore innovation, it would close the coverage gap, and would make healthcare make sense in Nebraska. Thank you. [LB472]

SENATOR HOWARD: Thank you, Mr. Goddard. Are there questions? Senator Crawford. [LB472]

SENATOR CRAWFORD: Thank you, Senator Howard. So I also was struck when I saw the increase in positions that were assumed in the report so I just want to make sure I have this right. You said there are 480...would you just repeat how many staff are currently there? [LB472]

JAMES GODDARD: As I understand it, 482 total staff. That's not just caseworkers, that's administrators, policy analysts, top to bottom Medicaid. [LB472]

SENATOR CRAWFORD: And that would be for how many people, do you know how many that's for? [LB472]

JAMES GODDARD: It's approximately...for Medicaid it would currently be about 235,000 people. [LB472]

SENATOR CRAWFORD: Okay. [LB472]

JAMES GODDARD: And the addition is 435 staff to add 77,000 people. [LB472]

SENATOR CRAWFORD: All right. Thank you. I appreciate that. [LB472]

JAMES GODDARD: My pleasure. [LB472]

SENATOR HOWARD: Other questions? Senator Crawford. [LB472]

SENATOR CRAWFORD: So one discussion we haven't had yet, I don't think, and I probably should have asked Mr. Otto this question but you're sitting in front of us now, so. So I think one of the other implications of the bill for low-income workers would be to address the issue that some are having now where they're finding their hours cut to 30 hours. Do you...because some of those lower-income workers would get paid by Medicaid expansion and that coverage would then make sure they're covered. And there wouldn't be that pressure on the employer to reduce hours because I don't think they get that penalty if the person is actually covered by Medicaid expansion. Is that true? [LB472]

JAMES GODDARD: That's correct. As I understand it, they would not face the penalty if the person is covered by Medicaid expansion. I'm not sure I really can speak to the rest of your question. I'm sorry. [LB472]

SENATOR CRAWFORD: All right. That's all right. Thank you. [LB472]

SENATOR HOWARD: Any other questions? Senator Riepe. [LB472]

SENATOR RIEPE: Thank you, Senator. I want to follow up on Senator Campbell's question. You said we have 482 currently in HHS. Is that correct? [LB472]

JAMES GODDARD: Yes. From top to bottom, caseworkers, administrators, policy analysts. [LB472]

SENATOR RIEPE: And these...they're taking or carrying 235,000 enrollees? [LB472]

JAMES GODDARD: Yes, correct. [LB472]

SENATOR RIEPE: And we're going to double the number of workers to 435 to take an added 77,000. That number seems strange to me. [LB472]

JAMES GODDARD: That's exactly my point, Senator. That doesn't make sense that you would need to, effectively, double your staff to take care of such a small amount of individuals. And so I'm raising the point that $18 million in year one and $21 million in year two for administrative cost seem really surprising to me. [LB472]

SENATOR RIEPE: Me too. [LB472]

SENATOR HOWARD: Any other questions? Seeing none, thank you for your testimony today. [LB472]

JAMES GODDARD: Thank you. [LB472]

SENATOR HOWARD: Is there anyone else in the hearing room wishing to testify as a proponent? Seeing none, Brennen, are there items for the record? [LB472]

BRENNEN MILLER: (Exhibit 46) Just one more, Senator, thank you. A letter in support from the Nebraska Nurses Association. Thank you. [LB472]

SENATOR HOWARD: Okay. And we will take a five-minute break. [LB472]

BREAK

SENATOR HOWARD: All right. Before we take our first opponent testifier, Brennen, are there items for the record? [LB472]

BRENNEN MILLER: (Exhibits 47, 49) Yes, Senator. Thank you. Two more support letters from Nebraska Child Healthcare Alliance and the Nebraska Pharmacists Association. Thank you. [LB472]

SENATOR HOWARD: Thank you. So we'll open the floor for opposition testimony for LB472. Good afternoon. [LB472]

DOUG KAGAN: (Exhibit 50) Good afternoon. My name is Doug Kagan. That's K-a-g-a-n, and I represent Nebraska Taxpayers for Freedom. Our objections to LB472 are many. Obamacare has caused anarchy in the medical healthcare system nationwide. Therefore, we see no valid reason to in any way link our Medicaid system to it. Nebraskans already spend millions on Medicaid and other medical benefit programs with no cost controls evident. Medicaid eligibles increased by 11 percent from fiscal year 2010 to fiscal year 2015 estimated. The average monthly cost for children services rose by 27 percent in 2013. And those are statistics from the Department of Health and Human Services. The proposed additional costs depend on the federal government reimbursing us at higher than 90 percent rates for several years eventually ratcheting down to 90 percent however no guarantee that this waiver federal matching funds will ever materialize. Recall that the federal government pledged to reimburse states for added costs stemming from No Child Left Behind and then reneged, leaving Nebraska taxpayers the unfortunate duty of paying the total costs. If the federal government reneges on this new pledge, state senators never would throw thousands of new residents off the Medicaid system, thus yoking taxpayers with millions in annual bills. There is one LB472 stipulation supposedly to make the new Medicaid enrollees cost conscious. However, we saw in the bill little inducement for them to behave in this manner. It is ridiculous to assume that the state successfully will use the legal process to collect owed monthly premiums...no guarantee of a sufficient motive for the covered to engage in wellness activities. This plan does not have a credible incentive for moving the new Medicaid clients into the private marketplace. There is an assumption but no guarantee that a large number of additional healthcare providers will abandon their present doctor-patient models and incorporate this plan with its model and regulations void of accompanying evidence or proof of previous success. The state has no framework in place now to implement both a current and new payment model. This legislation does not expressly prohibit in addition these expanded Medicaid services for illegal aliens. We suggest alternatives that would reach objectives that this bill intends to accomplish: untaxed state health savings accounts; permit groups of citizens to pool together to buy insurance policies; permit small businesses to pool together to obtain lower insurance rates for their employees; offer tax credits to the poor to purchase health insurance; allow wellness tax credits of $500 or more to individuals and employees who follow a specific wellness regimen; reform our state legal system to reduce medical malpractice liability offering as one defense a professional following "best practices"; permit medical licenses to apply across state lines so that a physician could work remotely from another state; allow the chronically uninsurable to gain access to coverage in a high-risk state or multistate pool; safeguard

individuals with preexisting medical conditions from discrimination against purchasing health insurance by bolstering a state high-risk pool; lobby Congress to allow purchase of policies across state lines. The Intermountain Healthcare system in Utah offers private alternatives in several states that are less costly than Medicaid programs. We should examine this alternative. These proposals would offer individuals, not government, control over their insurance and increase competition among insurance companies to drive down costs. These options would encourage personal responsibility; benefit employers who want to offer employee insurance; and focus on prevention and wellness, healthy behaviors, competition, consumer choice, and cost reduction in the private marketplace. Moreover, these solutions would not make additional Nebraskans dependent on more...dependent upon government. Thank you. [LB472]

SENATOR HOWARD: Thank you, Mr. Kagan. Are there questions for the...Senator Riepe. [LB472]

SENATOR RIEPE: Thank you, Senator Howard. Mr. Kagan, how long have you been following this expanded Medicaid... [LB472]

DOUG KAGAN: For several years now. And we've looked at...and I wish I had my documentation with me but we gave it all away at state senators' offices this morning. We followed what's happening with these HSAs, the health savings accounts, and these insurance pools that have been used in other states, and they are very successful. There are very successful alternatives. [LB472]

SENATOR RIEPE: Okay. Thank you. [LB472]

SENATOR HOWARD: Senator Cook. [LB472]

SENATOR COOK: Thank you. And thank you, Mr. Kagan. Does not an HSA assume that a person has savings into which...they would place into a healthcare (sic) savings account? [LB472]

DOUG KAGAN: They would have to put some money into the health savings accounts. [LB472]

SENATOR COOK: Okay, because the testimony that we've heard the last three years are people who by and large aren't able to have savings of any kind. So I guess that's something that I don't know that you've thought about. [LB472]

DOUG KAGAN: Well, there's different varieties of health savings accounts. And I can't point to any particular one, but some of them are subsidized by the state. So the customers or clients would not have to pay just...only their money into the health savings account. [LB472]

SENATOR COOK: Okay, thank you. [LB472]

SENATOR HOWARD: Any other questions for Mr. Kagan? I just have one. While the legislation--and this may be more appropriate for Ms. Miller who is, I believe, right behind you--the legislation doesn't expressly prohibit expanded Medicaid services for undocumented individuals, but I believe there are only portions of our Medicaid plan that allow undocumented individuals to receive those services. So they would not be eligible for this expansion is my understanding. [LB472]

DOUG KAGAN: Okay, well, when we read the bill, when we read the actual text of LB472, we didn't see a particular specific disclaimer in that bill. [LB472]

SENATOR HOWARD: Certainly, and I believe Ms. Miller may be able to clarify that portion of it, so she's right behind you. [LB472]

DOUG KAGAN: Okay. [LB472]

SENATOR HOWARD: But thank you. Anything else for Mr. Kagan? [LB472]

DOUG KAGAN: Thank you. [LB472]

SENATOR HOWARD: Seeing none, thank you. Good afternoon. [LB472]

COURTNEY MILLER: (Exhibit 51) Good afternoon. Senator Campbell, members of the Health and Human Services Committee, my name is Courtney Miller, C-o-u-r-t-n-e-y, Miller, M-i-l-l-e-r. And I am the deputy director of programs for the Division of Medicaid and Long-Term Care. I am here to testify in opposition to LB472. The Nebraska Medicaid program currently provides coverage for low-income individuals in specific categories. In fiscal year 2014, Nebraska Medicaid covered on a monthly average over 235,000 individuals at a total cost of more than $1.8 billion. The Medicaid program is the single largest program in state government. It is also one of the fastest-growing programs in the state budget. The biennial budget approved in 2013 by the Legislature increased Medicaid spending by $228 million in General Funds alone, an amount larger than many states' agency budgets. When combined with the federal matching funds, which are also taxpayer dollars, the Medicaid budget increased by $433 million in the last

biennial budget in large part due to the implementation of the Affordable Care Act. My testimony today is very similar to the testimony you heard last year opposing LB887. Under both bills, Nebraska Medicaid would be required to cover a new optional category of adults up to 133 percent of the federal poverty level. The department estimates that the expansion under LB472 will result in a little over 127,000 new Medicaid eligibles through fiscal year 2020 with a cost of direct services of $3.3 billion. The department commissioned an independent actuarial analysis of LB472 through the Milliman company. Milliman's fiscal analysis of Nebraska's expansion of the Affordable Care Act under LB472 is based on actual costs incurred by other states rather than the projected data of previous analysis. In addition, Milliman has found no states that have realized Medicaid expansion enrollments lower than the state projections. We were happy to provide the draft Milliman report to the Legislative Fiscal Office at their request so they would have it over the weekend which was prior to the review by the Governor. The department has since requested an updated report to include fiscal year 2021 to provide a comparative time period to previous reports. This has been provided to LFO as well and it has been published on our public Web site. As a result of LB472, nearly one in five Nebraskans would be enrolled in Medicaid. Even with initial federal support under the Affordable Care Act, ACA, federal funds will decline by 10 percent by the end of the next four years shifting a huge burden onto the state budget. The uncertainty in the federal funding of the Medicaid program is clear. Our state is currently dealing with the General Fund impact in the Medicaid program due to the federal government's change in our state's federal match rate, or our FMAP. LB472, much like LB887 proposed in 2014...Medicaid expansion is there but at a higher cost. The optional premium assistance program proposed in LB472 requires Medicaid to pay not only private insurance premiums for recipients but also to provide additional wraparound benefits to pay all deductibles and copays. Premiums for private insurance are based on provider rates which are significantly higher than Medicaid provider rates making LB472 not only an expansion of Medicaid but a very costly expansion. The administrative duties created under LB472 to the department are significant. The administrative costs to develop, implement, and administer the additional waiver requirements of LB472 are in excess of $10 million in the first two years. These costs, along with the administrative costs associated with enrolling new recipients, total over $50 million in the first two years alone. Through 2020, these costs exceed $140 million. It is important to keep in mind that these administrative costs are not funded with the 100 percent federal dollars but at a 50 percent match rate with the state. Many providers either limit the number of Medicaid clients they see or will refuse to see any Medicaid clients. Expanding enrollment in Medicaid will exacerbate this problem. Access to care issues always add pressure to increase provider rates which would further increase the cost to the state budget. Finally, the Centers for Medicare and Medicaid Services, CMS, has stated that it will grant a limited number of demonstration waivers which includes the waiver the department is directed to apply for under the bill. CMS has also stated that such waivers will only be effective until December 31, 2016. CMS is approaching this untested territory with limited and very short approval periods, in essence acknowledging the risk involved. There is a significant cost involved with piloting this program with no guarantee of

either initial or ongoing federal approval. For all the reasons stated, the department opposes LB472. I'm happy to respond to any questions you may have. [LB472]

SENATOR HOWARD: Thank you, Ms. Miller. Before we get started, I have not seen the Milliman report. I'm looking on the Web site now and I can't find it. Where is it? [LB472]

COURTNEY MILLER: Okay. I can have someone send you the link. I...where exactly it is I'm... [LB472]

SENATOR HOWARD: Yeah, because I just searched your site for the word Milliman and it's not coming up. [LB472]

COURTNEY MILLER: Okay. Well, I'm happy to find that and send you the link. [LB472]

SENATOR HOWARD: And so the department commissioned the Milliman report? [LB472]

COURTNEY MILLER: Yes. [LB472]

SENATOR HOWARD: And what was the cost of that? [LB472]

COURTNEY MILLER: I do not know the cost, but I can get you that information. [LB472]

SENATOR HOWARD: I would love that. Thank you. I know last time we spent over $40,000 on that of taxpayer funds to do the same report a year later. Are there any questions for Ms. Miller? Senator Riepe. [LB472]

SENATOR RIEPE: I have a quick question. Your title...or you're from the Division of Medicaid and Long-Term Care. We saw in the paper, like everyone else, that there has been a new director hired. Is that director over Medicaid and Long-Term Care or just on Medicaid? I thought the article in the paper, Omaha World-Herald, said Medicaid. I don't remember seeing long-term care. Is that right? [LB472]

COURTNEY MILLER: The new director begins March 9 and it will be for Medicaid and Long-Term Care. [LB472]

SENATOR RIEPE: Okay, okay. [LB472]

COURTNEY MILLER: Yes. [LB472]

SENATOR RIEPE: Okay, thank you. I'm just... [LB472]

SENATOR COOK: That's one job. [LB472]

SENATOR HOWARD: Senator Kolterman. [LB472]

SENATOR KOLTERMAN: Thank you, Senator Howard. I have a question. You're familiar with the Affordable Care Act, I assume. And under the Affordable Care Act, people can apply for coverage through the exchange if they're between 100 and 400 percent of poverty and expect to get some form of help. Do you know, is there any way we could--as a state--could adjust that so that--and this is maybe...I guess I'm asking because you're more familiar with waivers and things of that nature--where we could adjust and pick up the lower end population and not go so far as 400 percent, because I...personally believe that's a real flaw in the system. I just wondered if you know if any state that's looked at doing anything like that or if that's charting new territory as well? [LB472]

COURTNEY MILLER: Unfortunately, I don't have an answer for that. I am one of three deputy directors. And I'm over program...the benefit package. And Ruth Vineyard, my colleague, is over eligibility initiatives. [LB472]

SENATOR KOLTERMAN: Okay. [LB472]

COURTNEY MILLER: So she would...I can follow up and have her answer that question for you. [LB472]

SENATOR KOLTERMAN: I'd just be curious because, I mean, the population we're talking about, in my opinion, are more vulnerable than the ones that are at 400 percent of poverty. Some might dispute that. But just thinking maybe that's another solution to some of our challenges. [LB472]

COURTNEY MILLER: I'll certainly have her follow up with you. [LB472]

SENATOR KOLTERMAN: Thank you. [LB472]

SENATOR HOWARD: Senator Crawford. [LB472]

SENATOR CRAWFORD: Thank you. I was going to ask when the report got sent to the committee, but I think... [LB472]

SENATOR HOWARD: It wasn't sent. [LB472]

SENATOR CRAWFORD: ...it wasn't sent to the committee? I don't believe so. How many of the Milliman reports have we done to analyze the cost of possible expansion? [LB472]

COURTNEY MILLER: That predates me, so I believe the last couple of years. They've had the historical knowledge and information on Nebraska. [LB472]

SENATOR CRAWFORD: Right. I think maybe this is our fourth. And I may not have been here for all of them. (Laugh) I think I've been here for...I think this is our fourth. [LB472]

COURTNEY MILLER: That sounds reasonable. [LB472]

SENATOR CRAWFORD: I think so. I think this is our fourth. And I guess when we get these reports from Milliman then we always have to spend the next few months correcting the bad assumptions in this report like 80 percent--and that's their average--like, that doesn't make any sense given what we know about healthcare programs that that would be an average expected enrollment. That's just a bad assumption. And I guess...and we've seen this again and again. So my question is, why do...why are we paying taxpayer dollars for these reports that are poor quality? [LB472]

COURTNEY MILLER: Well, we believe that...we know that Milliman made assumptions in prior years based on something that had not been done before. And we know that this year it was based on other states' actual experience in their actuarial firm. [LB472]

SENATOR CRAWFORD: So you think that 80...and we can check this out, but if it's based on other states' experience, I find it hard to believe that 90...80 and 90 percent enrollment is based on other states' experience. I just find that very hard to believe. But we'll be able to check that out. I mean, is that what you would expect, 80 to 90 percent enrollment, based on your discussions with other Medicaid people in other states? [LB472]

COURTNEY MILLER: Yes, but with my discussions with other Medicaid directors and our all-state calls is that they are experiencing higher than anticipated rates. [LB472]

SENATOR CRAWFORD: But that's not necessarily 80 to 90 percent...higher than expected. All right. Well, I guess my other question then...the other assumption--and we've talked about this already--was the assumption that we would have to add 435 more people and which...that's pretty close to double the number of people in the division and only to add...it's your higher rate that's 77,000 people. And whereas right now you have about half that covering 235,000 people. And that seems like a bad assumption on its face. But when you add to it that these new people we're bringing in are likely less challenging than some of our existing people, because the people in our system now that cost the most and require the most coordination are people who have long-term care needs or disability needs that are...those are the people that are on our system now. So it should take...why wouldn't it take less people per Medicaid recipient for this new population than the current staff per person that we have now? [LB472]

COURTNEY MILLER: Well, I know that by adding the waiver services, that that's essentially a new program. And so the current staff wouldn't have the subject matter expertise to administer that benefit of the wraparound benefits and of the waiver package. I'm not sure at this...right now of what that exact number is to say if that's correct or not. But we can certainly follow up with that. [LB472]

SENATOR CRAWFORD: I'd appreciate that, because it would seem less, especially if you have, again, the less complicated population. I appreciate some explanation of why that would be so...such a high number per person that you're bringing in. [LB472]

COURTNEY MILLER: Absolutely. [LB472]

SENATOR HOWARD: Are there other questions for Ms. Miller? [LB472]

SENATOR COOK: I have a question. [LB472]

SENATOR HOWARD: Senator Cook. [LB472]

SENATOR COOK: Pretty basic question for somebody with your level of expertise: why was our FMAP percentage federal match rate dropped? [LB472]

COURTNEY MILLER: Okay. There are several factors that go into the FMAP determination. And essentially in a nutshell is, as the economy gets better, the FMAP rate goes down. [LB472]

SENATOR COOK: That's the only reason that Nebraska's went down? [LB472]

COURTNEY MILLER: Like I said there are several factors and one is based on the economy. I can follow up with you on the exact... [LB472]

SENATOR COOK: You don't know the other ones right now? [LB472]

COURTNEY MILLER: Not right off the top of my head, no. [LB472]

SENATOR COOK: Okay, thank you. [LB472]

COURTNEY MILLER: I know that essentially it's based on the economy. [LB472]

SENATOR COOK: The...our local economy or the national economy? [LB472]

COURTNEY MILLER: The Nebraska economy. [LB472]

SENATOR COOK: Oh, okay. Thank you. [LB472]

SENATOR HOWARD: Ms. Miller, can you tell me, what's our current FMAP? [LB472]

COURTNEY MILLER: Our current FMAP is 53.27 percent. [LB472]

SENATOR HOWARD: Okay. And what would be the FMAP for this new eligibility category? [LB472]

COURTNEY MILLER: The FMAP for the new... [LB472]

SENATOR HOWARD: The new...under LB472, what would be the FMAP there? [LB472]

COURTNEY MILLER: Under the new population it would be the percentage that's incorporated at the time that it's implemented. [LB472]

SENATOR HOWARD: So what do you think that would be? [LB472]

COURTNEY MILLER: So between 100 and then the 90 percent at the end, you know, depending when the implementation date is for that year. [LB472]

SENATOR HOWARD: Okay. So 100 and 90 percent sounds quite a bit higher than 53.27 percent. Would you agree? [LB472]

COURTNEY MILLER: Well, 100 is higher than the 53.3, yes. [LB472]

SENATOR HOWARD: Certainly. And so when we consider this new population and the FMAP that's being offered for this new population, even at its floor it's significantly higher than our current matching rate. Is that...do you agree? [LB472]

COURTNEY MILLER: I'm sorry, can you repeat the question? [LB472]

SENATOR HOWARD: So even at its floor of 90 percent, the FMAP that's being offered with this new population is significantly higher than our current matching rate. [LB472]

COURTNEY MILLER: For the new population, yes. [LB472]

SENATOR HOWARD: Perfect. I'm a little...I do have some concerns about the provider environment. We have had some discussions, and I know you've been here during the hearing. Do you feel as though the department is creating an environment that providers want to be a part of our Medicaid program? [LB472]

COURTNEY MILLER: I believe so. I mean, the rates are based on the budget and I believe that we...that Governor Ricketts has included a provider increase in his budget proposal. So I believe that we've worked really hard with provider relations. [LB472]

SENATOR HOWARD: I know we had a...or I had a bill last week or the week before about the auditing process and how that had sort of alienated some providers. And I want to make sure that when we're considering expanding this population that we're really thinking about how we treat providers to ensure that they want to take these types of patients, especially children, because I think for us, we obviously have a mandate that we have to have access for children in our Medicaid program. And so we certainly wouldn't want to provide a hostile environment for those providers. Would you agree? [LB472]

COURTNEY MILLER: Absolutely. [LB472]

SENATOR HOWARD: And then at the bottom, your last paragraph, you mentioned a limited number of waivers. And interestingly enough, I work at my other job as a director of

development, so I write a lot of grants with our fingers crossed. At no point have we ever thought, there's only going to be a few number of grants, that we shouldn't apply. Do you think that we shouldn't apply because there are a limited number of waivers? Is that your intention with this paragraph? [LB472]

COURTNEY MILLER: There's a limit to the number of demonstration waivers that CMS will approve based on Medicaid expansion. [LB472]

SENATOR HOWARD: So is it your... [LB472]

COURTNEY MILLER: In 2017, they are beginning to approve and...review and approve innovation waivers. And so they're moving us towards that direction for the type of expansion that we're looking at. [LB472]

SENATOR HOWARD: And so your recommendation is that we shouldn't apply at this time? [LB472]

COURTNEY MILLER: Well, the innovation waivers are not available at this time. They don't start until January 1, 2017. [LB472]

SENATOR HOWARD: So we shouldn't apply for any waivers at this time? [LB472]

COURTNEY MILLER: I think Governor Ricketts has been clear about his opposition to expanding the Medicaid program. [LB472]

SENATOR HOWARD: Certainly. Are there other questions? Senator Crawford and then Senator Kolterman. [LB472]

SENATOR CRAWFORD: Thank you. Would you say it's the...if we are paying $40,000 for a report, fiscal analysis, that we should expect them to read the bill carefully and do the analysis for the specific bill that's being offered this year? [LB472]

COURTNEY MILLER: I think that would be a general expectation. [LB472]

SENATOR CRAWFORD: I think that I agree. So I guess it's very frustrating then to see...it looks like the analysis is really a repeat of the analysis on LB887 in terms of what the expected to be in the bill. So I would expect and hope that you would follow up with them and require that they

redo analysis correctly reading the bill, because if we've paid $40,000 for this analysis, they should do analysis of the actual bill that's being offered. So I'd respectfully request that you follow up with Milliman on that. [LB472]

COURTNEY MILLER: Okay. [LB472]

SENATOR HOWARD: Senator Kolterman. [LB472]

SENATOR KOLTERMAN: Thank you, Senator Howard. This might sound really like a foolish question, but let's say this gets out of committee and it gets through the floor and it all passes and everything is hunky-dory. Where do we house 435 new people? [LB472]

COURTNEY MILLER: That's a great question. [LB472]

SENATOR KOLTERMAN: I'm just thinking of logistics? I mean, how do you...where do you get that population to come in to work? [LB472]

COURTNEY MILLER: I can't answer that, but I can follow back up with you. (Laugh) [LB472]

SENATOR KOLTERMAN: I'm just thinking through the process and that's like bringing a new employer to town in my book. Thank you. [LB472]

SENATOR HOWARD: Senator Cook. [LB472]

SENATOR COOK: Thank you, Madam Chair. I'd love to bring a new employer to Legislative District 13, and I have some empty spots. (Laughter) Let's do it. Let's do it. [LB472]

COURTNEY MILLER: Well, we won't fit in the State Office Building, I can tell you that. [LB472]

SENATOR COOK: Heck yeah. My question--I'm going to be thinking a little bit out loud because I had lunch so many hours ago (laughter)--I serve...I'm honored to serve as the Chair of the Planning Committee. Part of the information that we have is that the children...number of children in poverty has risen in the state of Nebraska between the time the American Community Survey was completed about the year 2000 and then of course again in 2010. So it would appear, as the administration--not just Governor Ricketts, the previous administration--continues to be wary of proposals such as this to planfully expand Medicaid that it will expand anyway. So I'll

need those 400 folks to come to LD13 and work as some point. And I guess I'm wondering--and this is a question--what plans...or can you name one plan that you might be aware of as an employee of the Health and Human Services system that is in place to deal with people who are unable to afford their healthcare and...well, they're not eligible now for Medicaid, but boy, at this rate, they're going to be. Do you have a response for that? [LB472]

COURTNEY MILLER: I don't. [LB472]

SENATOR COOK: Okay. So you aren't aware of any plans that the agency--any part of the agency--has in place to minimize the number of people that continue to make that part of the budget pie grow in this state? [LB472]

COURTNEY MILLER: I don't. My roles and responsibilities remain within the Division of Medicaid and Long-Term Care. [LB472]

SENATOR COOK: All right. Thank you. [LB472]

COURTNEY MILLER: Thank you. [LB472]

SENATOR HOWARD: Ms. Miller, can you help with the undocumented immigrants question that we had previously? [LB472]

COURTNEY MILLER: Yes. The undocumented that...the barriers that exist today for Medicaid eligibility for those folks would remain with the expansion population. [LB472]

SENATOR HOWARD: So nobody who is undocumented would be able to access this program? [LB472]

COURTNEY MILLER: Correct. [LB472]

SENATOR HOWARD: Okay. Other questions for Ms. Miller? Seeing none, thank you for your testimony today. [LB472]

COURTNEY MILLER: Thank you. [LB472]

SENATOR HOWARD: Good afternoon. [LB472]

BRUCE RAMGE: (Exhibit 52) Good afternoon. Good afternoon, Chairperson Campbell...or Howard, I guess... [LB472]

SENATOR HOWARD: Thank you. [LB472]

BRUCE RAMGE: ...and members of the Health and Human Services Committee. My name is Bruce Ramge, spelled B-r-u-c-e R-a-m-g-e. And I'm the Director of Insurance. I'm here this afternoon to appear in opposition to LB472. The legislation is proposing to create by way of Medicaid a premium assistance program to purchase private insurance for certain individuals via the federal marketplace between 100 and 133 percent of the federal poverty level. These individuals are already eligible to receive significant premium and cost-sharing assistance from the federal government. As the chief financial regulator of Nebraska insurance companies, my opposition to the legislation comes more in the form of a warning to the committee based upon the department's real experience with the federal government's implementation of the Affordable Care Act, or ACA. The implementation of the ACA has been a long litany of empty federal promises, great uncertainly for insurers and insurance regulators, and decisions that have, to say the least, been unpredictable from the federal government. I think it might be the most useful for the committee, given the time constraints, to give you one real-life example of the problems with ACA implementation that has greatly affected a large number of Nebraskans and which has also an impact on potential funding for this legislation, and that is the insolvency and impending liquidation of CoOportunity Health. CoOportunity Health is an Iowa domestic insurer which had operated in both Iowa and Nebraska. It was created as a health insurance co-op, one of the consumer-driven health insurance entities created with ACA legislation. CoOportunity Health received from the federal government low interest start up loans and solvency loans as well as other federal financial assurances. Like all insurers participating in the federally facilitated marketplace, open enrollment began for CoOportunity in October 2013 and it began providing coverage on January 1, 2014. And like all insurers, it was flying blind into a new world with new exposure to risks that insurers were having--and continue to have--a difficult time underwriting. CoOportunity in particular was reliant on additional federal assurances for continued support. Unfortunately these promises made to both the company and to the insurance regulators were not kept. Despite the federal government touting the success of CoOportunity enrolling more insureds than nearly every other co-op in the nation, the federal government decided not to extend additional promised resources to CoOportunity in December, instead opting to provide such assistance to other co-ops in other states. This decision was communicated to the states on the December 16, the day after the last day to effectuate coverage off the marketplace for January 2015. Iowa, as the primary solvency regulator, relied on the federal promise of additional loans to allow CoOportunity to sell in 2015. Without these additional promised funds, Iowa had no choice but to start statutory solvency controls. Iowa moved swiftly to take control of CoOportunity and it is scheduled to begin liquidating the company later this week. This liquidation will come with a price to Nebraskans. Once Iowa took control, both states urged

policyholders to more out of CoOportunity for their own sake. Insureds who utilized CoOportunity in January or February will reset their deductibles and other cost-sharing limits when coverage with a new company is effectuated. Once CoOportunity is liquidated, $500,000 in coverage is guaranteed by the Nebraska Life and Health Guaranty Association, an association of life and health insurers writing business in Nebraska. This $500,000 limitation is a risk to any Nebraskan that continues to hold a CoOportunity policy. They will lose any premium and cost-sharing assistance from the federal government. Agents, brokers, navigators, and solvent health insurers have done a great job in moving CoOportunity policyholders to other insurers. To help prepare for this liquidation, the association assessed health insurers writing the business in Nebraska $46.8 million. And those assessments can be offset by 20 percent each year from their premium taxes. I share this example with you to provide you with the skepticism of an insurance regulator related to any program that relies upon promises by the federal government that it appears LB472 relies upon. And even now, the marketplace continues to struggle and more confusion has been created. Recently, there has been a special enrollment period issued by the federal government because the technology created under the ACA provided incorrect tax information to over 800,000 American taxpayers. The premium assistant aspect of LB472 with premiums presumably being made by the Nebraska Department of Health and Human Services would add yet another new information technology aspect into an insurance system already overloaded with change and difficulties. And I appreciate the opportunity to come before the committee and discuss the Department of Insurance's concerns with LB472. Thank you. [LB472]

SENATOR HOWARD: Are there questions? Senator Cook. [LB472]

SENATOR COOK: Thank you. And thank you for coming to testify. [LB472]

BRUCE RAMGE: You're welcome. [LB472]

SENATOR COOK: One would think that as an insurance person you're kind of hard-wired for skepticism as that's kind of actuarial science partly...part of it's definition. [LB472]

BRUCE RAMGE: Part of it, yes. [LB472]

SENATOR COOK: I...my question is--not as an insurance professional--is, has there ever been a liquidation of any other insurance company before anybody ever heard of Barack Obama or before anybody ever heard of ACA? [LB472]

BRUCE RAMGE: Yes, it... [LB472]

SENATOR COOK: Has that ever happened before? [LB472]

BRUCE RAMGE: It has happened before. That's correct, yes. There are insurance solvencies. And fortunately the system is set up to help protect policyholders. But this could have been prevented had the federal government followed through on what they had promised. [LB472]

SENATOR COOK: Sure. And my guess, once again as a relative novice other than an insurance consumer, the other liquidations could had been prevented had it not been for fill-in-the-blank. [LB472]

BRUCE RAMGE: Correct. There... [LB472]

SENATOR COOK: Malfeasance, a change in policy, for whatever reasons those were... [LB472]

BRUCE RAMGE: There's a multitude of reasons. [LB472]

SENATOR COOK: ...there are multiple reasons. Thank you. [LB472]

BRUCE RAMGE: Yes, you're right. Thank you. [LB472]

SENATOR HOWARD: And just as a point of clarification, when you say that the federal government promised funds, was that in the statute? [LB472]

BRUCE RAMGE: No, it was verbally given to both the company and to the regulators. [LB472]

SENATOR HOWARD: And you and I sort of know that if it's in statute it's very different than a verbal promise. [LB472]

BRUCE RAMGE: Absolutely. Yeah. [LB472]

SENATOR HOWARD: Absolutely. Just clarifying. Other questions for Director Ramge? Senator Crawford. [LB472]

SENATOR CRAWFORD: Thank you. And thank you for coming to testify. So is part of your job tracking premium costs across time? [LB472]

BRUCE RAMGE: The premiums are filed. We make certain that they are actuarially reviewed and actuarially established using the proper methodology. [LB472]

SENATOR CRAWFORD: So you're reviewing if the premiums are appropriate given what their coverage is and assumptions. [LB472]

BRUCE RAMGE: Yeah. Yes. [LB472]

SENATOR CRAWFORD: But do you also, as a department, track premium costs over time to see if they're going up or going down or how much they're going up? [LB472]

BRUCE RAMGE: Well, you know, each filing is reviewed independently. We have to evaluate the trends that are used by the actuaries such as, you know, medical costs, inflation, utilization, that type of thing. And that can vary by company depending on the mix of business that they have received. [LB472]

SENATOR CRAWFORD: Okay. I was just curious if you would see or know if the decline and the rise in premiums we were seeing previously that we hear reported nationally is similar to what we're seeing in Nebraska. [LB472]

BRUCE RAMGE: I expect Nebraska's premiums will continue to rise. And part of that is because of this large block of business that was in CoOportunity that was very high utilization will now shift over to the other insurers and they're going to have to charge a premium that's substantial enough to cover that exposure. So I don't think Nebraska has hit that point where things are going to level off. [LB472]

SENATOR CRAWFORD: I think I saw somewhere recently...it was about 3 percent increase nationally. [LB472]

BRUCE RAMGE: In medical cost inflation. [LB472]

SENATOR CRAWFORD: And in premium costs. [LB472]

BRUCE RAMGE: In premiums...yeah, and Nebraska's was much higher between 2014 and 2015. It varied by insurer. [LB472]

SENATOR CRAWFORD: Than 3? [LB472]

BRUCE RAMGE: Oh, yes. Yes. It... [LB472]

SENATOR CRAWFORD: But how about how it compares to what it was prior? [LB472]

BRUCE RAMGE: Before the ACA? [LB472]

SENATOR CRAWFORD: Right. [LB472]

BRUCE RAMGE: It's probably 40 percent higher than before the ACA. [LB472]

SENATOR CRAWFORD: The rate right now? [LB472]

BRUCE RAMGE: The rate. Four... [LB472]

SENATOR CRAWFORD: But not the rate of increase per year? [LB472]

BRUCE RAMGE: Correct. [LB472]

SENATOR CRAWFORD: No. [LB472]

BRUCE RAMGE: Yes. [LB472]

SENATOR CRAWFORD: Yes. Yeah, yeah. [LB472]

BRUCE RAMGE: And especially in the individual market, because a lot of individuals had policies that were less robust in their coverage... [LB472]

SENATOR CRAWFORD: Right, it's a different... [LB472]

BRUCE RAMGE: Yes. [LB472]

SENATOR CRAWFORD: It's basically a different product in some ways. [LB472]

BRUCE RAMGE: Correct. [LB472]

SENATOR CRAWFORD: Isn't that correct? [LB472]

BRUCE RAMGE: Right. [LB472]

SENATOR CRAWFORD: It's a different product. [LB472]

BRUCE RAMGE: Right. [LB472]

SENATOR CRAWFORD: So it may be more costly, but it's a different product now. [LB472]

BRUCE RAMGE: Right. And they're not able to purchase those lower-cost policies now. [LB472]

SENATOR CRAWFORD: Right. Right. Yeah. Thank you. [LB472]

BRUCE RAMGE: You're welcome. [LB472]

SENATOR HOWARD: Are there any other questions for Director Ramge? Okay, I have a few questions. [LB472]

BRUCE RAMGE: Okay. [LB472]

SENATOR HOWARD: Can you tell me, what role did the Department of Insurance play in allowing CoOportunity Health to serve Nebraskans in the first place? [LB472]

BRUCE RAMGE: Yeah. The insurance regulation in the United States is...there's a reliance on other states for financial solvency of their domestic insurance companies. So once they have domiciled in another state then...and have met all those obligations, then they are able to come to Nebraska and apply for a license here. And there's a great deal of deference given to those other states through the accreditation process. And they still have to meet all the solvency requirements. And those solvency requirements were met when they came in, but it deteriorated rapidly and especially during the last half of 2014 because of their...they were undercapitalized. They just didn't have enough capital for the number of people they had. And they got much higher utilization than they had expected. [LB472]

SENATOR HOWARD: So would you consider CoOportunity Health to have been sort of more of a market-driven system? [LB472]

BRUCE RAMGE: In a way, yes. It was market driven...both market driven and driven by the ACA, because they got customers both through the federally facilitated marketplace or exchange. They also sold extensively through agents and brokers. And they were, you know, aggressive in their approach. And they probably should have tried to limit their numbers rather than expand. [LB472]

SENATOR HOWARD: So as a market-driven version of healthcare, then when the government sort of stepped out of the picture, this would have been a failure of that market-driven method? [LB472]

BRUCE RAMGE: Yes, it would have. You know, being...it was a company in its infancy. And it just needed to get through those first couple of years. And it was kind of like they were relying on those funds. If they could have just helped their cash flow situation along, it could have been a success rather than a failure. [LB472]

SENATOR HOWARD: Certainly. Senator Crawford. [LB472]

SENATOR CRAWFORD: So...thank you. So do I hear you correctly saying we should have had a government bailout of CoOportunity Health? [LB472]

BRUCE RAMGE: Not a bailout. I'm not suggesting that it should have been a bailout. I'm suggesting that the federal government created these entities and for what reason I have no idea. I mean, there's adequate market out there for health insurance. Granted, not a lot of them want to participate in states. But the company appeared to rely on assurances that the federal government was going to be there for them. And it didn't happen that way. [LB472]

SENATOR HOWARD: I'm sorry, you said the federal government created CoOportunity Health? [LB472]

BRUCE RAMGE: The Affordable Care Act has provision to create... [LB472]

SENATOR HOWARD: Oh, allowed it to be created. [LB472]

BRUCE RAMGE: Yes. [LB472]

SENATOR HOWARD: But they didn't themselves create it. [LB472]

BRUCE RAMGE: No. No, it was...correct, individuals. [LB472]

SENATOR HOWARD: Just to clarify, because it's market driven and it's not the government. [LB472]

BRUCE RAMGE: That's right. [LB472]

SENATOR HOWARD: Okay. [LB472]

BRUCE RAMGE: Okay. [LB472]

SENATOR HOWARD: And so in this, in your testimony, you talk a little bit about how, you know, it's hard to rely on promises from the federal government, and we've specified verbal versus statutory. Do you feel as though we can't rely on statutory promises? [LB472]

BRUCE RAMGE: There have been a lot of portions of ACA which are in statute which have not been implemented. [LB472]

SENATOR HOWARD: Certainly. The CLASS Act is a good example. Absolutely. So in that sense, it's just this one bill. It's not all other types of funding. It's not roads, it's not farm subsidies. It's just this bill. [LB472]

BRUCE RAMGE: Yeah, sure, I'm just here to give you my experience, my firsthand experience... [LB472]

SENATOR HOWARD: Certainly. [LB472]

BRUCE RAMGE: ...and to let you have a balanced view of... [LB472]

SENATOR HOWARD: And we definitely appreciate it. [LB472]

BRUCE RAMGE: Yeah, you bet. [LB472]

SENATOR HOWARD: And last year you talked a lot about ACOs and so I was hoping you could give us a little update on ACOs and how that's going. [LB472]

BRUCE RAMGE: Accountable Care Organizations? [LB472]

SENATOR HOWARD: Absolutely. [LB472]

BRUCE RAMGE: You know, I believe that the concept is still being talked about. I think it's a positive concept. I think the first step that we're going to see is with the medical home concept. And that seems to be very well thought of. It's just a matter of...in terms of the market forces, I think, will bring about those changes. And it just takes time. [LB472]

SENATOR HOWARD: Thank you. Are there any other questions for Director Ramge? Seeing none, thank you. [LB472]

BRUCE RAMGE: Thank you. [LB472]

SENATOR HOWARD: And I should apologize. I kept calling Ms. Miller "Ms. Miller." She's "Director Miller." My apologies, Deputy Director. [LB472]

BRUCE RAMGE: I go by whatever anyone wants to call me. I'm... (Laughter) [LB472]

SENATOR HOWARD: Thank you. Our next opponent testifier? Good evening, Dr. Truemper. [LB472]

EDWARD TRUEMPER: Good evening, Senator Howard. It's a pleasure to see you again. My name is Dr. Edward Truemper. That's E-d-w-a-r-d T-r-u-e-m-p-e-r. First I'd like to apologize for not bringing a copy of my remarks. I'm a medical instructor and over the many years I've realized that if I give a copy of my remarks or handouts, people spend their time reading and not listening. And so I've decided that I would pass them on to you all via e-mail. Now, I'm a pediatrician and a pediatric critical care specialist. I practice in the hospital. I actually practice in two hospitals in Omaha for the last 2 years...excuse me, 13 years. I practice in two pediatric ICUs. I'm an academician. I do medical research at the University of Nebraska in Lincoln and also at Children's Hospital. I'm a member of the state and local medical societies. I'm also a member in good standing with my professional societies in critical care medicine and pediatrics. Despite these many associations, my remarks are strictly my own. No one else's opinion is coming forward here today. First I'd like to thank the committee for the opportunity to speak concerning the Medicaid Redesign Act, LB472. This is my first opportunity to actually speak in front of this committee or any other committee, and it's great to be part of participatory democracy. I'm in opposition to the Medicaid Redesign Act for reasons that are quite different than most of the folks in here have presented. And my rationale for this is threefold. Personally,

my experience as a pediatrician and critical care specialist for the last 30 years, I practiced in four states: Texas, Oklahoma, Georgia, and Nebraska. And I was intimately involved with all four of those Medicaid groups. And I was also involved with 16 others in surrounding states and still involved in more than a dozen at this time. The second is, I've spent 25 years designing outcomes research, performing project improvement within the hospital. And the third is that I actually designed and built and managed a children's center for 400,000 underserved children in north Georgia for approximately four years. And for that reason, I stand in opposition and I will explain why. Now, as I read the Medicaid Redesign Act, it really serves twofold purposes. The first is to cover the remaining under- and uninsured using current federal money that has been allocated but also, more importantly, to reconfigure the healthcare system initially for a new Medicaid population, eventually the current Medicaid population, and eventually it will have an impact on the entire state. Now that puts a lot of people depending on a new coverage model in our current system of Medicaid coverage at risk. We're going to ask physicians and other healthcare providers to accommodate their practices and reconfigure their medical process to provide care and follow a new bevy of as-yet-unknown regulations and surveillance. The patients will also have to learn to comply with a new healthcare delivery model. Now the state, as they've stated, is planning to experiment with new, innovative healthcare models. The doctors and the patients are going to serve as the guinea pigs. Subjecting the healthcare system and patients to an ill-defined, bureaucratically driven developmental mechanism is dooming the entire process to failure. The program may fund through the Affordable Healthcare Act desired financial coverage. But you will not get the healthcare outcomes that you hope to achieve. The system to administer the program has not even been designed yet. Haphazard implementation will only breed practice chaos. Coupled with providing financial compensation to the healthcare providers through a new, untested, value-based fee system that has yet to be designed only is going to bring more disorder. My principle concern, however, in the Medicaid Redesign Act is outlined in Section 8, which has a request for the Medicaid demonstration waiver to adopt a new practice model where a new patient population will be served. In short, the proposed plan is to put newly covered patients in a patient centered medical home or a health home for all medical care. We don't have enough medical homes or health homes now. We also have a serious shortage of primary care doctors in rural Nebraska as well as other healthcare workers. Currently primary care physicians are struggling to meet the needs of the sick they deal with now. And how are these folks with limited staff and resources going to administer a new healthcare paradigm to the subject of...this subset of patients? The patient centered medical home model has the potential to improve healthcare in Nebraska and even reduce cost. Sixteen recently published peer-reviewed medical studies support both of my assertions. With this legislation, you will bind this model to an increasingly complex, ever-changing vortex of rules, regulations, and performance metrics. You will... [LB472]

SENATOR HOWARD: Dr. Truemper, would you help us... [LB472]

EDWARD TRUEMPER: I have one more paragraph. Can I finish? [LB472]

SENATOR HOWARD: Certainly. [LB472]

EDWARD TRUEMPER: Thank you. You will doom the medical home model to failure. LB472 is not a plan but an outline of an idea for Medicaid in the future. Abandon this legislation and ask for a waiver to use the patient centered medical home model for existing Medicaid covered population. The 150,000 children currently covered under SCHIP would be a good choice to receive healthcare through the medical home and health home models which would serve as a more robust test. Thank you. [LB472]

SENATOR HOWARD: Are there questions for Dr. Truemper? Senator Riepe. [LB472]

SENATOR RIEPE: Dr. Truemper, thank you for being here. You mentioned several new patient categories in the Medicaid Redesign Act. What do these categories mean to you? [LB472]

EDWARD TRUEMPER: Okay. When I read them, the super-utilizers, the medically frail...I can't remember the exact combination of terms. These describe patient populations who use the medical system inordinately more than the average population but also have chronic healthcare conditions of a varying level of intensity and number. From my standpoint, disease operates on a continuum. It doesn't operate as a categorical. So when you talk about obesity as a chronic medical conditions which is defined by a number of medical organizations, what are we going to use to define that as a condition as part of either being a super-utilizer or medically frail? And that is a concern that I have, because you've got 8,800 medical diseases all on a continuum. Where are we going to put that? [LB472]

SENATOR RIEPE: You have some...it's very helpful that you have a number of experiences in other markets, because sometimes just by the virtue of all of us...you know, we become parochial in our knowledge. You had some experience with TennCare, and I know it went down in ashes at one time, and I don't know whether it came back up or not. [LB472]

EDWARD TRUEMPER: It came back in another form. TennCare came about back in my first years in Georgia as one of the first waivers to the federal government to basically opt in uninsured patients. And it used many of the same methodologies that you guys are talking about in this bill. And it was quite interesting. The number of patients that they projected was way more than they had anticipated. The costs exploded. The costs exploded so much they had to break out mental health from the other portion of medical care in order to get a handle on the costs. As a result 200,000 people got thrown off the rolls. There was...payments to clinicians

were either delayed, denied, or they just cut the payment scales. It put a lot of doctors out of business, drove a lot of primary care doctors out of the state. In fact, one-quarter of the rural pediatricians within five years were driven from Tennessee. And that's published in the Southern Medical Journal as a peer-reviewed article. It exploded from a projected $1.5 billion to $7 billion in costs per year for 1.2 million people. [LB472]

SENATOR HOWARD: Other questions for Dr. Truemper? Senator Crawford. [LB472]

EDWARD TRUEMPER: Hello, Senator Crawford. [LB472]

SENATOR CRAWFORD: Thank you, Senator Howard. It's nice to see you, Doctor. I don't know how long you've been in the room, so I don't know if you had a chance to hear from the doctor who is part of the pilot...who are piloting some of these efforts that are described in the bill who talked about having 10 percent lower costs and 9 percent drop in hospitalizations and 40 percent drop in ER from their pilots that were...basically I think the language in the bill was based on, in part, that success pilot that we saw there. Did you get to hear that testimony? [LB472]

EDWARD TRUEMPER: Oh, I did, and I'm actually a very big supporter of the medical home model. What wasn't shared with the committee by the gentleman was that at one hospital that they serve, they had a 50 percent reduction at admissions. That hospital is caterwauling about the fact that they're not admitting as many patients. So we've got all of these dyssynchronies in the system. So if you adopt a medical home model, okay, you have...and I favor pediatrics, because we have a lot of synergy within our system. You got to have buy-in from everybody. In fact, one senator's legislative aide said that everybody has got to be in the medical home model to make it succeed. I don't necessarily buy into that. But there is cost savings. But here's the thing: You got two Medicaid populations. You got the original Medicaid population and now you got this other population. The original Medicaid is fee-for-service or managed care. And now you have this value-added payment schedule which has yet not even been worked out. And in all my review--and I'm not a financial analyst--but I see a great deal of concern about putting that kind of model together. And in looking at this bill and the time lines that you put into place, I don't see how you can do it for the vast array of different diseases and problems that patients experience, because here's two things: There is two reasons why we expend so much money in the healthcare system. Everyone looks at the medical literature and reads, these are the biggest disease drivers. You know, they talk about cancer, diabetes, and heart disease. That's wrong. The biggest cause of death and morbidity in the United States is ignorance followed by noncompliance, ignorance with their disease process and their inability to follow a prescription of care that they understand. So this morning I...one of the reasons why I got a little stuff in my voice is I was on call and I'm operating on about two hours of sleep right now. As I looked at the 17 kids I had in the pediatric ICU and I interviewed all of the parents that were there, and it was quite interesting that half the

kids probably didn't need to be there, because they were ignorant of immunizations, preventative healthcare. One child had a kidney infection that led to septic shock because she didn't finish her antibiotics and a child with diabetes who'd been there seven times for management of DKA because of noncompliance. Now, I can tell you this flat out: That child's five-day stay for DKA, when you look at the cost that is expended with noncompliance for a five-day hospital stay...I can provide outpatient healthcare for that child for ten years. We need to change our system to where we deal with noncompliance and give doctors time--or our other healthcare providers--to spend time teaching patients how to take care of themselves. I'm sorry to be so long-winded, but the lady here who was from MoveOn.org talked about how healthcare is a right. I absolutely agree with that. But here's what I will tell you: Look in the mirror. The first right is executed by you. And if you don't comply with your medical care and the prescriptions that you have, why should the taxpayers of the United States and Nebraska have to pay for failure? And that's one of my problems with the way we continue to keep escalating costs and continue adding money to the problem and not dealing with those two fundamental issues. We deal with those, I believe that we will have enough money not only to provide efficient care and improve the health for the subject--the people in the state of Nebraska--we will also have enough money to take care of the people who came in today and talked about not having coverage. The one thing that every single one of those people had was they were invested in their health. They were invested in their health. They wanted access to healthcare. And they will use it properly. Giving it out willy-nilly to a whole new group of people is not going to get there. And I'm sorry, that's just my opinion. [LB472]

SENATOR HOWARD: Senator Cook. [LB472]

SENATOR COOK: Thank you, Madam Chair. Thank you, Dr. Truemper. It sounds as though from your testimony that you think the words ignorance and noncompliance are synonymous. Is that the case, Doctor? [LB472]

EDWARD TRUEMPER: No, but they can be additive. [LB472]

SENATOR COOK: Absolutely. Can you think of any other reasons why a patient might not be compliant with her or his prescription just off the top of your head as a physician and medical director with your many, many, many years of experience? Can you think of any other reasons? [LB472]

EDWARD TRUEMPER: You mean if they already have their prescription or are you talking about if they haven't gotten it? [LB472]

SENATOR COOK: Any other reason. It's your question to answer. [LB472]

EDWARD TRUEMPER: If they don't have the funding to purchase the prescription. [LB472]

SENATOR COOK: All right. That would be one. [LB472]

EDWARD TRUEMPER: I agree with that. [LB472]

SENATOR COOK: And that would be one that I have identified in my work and my experience and many others in this room and outside this room have identified. [LB472]

EDWARD TRUEMPER: But here's the thing, Senator. [LB472]

SENATOR COOK: Thank you. [LB472]

EDWARD TRUEMPER: Senator Cook, here's the thing. [LB472]

SENATOR COOK: I'm done. You've answered my question. Thank you very much, Doctor. [LB472]

EDWARD TRUEMPER: Thank you. [LB472]

SENATOR HOWARD: Doctor, I also have a few questions. You mentioned new regulations. You don't consider the Medicaid program itself to be a new program, correct? [LB472]

EDWARD TRUEMPER: The current Medicaid program, no. [LB472]

SENATOR HOWARD: And so, sort of the regulations around the way that hospitals and care providers manage Medicaid potentially wouldn't really change. [LB472]

EDWARD TRUEMPER: You're setting up a whole new program for a whole new group of people who are currently uninsured and uninsured, correct? [LB472]

SENATOR HOWARD: So in the past... [LB472]

EDWARD TRUEMPER: Yes? [LB472]

SENATOR HOWARD: In the past...I was thinking about...you actually reminded me of my mom, because I know you hung out with her a little bit previously. One of her proudest votes--and there were two of them and they both dealt with the Medicaid program--one was when they clarified the eligibility for undocumented women who were pregnant, and the other one was when they expanded program eligibility for children up to 200 percent under CHIP. With that expansion did you--and you've been working in this field for a long time--did you feel as though there were sort of catastrophic implications for those changes? [LB472]

EDWARD TRUEMPER: Catastrophic implications for those changes? No, what we ended up with was... [LB472]

SENATOR HOWARD: Well, you mentioned the regulations. [LB472]

EDWARD TRUEMPER: I'm happy to...if you would like, allow me. [LB472]

SENATOR HOWARD: Certainly. [LB472]

EDWARD TRUEMPER: No, the expansion of the coverage did provide more medical care. But it wasn't efficient medical care. We haven't seen a drop in the number of ER visits. My ICU is largely filled with children who have preventable medical conditions or, if properly managed, on an outpatient basis with the time to give devoted parents the opportunity to care for their kids in a consistent, knowledgeable way. I think we can keep those kids out of the high healthcare and financially intensive situations. [LB472]

SENATOR HOWARD: Thank you, Dr. Truemper. Senator Riepe. [LB472]

SENATOR RIEPE: Thank you, Senator Howard. I'll give you this and ask you to respond to it, Dr. Truemper, is one of my concerns gets to be under whether it's a consumer-driven model or a government-driven model, it's just the manpower piece. And you have what I call, like, old oil and new oil. You have those people who are fragile and have been on Medicaid at the risk of the new ones crowding out, taking the appointments. You know, you don't just drop in...if the number was 54,000, you just don't drop that new number in with the same manpower and get the same or maybe a better outcome, right? You know, that's a major piece. [LB472]

EDWARD TRUEMPER: It is, and one of the things that I think is very important that needs to be really focused on if this bill passes is the issues of our healthcare providers. Someone spoke in here about two-thirds of the uninsured and underinsured are in rural Nebraska. And guess where we have the biggest dearth of primary care providers, both mental health and routine medical

care? It's in rural Nebraska. And to cover these tens of thousands of people, where are they going to go? And that's a big hurdle. And it's one that you can provide all the money that you want, but if you don't have the people there and the circumstances to provide the care in a system that is understandable and affordable to the clinicians who will provide it, whether it be through government-run or through a private-run operation, it isn't going to succeed. [LB472]

SENATOR RIEPE: Wasn't that the case in Massachusetts? I read somewhere where there was more difficulty, just pent-up demand, and it's supply/demand and trying to get to a physician. [LB472]

EDWARD TRUEMPER: The only thing I can claim that I know about Massachusetts is I know where Boston is. (Laughter) [LB472]

SENATOR RIEPE: That's a good starting point. [LB472]

EDWARD TRUEMPER: And that's because I was there to confirm it. [LB472]

SENATOR RIEPE: Okay. [LB472]

SENATOR HOWARD: Are there any other questions for Dr. Truemper? I only have a comment. I work at a health clinic, as you know. [LB472]

EDWARD TRUEMPER: I do. [LB472]

SENATOR HOWARD: And our providers take great pride in their role as participants in our patients' compliance. And so, sort of, our provider team really refuses to accept that noncompliance is something that can't be helped. And so I think there is a huge role for a provider to the entire provider team in ensuring that patients have the education they need to be successful and also the backup and the help that they need to be compliant. But with that, we thank you for your testimony. [LB472]

EDWARD TRUEMPER: Thank you very much. [LB472]

SENATOR HOWARD: Our next opponent? And by a show of hands, how many opponents do we have in the room? I see three? Three? Okay. All right. We're getting there. Four. Okay. Good evening. [LB472]

MARY JANE TRUEMPER: Hi. [LB472]

SENATOR HOWARD: We're getting there. [LB472]

MARY JANE TRUEMPER: Hi, hi, hi. You get your second Truemper, Mary Jane Truemper (laughter), T-r-u-e-m-p-e-r. And I will tell you, I'm the Truemper that probably has more questions than answers. My concern about LB472 is--and I guess my question about it--it seems like it wants to facilitate the expansion of medical services into schools by authorizing Medicaid to pay for health services performed in schools. And I'm referring particularly to page 16 starting line 8. The Nebraska statute it referenced, 68-911, lists a comprehensive number of medical services including midwife and pregnancy services. And I...my question is, do we really want our schools to become health clinics for our children? I don't presume to answer for everybody. I can only answer for myself, and my answer would be, thank you but no thank you. But, you know, if other people want that, they should have that discussion. I worry that parents get removed from the equation altogether if you consider that Nebraska statute 79-248 that last year authorized HHS to inspect children for conditions as prescribed by the Department of Health and Human Services and there was no opt-out in Nebraska statute 79-248 for parents. And so I guess my question is, I don't really understand what the plan is. And if there is discussion between Education Committee or educators in the state with providing Medicaid in schools. But I would like to see, if that is the plan going down the road, that we have discussion with parents about that and that we open up that dialog and it not be kept to the upper echelons until the decisions are made. Thank you. [LB472]

SENATOR HOWARD: Thank you, Mrs. Truemper. Ms. Truemper? [LB472]

MARY JANE TRUEMPER: Missus. (Laughter) [LB472]

SENATOR HOWARD: Missus. All right. Okay. And just as a point of clarification, page 16--all of page 16 almost--is all existing law. So school-based health centers, it was a bill several years ago. [LB472]

MARY JANE TRUEMPER: Yeah. [LB472]

SENATOR HOWARD: We have seven operating in the city of Omaha, another one in Grand Island. [LB472]

MARY JANE TRUEMPER: Right. Right. And I realized, but it seemed to me when I read it that it was going to expand that even further. But maybe I misread it. [LB472]

SENATOR HOWARD: No, ma'am. Nope, not this one. [LB472]

MARY JANE TRUEMPER: Okay. Thanks. [LB472]

SENATOR HOWARD: Thank you. Our next opponent? Good evening. [LB472]

DICK CLARK: Good evening. Chairwoman Howard, members of the Health and Human Services Committee, my name is Dick Clark, D-i-c-k C-l-a-r-k. I'm testifying today on behalf of the Platte Institute. Thank you for this opportunity to speak in opposition to LB472. I'll start out with something that may surprise you. There are some elements of this bill that I very much believe are worthy objects of discussion for this committee and for the Legislature in terms of reforming our current Medicaid program. This Legislature should look to address how to better serve super-utilizers and for those with exceptional medical conditions more efficiently and more effectively provide services. The conversation about patient centered medical homes is well worth having. I greatly appreciate that Senator Campbell's bill proposes a comprehensive review of Nebraska's Medicaid program. And I'll tell you that, in fact, one project the Platte Institute will undertake this year is an organization-wide review of DHHS including the division that houses Medicaid and Long-Term care. But unfortunately despite these components that we share in common as something that we think we need to talk about, I could still come in here today and repeat for you nearly the same testimony that I offered last year, because our objections to LB887 still generally apply when it comes to LB472. This bill, no matter what aspirational language it includes, is still Medicaid expansion. It's still a plan to grow Nebraska's most expensive entitlement program. Medicaid expansion will begin to seriously pressure state budgets as early as 2019. The scheduled tapering off of federal funds between now and 2020 will predictably increase the financial burden on states that expand Medicaid. That means potential dollars for schools or roads will instead be going to pay for expanded Medicaid. And despite lots of analytical heavy lifting by multiple research organizations both political and nonpolitical, all discussion that's already gone on in this hearing today and which I won't repeat, the costs of this bill are indeterminate. But we know that they will be substantial. And that's a conclusion that's shared by those analysts from all across the spectrum. As with last year's bill, this would be a major expansion of Medicaid. Let's be mindful of the experiences of others states that have voluntarily expanded Medicaid to learn the lesson that we need to learn for Nebraska rather than learning it the hard way. Actual costs always exceed initial estimates. However expensive expanding Medicaid ends up being, if this bill becomes law, there's no good evidence that it will actually make Nebraskans healthier. As I discussed last year and as described by the researchers who conducted the Oregon Health Insurance Experiment, expanding Medicaid does increase utilization of services, but it doesn't necessarily lead to better health outcomes. It's clear that this bill will drive up healthcare costs in Nebraska. It's clear that this bill will result in more state and federal tax dollars being spent on Medicaid. What is not clear is that there will be any benefit in

terms of making Nebraska a healthier state. Thank you again for the opportunity to testify today. [LB472]

SENATOR HOWARD: Thank you, Mr. Clark. Are there questions? Senator Riepe. [LB472]

SENATOR RIEPE: What's your time line on terms of the organizational plight of DHHS? [LB472]

DICK CLARK: I'm afraid that it won't be by the time you wrap up your regular session here, but it is something... [LB472]

SENATOR RIEPE: You mean today? (Laughter) [LB472]

DICK CLARK: I'm afraid not. I'm afraid not. It's... [LB472]

SENATOR RIEPE: We're looking for QuickBook or something. [LB472]

DICK CLARK: Well, you know, quick and thorough don't always go together. And so, you know, we are working with...we've got a principle researching lined up. But it's one of the biggest research projects that the Platte Institute has undertaken in its history. And so it is something that will be a deliberate process and we hope to involve a significant number of stakeholders in that research process, so... [LB472]

SENATOR HOWARD: Senator Crawford. [LB472]

SENATOR CRAWFORD: So, I was trying to find it, but I'm not finding it in time. I know everybody is wanting to go. So I would just say, it is the case that there have been multiple instances when cost estimates have actually...I mean, the savings has actually been higher than the estimates. And we have examples--and I'll be happy to provide those with you later--I mean, examples such as when we went to prospective payment in Medicare/Medicaid. There was...the savings on that was much, much higher than was expected in the initial estimates. So I'd be happy to share that with you. [LB472]

DICK CLARK: Sure. [LB472]

SENATOR CRAWFORD: But just to clarify that it is the case, and that's one of three examples that's in this document that I was trying to pull that I wasn't speedy enough at pulling up. So I'll

be happy to share that with you just to...you know, I think it's just important for the record to note that we have often seen that actually, that we're pretty cautious often with our cost estimates. And we have seen instances where it cost less than expected. [LB472]

SENATOR HOWARD: Any other questions for Mr. Clark? Seeing none, thank you for your testimony. [LB472]

DICK CLARK: Thank you. [LB472]

SENATOR HOWARD: Good evening. [LB472]

MATT LITT: Good evening. Chairwoman Howard and members of the Health and Human Services Committee, my name is Matt Litt, M-a-t-t L-i-t-t, and I am the state director of Americans for Prosperity Nebraska and on behalf of our members across the state, and I'm here to voice our opposition to LB472. We oppose this bill for the same reasons we have appeared before this committee over the last few years. Our organization believes the Affordable Care Act, also known as Obamacare, was the wrong approach to healthcare reform. By freely participating in the entitlement expansion provision afforded by the federal healthcare law, Nebraska would be participating in a program with state tax dollars that the majority of us would rather see repealed, not expanded. LB472, no matter the title of the bill, is Medicaid expansion as provided by Obamacare. As stipulated in Section 4, the program wishes to administer as, quote, a result of the enactment of the federal Patient Protection Affordable Care Act, end quote. It should come as no surprise to many elected officials in Nebraska but the public sentiment in our state towards the Affordable Care Act is unfriendly, to put it mildly, and for good reason. Insurance rates for many Nebraskans, particularly in rural parts of our state, are going up, not down, as a result of the federal healthcare law. These massive premium increases coupled with the false promise that those who liked their plans could keep it are just the tip of the iceberg for why Nebraskans opposed the law. For our legislators to participate in the expansion of Obamacare by supporting LB472 and institutionalization of this unpopular law by using state resources for implementation would be opposing the clear will of the majority of our state. Polls have seen...polls have shown that a majority of Nebraskans not only oppose the bill...or the law, but support full repeal including provisions like LB472. In addition to our broad opposition to the concept of LB472, we have specific concerns with the bill as well. Primarily, the legislation differs from past Medicaid expansion models by attempting to incorporate an evaluation component. The concern is that the state based concepts by attempting to incorporate an evaluation...it cannot be promised. Subsection (g) of Section 6 highlights the wishful thinking inherent in this bill by stipulating that any policy recommendations to improve the Medicaid program offered by the newly created Medicaid Redesign Task Force would be subject to a federal Medicaid demonstration waiver. Simply put, the federal government would have to sign off on any reforms

that Nebraska may want to implement. And states across the country, Arkansas and Iowa, to name two, have seen the idea of local control is a myth, not only that states have seen their budgets pressured due to unexpected costs of expansion. Arkansas, for example, with their private option plan, has run over budget every single month, and Arkansans are footing the bill. Another problem we have with this bill is the trust proponents have in the federal government. Time and again, proponents have...say by not implementing Obamacare's expansion provisions, we are leaving money on the table and that this is free money. This point of view neglects the fact that federal tax money is taxpayer money, too...state taxpayer dollars, too, excuse me. And with entitlement programs already in fiscal jeopardy and the retirement of baby boomers, it is hard to understand how it makes sense to expand these programs without a solution to keep the programs we already have solvent. Yet even a cursory review of recent Medicaid funding should make state legislators anxious about trusting the federal government's promise of funding. In 2011, President Obama proposed $72 billion in Medicaid cuts and reducing federal support for state Medicaid costs by $15 billion. In 2012, the President again proposed $70 billion in cuts from Medicaid by revising the federal match to states. And the White House's 2013 budget proposed to cut $351 billion from entitlement programs over ten years. When the federal government is forced to confront its spending problem, whether during the debt limit crisis of 2011, the fiscal cliff crisis of 2012, or the sequestration crisis of 2013, entitlement programs and the Medicaid program specifically are routinely scrutinized for cost savings. Current entitlement spending is unsustainable and expanding the Medicaid program as allowed by President Obama's healthcare law and proposed by Senator Campbell would only put the program and its current beneficiaries at greater risk, yet no one is talking about this problem. When expansion squeezes out funding for current beneficiaries, how will we provide needed health benefits for those most vulnerable who are currently relying on medical care support? There's also the issue of uncertainty regarding the fate of the Affordable Care Act or at the very least its scope due to lawsuits that are working their way through the courts. And in the interest of time, I will move along. Nebraskans dislike the law because it...we have a...because of reasons we have identified for what it is: a top-down government-centric approach where decision rights are retained by Washington, D.C., and the law is simply unaffordable. We must remember this undeniable reality. At the very least, we believe proponents of LB472 would be on clear footing by indefinitely postponing this bill and wait until the legal process has run its course to remove legal uncertainty from the equation. Increased entitlement spending is neither practical nor ethical. Expanding entitlement programs without a solution to the problems we currently face will bankrupt our social safety net and prohibit the government from providing support for those who truly need it. While providing access to affordable healthcare coverage for all Americans is a laudable goal and we do applaud Chairwoman Campbell and this committee for shining a light on the issue of access and affordability, LB472 is not the right solution. By simply expanding government programs and adding to our already unmanageable entitlement system is not the right approach. And we encourage this committee to oppose the bill. Thank you. [LB472]

SENATOR HOWARD: Thank you, Mr. Litt. [LB472]

MATT LITT: Thank you. [LB472]

SENATOR HOWARD: Are there questions for Mr. Litt? Seeing none... [LB472]

MATT LITT: Great. It's about that time. (Laughter) [LB472]

SENATOR HOWARD: All right. Any other opponents to LB472? Seeing none, is there anyone wishing to testify in a neutral capacity? [LB472]

PAMELA SMITH: Good evening. [LB472]

SENATOR HOWARD: Good evening. [LB472]

PAMELA SMITH: (Exhibit 53) Since I provided the written documents, I'm going to go straight to the chase. But my name is Pamela Smith, P-a-m-e-l-a S-m-i-t-h. Community Action has a 50-year history of empowering people struggling in poverty to reach their full potential and achieve self-reliance. Together with 8 other community action agencies in Nebraska and over 11,000 agencies nationwide, we serve 99 percent of America's counties in rural, suburban, and urban communities with the common goal of eliminating the causes and conditions of poverty. I'm going to skip down to our role. I was asked to address the individuals who access Community Action Navigator services work. And many of them do work, but they were struck by an unexpected illness or a job loss. By contacting Community Action agencies for help, these households have taken steps to try to secure health insurance but are just not able to afford it. So allow me to provide some examples of households served who are not eligible for tax credits through the health insurance marketplace and were not eligible for Medicaid in the state of Nebraska: a single parent under 30 with a young child who works part time and goes to school full time. A single person in their 50s who works part time: the person requires medicine for a chronic disease, has trouble standing, and was recently diagnosed with cancer. They ration medicine and have not pursued treatment for cancer. A single person in their 50s who lost their job after 30 years will have no coverage while job hunting. A couple in their 50s: one spouse was laid off from a full-time job of many years. The other spouse had to take a leave from a part-time job due to illness. Then, due to a severe illness, one spouse required hospitalization for several weeks and still needs further healthcare. Both applied for Social Security Disability Insurance. Both were denied and both are appealing the findings. The unemployment insurance runs out soon. And because of the mounting medical bills, they will soon have no income and are on the verge of losing their home. A couple in their 40s, both of whom are disabled with chronic health

conditions: both applied for and were denied SSDI and are going through the appeals process. Currently they have no income and are on the verge of becoming homeless. Their chronic health conditions require regular doctor visits and medication. But they do not go to the doctor and they do not take any needed medications because they cannot afford either. A single person in their 30s injured in a car accident: the consumer's employer did not offer health insurance benefits. Due to the injuries from the accident, the person requires physical therapy and medications, but the individual has stopped all healthcare because they can't pay the bills. Without treatments, the doctor will not approve a return to work, so the individual will not have a job to help pay for the past-due bills and the needed treatments. Without any income, the individual has lost housing and may soon be homeless. A single parent of three in their 30s works part time, attends school part time, and hopes to secure a full-time job in their chosen field after graduation...now has no health coverage. These are only a few of the examples from our agencies of the individual Nebraskans who have tried to secure health coverage for themselves and for their families but could simply not afford it based on their household income. They respond to this news as anyone in their position would respond: with disbelief, tears, anger, and feelings of hopelessness. As a program, there is little we can do to help individuals and their families with their healthcare needs other than to offer them a list of free and sliding-scale-fee healthcare organizations in the area. Thank you all. [LB472]

SENATOR HOWARD: Thank you, Ms. Smith. Are there questions for the testifier? Seeing none, thank you for sharing these stories with us. [LB472]

PAMELA SMITH: Thank you. This was very exciting...first time. (Laughter) [LB472]

SENATOR HOWARD: First time...you did a very good job. Is there anyone else wishing to testify in a neutral capacity? Seeing none, just checking, Brennen, are there any items for the record? [LB472]

BRENNEN MILLER: No more items for the record. Thank you. [LB472]

SENATOR HOWARD: Perfect. Senator Campbell, you are welcome to close. [LB472]

SENATOR CAMPBELL: Senator Howard is a lot better about that checking on the letters than I am. We're going to make her the official letter checker of the... (Laughter) Colleagues, I will be brief because of the lateness of the hour. I want to thank all the testifiers, and I'm sorry that many of them have already left. And I appreciate the testifiers who testified in opposition to the bill, because we learn what people's questions are. We learn what people are thinking. And so I will spend some time taking a look at that but will not start going through point by point tonight, because I can see on your faces, like, oh, please not. (Laughter) I am very pleased, however, that

a lot of the testifiers on both sides saw that LB472 has two major components. It does talk about the access, but it also talks about Medicaid redesign. And we're at a point, like many other states, where we need to do that. The second thing that I pledge to the committee is that we will take a look at the fiscal note, the Milliman study, and also the information that Deputy Director Miller gave. And we'll try to take a look at all that to make sure we've got the correct figures from Senator Crawford's question. I would hope that we can soon get the rest of the professors' report, because we may want to spend some time taking a look at that. And I must--I must--put this in because I spoke on it on the budget of the biennium last year, and that is that we added a great number of FTEs already to the Medicaid. And I questioned it on the floor last year when we added all of those FTEs, so I have to say I still question those figures. I recognize that this is a bold approach. I mean, I understand that. The last two bills we've looked at that. But it is also a bold opportunity that 28 other states have looked at. And many of them have crafted it to what works in their state. We spent a lot of time today talking about the cost of this. But, quite frankly, what is the burden if we don't do it? And therein is...I think we need to spend more time. And hopefully the professors' report, at least some of the information that I saw earlier, may help us get to that question, because that's critical in our deliberations is if we don't do this, we know we have this population. We know we're going to have the population in the future. What is that burden if we don't? So with that, I thank you for your patience today. You've been great. [LB472]

SENATOR HOWARD: Thank you, Senator Campbell. Are there any final questions for Senator Campbell? [LB472]

SENATOR RIEPE: I always have one. You know me. [LB472]

SENATOR HOWARD: Senator Riepe. [LB472]

SENATOR RIEPE: Senator Campbell, thank you so much. I know that you've worked diligently and really, really hard for a long period of time...number of years. [LB472]

SENATOR CAMPBELL: I appreciate that. [LB472]

SENATOR RIEPE: And I guess, do you see any merit to looking at the market-based side of it? You know that that's a pet of mine. [LB472]

SENATOR CAMPBELL: Sure. Absolutely. [LB472]

SENATOR RIEPE: Or how does that get...it's not an intended "get it off the track forever" kind of thing. [LB472]

SENATOR CAMPBELL: No, no. [LB472]

SENATOR RIEPE: I agree with you. There's a problem. [LB472]

SENATOR CAMPBELL: You know, Senator Riepe, I think that's a great question and comment to make here at the end. You know, part of the reason that I went the whole direction to look at a redesign of Medicaid, looking at our current system and where do we think that system is going, that's a very legitimate question to say to the group of people that will look at it and hopefully stakeholders all across the state is to say, where do we think we're going? I would not dismiss that question to be looked at, no. [LB472]

SENATOR RIEPE: Thank you. You're very kind. [LB472]

SENATOR CAMPBELL: I don't know if I'm always kind. (Laughter) [LB472]

SENATOR RIEPE: I've never seen any other side, so I'm going to go with that. [LB472]

SENATOR CAMPBELL: Okay. We won't have you talk to my husband, but anyway. (Laughter) [LB472]

SENATOR RIEPE: But we all know how spouses can be. [LB472]

SENATOR COOK: No, we don't. [LB472]

SENATOR RIEPE: (Laugh) Oh, okay. [LB472]

SENATOR CAMPBELL: Yeah. [LB472]

SENATOR HOWARD: (See also Exhibit 48) Any other questions for Senator Campbell? Seeing none, this will close the hearing on LB472. [LB472]