[LB696 LB1032]

The Committee on Health and Human Services met at 1:30 p.m. on Wednesday, February 10, 2016, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB1032 and LB696. Senators present: Kathy Campbell, Chairperson; Sara Howard, Vice Chairperson; Roy Baker; Sue Crawford; Nicole Fox; Mark Kolterman; and Merv Riepe. Senators absent: None.

SENATOR CAMPBELL: Good afternoon and welcome to the hearings for the Health and Human Services Committee. I'm Kathy Campbell and I represent District 25, which is east Lincoln. We are glad to have you today. If there is a vacant seat next to you, maybe you could raise your hand if somebody comes in while we'll try to watch the door and see if we can get them all in today. I'm going to go through a few of the procedures for today and then we'll do introductions. I would like to remind you to turn off your cell phones or anything that you have that may make a noise. It's very disconcerting when a phone goes off. If you are testifying today and have handouts, we would like ten copies. And if you need additional copies, the pages to my far left will be glad to help you. As you come forward to testify, you will need one of the bright orange sheets that are on either side of the room filled out as legibly as you can. You hand those to Elice, the clerk. And if you have handouts, one of the pages will be happy to distribute them to the committee. You can take your place at the testifier chair. We use the lights in the committee and I am retaining the five minutes today per person. You will have four minutes and it will seem like it's green for a long time and then it will be yellow for a minute and then it will go to red. And today I will probably say we need to conclude your testimony because we have a lot of people who want to testify and I want to make sure that we can get everybody in. I think that's it. I think that's the instructions. I always think I've got them all and then I think of something else. Oh, I know what it is. When you sit down, you need to state your name for the record and spell it so that the transcribers can hear you. We will start with self-introductions and we'll start to my far right. Senator.

SENATOR FOX: Senator Nicole Fox, District 7: downtown and south Omaha.

SENATOR KOLTERMAN: Senator Mark Kolterman, District 24: Seward, York, and Polk Counties.

SENATOR BAKER: Senator Roy Baker, District 30: Gage County, part of southern Lancaster County, home of former state Senator Bill Burrows.

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

JOSELYN LUEDTKE: Joselyn Luedtke, committee counsel.

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

SENATOR RIEPE: I'm Merv Riepe. I represent District 12, which is Millard and Ralston.

ELICE HUBBERT: I'm Elice Hubbert. I'm the committee clerk.

JAY LINTON: My name is Jay Linton. I'm a senior ag economics major from Dalton, Nebraska.

SENATOR CAMPBELL: Will you be the only page today, Jay?

JAY LINTON: Ashlee is also with us today.

SENATOR CAMPBELL: Okay. Excellent. Senator McCollister, would you come forward, please. And we will open the hearing this afternoon on LB1032, Senator McCollister's bill to adopt the Transitional Health Insurance Program Act and provide duties for the Department of Health and Human Services. I would like to make a statement prior to the hearing and I will be reading from the fiscal note from the budget and Fiscal Office for the Legislature. "Rule 5, Section 7(h) which states," and I quote, "'If after investigation, it is determined that no dollar estimate is possible, the fiscal note shall contain a statement to that effect, setting forth the reasons why no dollar amount can be given.' A definitive fiscal note is not possible at this time due to the late delivery of the agency fiscal note and supporting documentation. A fiscal note will be supplied at a later date once information is fully analyzed." In six years that I've served as the Chair of this committee, I have never had to read that statement into the record. I am very disappointed that the information was given at a very late time period for the Fiscal Office to finish its work. I have been assured that they will finish their work as soon as possible, but I want you all to know that the fiscal note that is in front of you is not complete and it is not the one that this committee will be using. Our duty is to pay attention to what the fiscal note is, issued by our own Fiscal Office, and we will await that fiscal note. With that, Senator McCollister, welcome. And please go right ahead. [LB1032]

SENATOR McCOLLISTER: Thank you, Chairwoman Campbell and members of the committee. My name is John McCollister, J-o-h-n M-c-C-o-l-l-i-s-t-e-r, and I represent the 20th Legislative District in central Omaha. I'm here today to introduce LB1032, the Transitional Health Insurance Program Act, known as THIP. My interest in the American healthcare system goes back over 40 years to my service on the Health Planning Council of the Midlands. Through

the years I've seen the federal government take on an ever-bigger role in healthcare. In 2010 the Affordable health (sic) Care Act, or the ACA, which I didn't support, made big changes to our healthcare system. Despite its many flaws, the act provided for guaranteed insurability, young adult healthcare coverage inside their families until the age 26, and healthcare coverage for adults in the so-called Medicaid gap--persons who are between the ages of 18 and 64 who aren't currently eligible for Medicaid and who have income less than 138 percent of the federal poverty level. A hundred and thirty-eight percent of the poverty rate is $16,242 for a single person and $21,983 for a couple. The ACA stipulated the states would automatically share the cost of serving this population on a 90/10 basis, but the Supreme Court ruling in 2012 made this coverage optional for the states. The opportunity to decide whether or not Nebraska will expand its Medicaid coverage to 77,000 of our working poor is the reason we're here today. The candidate rhetoric that the ACA will be repealed in its entirety by Congress is a phoney political illusion. Because of the generous 90/10 funding split and the attractive features of the act mentioned before, 32 states, accounting for 60 percent of the population of the United States, have expanded Medicaid. And we know there are a few more states that are in the process. In the Midwest, Iowa, Minnesota, Colorado have expanded Medicaid, and South Dakota is working on an expansion plan. What have 32 states realized the state of Nebraska won't recognize--32 states? LB1032 has its critics to be sure, but thus far they have only offered critiques without viable alternatives. Criticism without solution rings hollow and doesn't do anything to deal with the situation that needs to be resolved. We contend that we're offering the country's best Medicaid expansion plan. Nebraska's THIP program is financially sustainable and will meet the needs of 77,000 uninsured Nebraskans. Let's review LB1032. LB1032 utilizes the private health insurance market for most enrollees through a premium assistance model where the Medicaid dollars are used to purchase private health insurance. Individuals who have access to cost-effective employer sponsored insurance, where the employer pays at least 50 percent of the costs, have a portion of their premiums, deductibles, and copays paid by Medicaid dollars. Individuals who have more significant ongoing medical conditions will have access to typical Medicaid coverage but will also have access to medical homes and other supports to help their health improve. All individuals above 50 percent of poverty, earning $837 per month for a family of three, will have to contribute to the cost of care by paying 2 percent of their monthly income as their premium. In this way, individuals who benefit will have shared responsibility for their health and the cost of care. The bill also emphasizes improved employment and employability through work referrals and the creation of a job training program modeled along the lines proposed by Governor Ricketts. Using these elements together, our goal is to make people healthier, more productive, and better able to increase their employability and earnings. The ultimate goal is to enable individuals served by the program to transition off of the program. What are the economic impacts of LB1032? Nebraska's up-front investment, at most only 10 percent of the cost of providing healthcare coverage under THIP, will draw about $2 billion in federal tax dollars over five years. The infusion of these dollars into our state will generate a significant amount of economic activity and, therefore, revenue. It's important to remember that these are tax dollars

we are already paying. Failure to pass LB1032 only means we're not getting our tax dollars back to work inside the Cornhusker state. It's our money; let's bring these resources back to Nebraska to help our poor neighbors. LB1032 will reduce spending by millions of dollars in several public assistance programs, including behavioral health, the state disability program, and on prescription drugs just to name a few. LB1032 uses the private market and does so in a way that will strengthen the health insurance marketplace. More individuals accessing care through the private marketplace means a larger risk pool with could mean lower costs for everyone down the road. LB1032 will help Nebraskans avert medical-related bankruptcies, projected to save as much as $142 million in bankruptcies in the next five years. LB1032 will address property tax relief by helping counties provide healthcare coverage. For example, it is estimated this proposal will save Douglas County $3.8 million and Lancaster County $2.5 million. Smaller counties will also see savings. LB1032 will spur significant job growth. According to a UNMC report, Nebraska could see an estimated 10,770 jobs to 13,044 new sustainable jobs. And most importantly, 77,000 uninsured Nebraskans will benefit from Nebraska's transitional healthcare insurance program. It's estimated that two-thirds of the insured population...of this insured population are the working poor of Nebraska, and over half of these people come from rural areas. Last summer and last fall I traveled from Lincoln to Aurora, from Wahoo to Scottsbluff, from Sidney to Lexington and beyond. My purpose was to better understand stakeholder views and to learn from and listen to my colleagues. During this process, what I heard was a need for a market-driven solution where people contribute to the costs of a program system and that rewards innovation where individuals transition to better health and increased employability. LB1032 is good policy and a positive solution to this enormous problem in our state. It's economically feasible. It will grow jobs, expand our economy, and provide health insurance for 77,000 poor Nebraskans. Thank you. [LB1032]

SENATOR CAMPBELL: Thank you, Senator. [LB1032]

SENATOR McCOLLISTER: I'd be prepared to answer any questions. [LB1032]

SENATOR CAMPBELL: Okay. Thank you, Senator McCollister. Questions, Senators? Senator Fox. [LB1032]

SENATOR FOX: Thank you, Senator Campbell. Senator McCollister, on October 7 last fall you did a radio interview with KLIN. In that radio interview you discussed your concerns about the financial sustainability of the government's proposal to fund a large majority of this expansion, 90 to 100 percent. And so you come today to introduce a bill. Can you elaborate on your concerns last fall and the change of heart in saying that you feel that this program is sustainable today? [LB1032]

SENATOR McCOLLISTER: Well, thank you, Senator Fox, and I'm glad you asked that question. As you may know, the ACA has written into statute 90 percent...that 90 percent funding level written into statute, and it will be very difficult to change by any administration, Republican or Democrat. Secondly, you should probably know that the federal government maintains Medicaid, Medicare, and those are programs that they've funded without fail. So you know, it's...I have long-term concerns about entitlement programs in general and I think we're probably going to have to resolve that. But overall, I think Medicaid for Nebraska in our THIP program will be sustainable. [LB1032]

SENATOR FOX: Thank you, Senator McCollister. [LB1032]

SENATOR McCOLLLISTER: Uh-huh. [LB1032]

SENATOR CAMPBELL: Any other questions? Senator McCollister, I assume you'll stay to close. [LB1032]

SENATOR McCOLLISTER: I have another... [LB1032]

SENATOR FOX: There's a question. [LB1032]

SENATOR CAMPBELL: Oh, I'm sorry. [LB1032]

SENATOR RIEPE: There's a question. [LB1032]

SENATOR McCOLLISTER: Oh, I'm sorry. [LB1032]

SENATOR RIEPE: Go ahead. [LB1032]

SENATOR KOLTERMAN: Thank you, Senator Campbell. Senator McCollister, when you were talking about the employer assistance, somebody writes a small group plan, where...is the employer responsible for paying 50 percent then of the employee's coverage or the family coverage? Or what are we talking about there? [LB1032]

SENATOR McCOLLISTER: Well, just like most employer programs, there's a split with the employee and, you know, we...our program envisions the continuation of the employer portion of that funding. But for some of the employer...employee costs, which would be the premiums, the

deductibles, and the copays, that's where some of the Medicaid dollars would come into play. [LB1032]

SENATOR KOLTERMAN: So if an employer elects to put a group in and one of their employees takes advantage of this plan, is the employer then going to be responsible for paying half of the employee's coverage? [LB1032]

SENATOR McCOLLISTER: No, sir. Yeah, he will continue with the employer portion of the coverage but the Medicaid dollars will help the employee portion of that plan. [LB1032]

SENATOR KOLTERMAN: So the employer will have to pay their portion. [LB1032]

SENATOR McCOLLISTER: Their portion, yes, sir. [LB1032]

SENATOR KOLTERMAN: Okay. And then talk a little bit about the job training aspect of this bill. [LB1032]

SENATOR McCOLLISTER: Well, it's detailed and I'll probably let some of my colleagues that will follow detail the specifics of the program. [LB1032]

SENATOR KOLTERMAN: Okay. Then I've got some just basic questions about... [LB1032]

SENATOR McCOLLISTER: Sure. [LB1032]

SENATOR KOLTERMAN: ...the demographics of this whole situation. [LB1032]

SENATOR McCOLLISTER: Fire away. [LB1032]

SENATOR KOLTERMAN: So at the present time in the state of Nebraska, and I can't give you exact numbers, but we have about 33,000 people that are in the exchange at the present time and they have anywhere from a bronze to a platinum plan. Well, there's no platinum anymore, but they have bronze to gold plans. [LB1032]

SENATOR McCOLLISTER: Uh-huh. [LB1032]

SENATOR KOLTERMAN: If we were to add 77,000 more people into that system, that exact system that exists today, how do we enroll them? How many employees are we going to have to put on staff to enroll them? Where are we going to house them? They're just basic questions I have about the demographics of how this would all get implemented. [LB1032]

SENATOR McCOLLISTER: As I indicated, Nebraska...there have been 32 states that have expanded Medicaid and I think we'd have to look to those other two states that have already expanded to, you know, figure out best practices and make it work in Nebraska. [LB1032]

SENATOR KOLTERMAN: Do you have any idea how many employees it's going to take to implement this? [LB1032]

SENATOR McCOLLISTER: I would not. [LB1032]

SENATOR KOLTERMAN: Okay. Thank you. [LB1032]

SENATOR CAMPBELL: Senator Riepe. [LB1032]

SENATOR RIEPE: Thank you, Senator Campbell. Thank you. Senator McCollister, good to see you. [LB1032]

SENATOR McCOLLISTER: Good to see you as well. [LB1032]

SENATOR RIEPE: First a comment: I guess I know Mrs. Clinton, who is a presidential candidate as we all know, has said that in 2017 there will be changes to the Affordable Care Act. Obviously, if Senator Sanders is elected, there will be significant changes. My question in part would be, why would we, with ten months away from a new presidency with...even though it may not be totally aborted, if you will, the accountable (sic) Care Act will experience some changes regardless of who the next President is. And would you have a response to that? Then I have a few questions I want to get into as well. [LB1032]

SENATOR McCOLLISTER: Well, after last night in New Hampshire, I think the odds of Mrs. Clinton being President have become lessened. But whoever the President is, the fact that the program has certain features that most people like--guaranteed insurability, you know, coverage of young adults inside their families, and Medicaid expansion--I think that will make the program hard to drop. [LB1032]

SENATOR RIEPE: Another concern that I have, being a hospital kind of a background, is what you may expose are having insurance is one thing, having...getting healthcare is another thing if you throw an additional 77,000 lives into a marketplace that's already short. And you can talk about 10,000 new jobs but does training a physician or training your clinical nurse practitioner takes 10 years. Takes 12 years. How do you address that you're going to cover that void (inaudible)? [LB1032]

SENATOR McCOLLISTER: Once again, we're going to have to look to some of the other states that have expanded already and look at best practices and figure out how some of the expanded roles...healthcare roles will be covered. So you know, I can't very well sit here today and tell you how that will be accomplished. [LB1032]

SENATOR RIEPE: Okay. But those are questions that I have as I look at this. I would have a difficult time passing legislation without some of those questions answered. [LB1032]

SENATOR McCOLLISTER: I understand. [LB1032]

SENATOR RIEPE: I also noticed in your opening remarks that deeded what I perceived as being some dynamic forecasting. And you know, my sense is we're not allowed to do that here in the Unicameral. But that's simply an editorial comment. [LB1032]

SENATOR McCOLLISTER: Well, we've had a number of studies that have looked at our proposal, you know, UNMC and also the professors from Kearney. So there are some predictions. And also the fact that 32 states have expanded Medicaid, we can look to those states for the dynamics occurring inside what we would propose. [LB1032]

SENATOR RIEPE: Okay. And I think we're going to hear from the states, or at least Arkansas, a little bit later. [LB1032]

SENATOR McCOLLISTER: Yes, indeed. [LB1032]

SENATOR RIEPE: I know that Senator Kolterman and I were at a conference in California several months ago and in the state of Nevada their projection was they'd have 300,000 covered lives. They ended up with 600,000. My point is looking to the other states is simply nothing more than a guess about terms of what this unchartered water might be. [LB1032]

SENATOR McCOLLISTER: Well,... [LB1032]

SENATOR RIEPE: More specific...I'm sorry. I'm sorry. [LB1032]

SENATOR McCOLLISTER: I was just going to say that the Nebraska Legislative Fiscal Office does a pretty good job, and a conservative job, in the way they look at some of the assumptions. And so when we have their analysis of this bill and its cost, I think we'll be able to better judge its sustainability. [LB1032]

SENATOR RIEPE: Okay. One of the concerns when I studied the bill, and I did, is it talks about premium assistance program. And this was...I can give you pages, sections and stuff like that I know. And maybe we can just talk in general terms though. But throughout this thing it talks about premium. It also requires that on some of these plans that they have to meet the minimum of what is offered to Medicaid patients. And our Medicaid patients or benefit package in the state of Nebraska is considered a very rich and generous program because there are like 13 federal requirements. And in addition to those 13 there are 19 additional programs which includes dental. My concern as I get into this is when I go back to my constituents, quite frankly, some of these programs that will be offered up here will be significantly better than programs that the people in my district, and my district is not a poor district, so they would be above that. And I don't know what I'm going to tell them. [LB1032]

SENATOR McCOLLISTER: I would tell you, Senator Riepe, that when LB1032 passes, it will be the obligation of the HHS Department to implement it, and so some of those benefits may or may not be included. So it's...that will unfold in due course. [LB1032]

SENATOR RIEPE: Are you saying that this will get amended to amend some of those out? [LB1032]

SENATOR McCOLLISTER: Well, I'm saying this is a dynamic process and reform needs to occur in healthcare, and we've talked about this often. And so passage of LB1032 will just start the process of reform in Nebraska and last for a long time, I believe. [LB1032]

SENATOR RIEPE: Okay. Another one that I have, if I may, Chairman, is of course you know I have an interest in direct primary care because it's a free market based piece. There's a stipulation in this legislation that talks about patient-centered medical homes, and this bill...this bill requires all enrollees to participate in primary care medical homes. First of all, there aren't that many out there and, two, that precludes any other models from coming in there. That's a serious concern of mine and one that, you know, quite frankly...and I support patient-centered medical homes. I just don't support it as an exclusive approach to how healthcare can and should be delivered. And particularly most of this is incremental change. It's not going to happen in one year or two years. It's going to take time. [LB1032]

SENATOR McCOLLISTER: I don't know. [LB1032]

SENATOR RIEPE: Is there some reason that this exclusivity is given to patient-centered medical homes? [LB1032]

SENATOR McCOLLISTER: No, I would...we intend to promote primary care because it's less expensive and better for the patient, and we hope to avoid sending those people to the emergency rooms, which is the most expensive kind of care provided. So those kinds of innovations will be built into the system, I'm sure. [LB1032]

SENATOR RIEPE: I think in the legislation as well it talks about something like emergency department visits and it talks about some number of visits, but it's not very specific. It says that you're going to leave that up to the Department of Health and Human Services to administer it. It says you can have so many visits and there's a larger copay. [LB1032]

SENATOR McCOLLISTER: I leave those kinds of decisions in their able hands. [LB1032]

SENATOR RIEPE: Okay. Another concern that I have is this has the potential of taking many of the insurance companies out of the market because you're going to crowd them out with government money. [LB1032]

SENATOR McCOLLISTER: Well, actually, our use of the insurance market is part of the program that we propose, so I'm not sure that's the case. [LB1032]

SENATOR RIEPE: I will halt at that. I may come back with some more, but. [LB1032]

SENATOR CAMPBELL: Thank you. Senator Crawford. [LB1032]

SENATOR CRAWFORD: Thank you, Chairwoman Campbell. I wondered, Senator McCollister, following up on that comment, if you would discuss how you see the bill using existing private market insurance plans, or... [LB1032]

SENATOR McCOLLISTER: I think we're going to have to leave that, those, that question to some of the folks that follow. [LB1032]

SENATOR CRAWFORD: Okay. [LB1032]

SENATOR CAMPBELL: Okay? Did you have a follow-up? Senator Howard. [LB1032]

SENATOR HOWARD: Thank you, Senator Campbell. Thank you, Senator McCollister, for visiting us today. I wanted to clarify something. In your opinion, are folks who are uninsured, the 77,000 who are uninsured, are they not getting healthcare now? [LB1032]

SENATOR McCOLLISTER: Well, they are getting healthcare and they get it through the emergency room. And as we just discussed, that's the most expensive healthcare there is and not particularly efficient. If you've got diabetes, for example, going into the emergency room means that you've neglected your health for a good time before that you...when you appeared in the emergency room. So that's not particularly effective care. So, yeah, and of that 77,000, as I mentioned in my testimony, two-thirds of those people are the people working at the fast-food restaurants; they're working in construction; or they're working in farm jobs. So it's...they're the working poor. [LB1032]

SENATOR HOWARD: Thank you for that clarification. I think, as I think about the structure of our healthcare system, I don't worry as much about work force because these folks are already getting healthcare. We're just trying to divert them to more preventive and primary care focused options. Is that correct? [LB1032]

SENATOR McCOLLISTER: If you would allow me to elaborate,... [LB1032]

SENATOR HOWARD: Oh, yes. [LB1032]

SENATOR McCOLLISTER: ...there's over $1 billion worth of uncompensated care that occurs in our hospitals throughout the state and one of the prime benefits is that LB1032 would give some of those hospitals the money that is now being uncollected. [LB1032]

SENATOR HOWARD: Thank you. [LB1032]

SENATOR CAMPBELL: Senator Fox. [LB1032]

SENATOR FOX: Again, Senator McCollister, you just mentioned a bit ago that it's the obligation of DHHS to implement the transitional healthcare. In Section 10 of the bill, it talks about how the coverage would terminate automatically if federal funding would fall below 90 percent. And I just want to make it clear, me being a healthcare provider, I definitely feel that, yes, we want to provide healthcare for those that are truly needy. But my big concern, even though we don't have an official fiscal note, I just have concerns about the financial sustainability

of this program. And I'm the type of person that likes to have a backup plan and I'm not going to take my concerns about the sustainability off the table. Who is going to be responsible should federal funding fall though? Is that going to be DHHS's responsibility to deal with that? [LB1032]

SENATOR McCOLLISTER: No, ultimately, the Nebraska Legislature. And inside our bill, LB1032, if federal funding falls below 90 percent, the program automatically ceases, period. I'd remind the senators, many of those people that have been here, were here in 2008, Nebraska chopped $1 billion out of our budget. So this Nebraska Legislature is dedicated to balancing the budget, and we will. In fact, we've cut people from the Medicaid rolls in order to save money. I'm here as the sponsor of the bill to tell you that we will be responsible to the citizens of Nebraska. And if for some reason this...the federal commitment falls through, we'll have to deal with that eventuality. [LB1032]

SENATOR FOX: So can I...? So essentially to say that supporting this bill is I also support taking blame for the consequences then if the federal government cannot fulfill their responsibility to us. [LB1032]

SENATOR McCOLLISTER: Well, everything we do here and everything we pass here, we're ultimately responsible for what has occurred. So we all have broad shoulders, don't we? [LB1032]

SENATOR CAMPBELL: I think we're going to proceed here. Thank you, Senator McCollister. We'll get back to the questions when you close, okay? [LB1032]

SENATOR McCOLLISTER: Yeah. And I have another committee meeting but I'll be back for a closing. [LB1032]

SENATOR CAMPBELL: Okay. A friend of mine talked with me about the fact that Manatt had done some analysis and worked with Arkansas, and so my office reached out to Manatt and asked if they would answer some questions. And they were more than willing to come and to testify but in a neutral position. So I have asked them to come today to talk about their experience with Arkansas and other consulting that they might have done with some of the plans. And so I'd like to welcome Patty Boozang from Manatt. Welcome. [LB1032]

PATRICIA BOOZANG: Thank you. Good afternoon. [LB1032]

SENATOR CAMPBELL: I'm going to let you go right ahead and start. [LB1032]

PATRICIA BOOZANG: Okay. Thank you very much. [LB1032]

SENATOR CAMPBELL: Would you spell your name for the record. [LB1032]

PATRICIA BOOZANG: (Exhibit 1) Yes. My name is Patricia Boozang, P-a-t-r-i-c-i-a B-o-o-z-a-n-g. Thank you, all. Thank you, Chairwoman. Thank you, members of the committee, for inviting me to speak with you today. I'm a partner at Manatt Health Solutions and I'll give you a little bit of background on Manatt and the work that I do and the work specifically that I've done with Arkansas over the past several years. Manatt is a consulting and legal advisory group that's part of Manatt, Phelps and Phillips, which is a national law firm with a significant interest and practice in healthcare. And in the last five years I've worked, nearly exclusively, with states, with foundations, and with other healthcare stakeholders, including providers, on issues related to the implementation of the Affordable Care Act. And within that scope of work, I have a particular expertise in Medicaid expansion, in design of state expansions, in their implementation, and in evaluating their impact. I've worked with New Hampshire, Montana, Louisiana, and a number of states that have contemplated and implemented expansion or are implementing expansion. But of most interest I suspect to all of you here today, I have worked and continue to work with the state of Arkansas on the design, the drafting, and implementation of their 1115 waiver for their Medicaid expansion, called the private option. I'll spend a few minutes just talking about the private option background. It's the first Medicaid QHP premium assistance program in the country. And as you all know, that's a program through which the state purchases private market QHP coverage through the marketplace for most of the healthy adults through the expansion with incomes up to 138 percent of the federal poverty level. And while Arkansas was the first state to pursue an 1115 waiver for sort of what we think of as an alternative expansion, they weren't the last. Since then, by my count, at least seven other states have pursued these alternate alternative expansion programs. So I wanted to talk for a few minutes about the impact of the private option in a couple of different areas. First, in terms of coverage today, the private option covers 199,000 Arkansans through QHPs. An additional 22 (thousand) Arkansans are covered in the traditional fee-for-service program, also new adults but medically frail, so in the fee-for-service program. That has driven a 13 percent decrease in the number of uninsured residents in the state, which ties Arkansas with the state of Kentucky for the largest drop in the uninsurance rate nationally. The private option has had a significant impact on providers. From 2013 to 2014, the utilization by uninsured people in the state has dropped substantially so that admissions to hospitals by uninsured people have dropped by nearly 50 percent, emergency room visits by nearly 40 percent, and outpatient visits by 46 percent. And that's led to hospitals experiencing a 55 percent decrease in their uncompensated care losses. That's about a $150 million impact to the hospitals. I'd also note that an independent analysis done by a consultant to...another consultant to the Arkansas legislature found that by using the private commercial networks in the private option, 10,000 new providers are serving private option enrollees as compared to the traditional Medicaid program in the state. The private option has also had a big impact on the

marketplace. It's nearly tripled the size of the Arkansas marketplace and, in fact, makes up about 80 percent of total marketplace enrollees. What was interesting in Arkansas is that the private option enrollees are younger on average than other marketplace enrollees and they've improved the risk pool. One of Arkansas's goals in implementing the private option was to increase competition in its marketplace and, in fact, the state has gone from having two carriers...two insurance issuers in the market in 2012 to having six carriers in the market today. In terms of premium impact, that bigger and sort of healthier risk pool is also believed to have led to a drop in premiums in the marketplace from 2014 to 2015. Premiums did increase between '15 and '16, but that rate of increase was lower than what other states experienced nationally. All states experienced premium increases between '15 and '16, but it was a bit lower. In terms of the impact to the state budget, the state economy, the state estimates that total state general fund savings and revenue gains related to the private option total $118 million in 2015 and that the net state budget impact between 2016 and 2021 is $438 million. And what the state has said and has been validated by, again, this legislative task force is that the private option appears to be self-sustaining through 2021, but there will be a state general fund requirement in the order of $50 (million) to $60 million to support the expansion beginning in 2022. That said, Governor Hutchinson, in a recent speech to the legislative task force, noted that ending expansion would take between $1.4 and $1.7 billion out of their state budget. That's sort of those federal dollars...those federal Medicaid dollars, plus those lost savings in revenues that the state has realized since implementation. I think one of the things that's important to keep in mind about the private option is that it is a pilot; it's a demonstration. It has evolved and changed over time since its implementation. The program is now in its third year. And it will continue to evolve and change. So some examples of that are the state implemented health independence accounts, which are HSA-like accounts, to which private option enrollees make required contributions on a monthly basis. Those were implemented in 2015 so the state amended its waiver to implement that program. The state in this year, 2016, implemented purchasing guidelines in the private option, which means that the sort of field of Silver Plans in which folks are able to enroll is more narrow and is based on the cost of that plan. So it's the two lowest-cost plans in the market and any plan that falls within 10 percent in terms of premium pricing of those lowest-cost plans, so focusing more on the cost-effectiveness of those plans. And as I'm sure many of you may know, state policymakers are now considering some additional modifications to the state's expansion amendment, really to make improvements related to some of the things you're considering, implementing ESI premium assistance, implementing work referrals, implementing premium obligations for enrollees, and other program integrity incentives, but I think importantly maintaining the core feature of the expansion, which is the QHP premium assistance program. And finally I would just say, you know, this program, I don't think any Medicaid demonstration is without its challenges and without its complexities. I think that premium assistance programs, whether QHP or ESI premium assistance, are complex to administer. They require coordination across state agencies and so there really has to be an acknowledgment of that administrative complexity going into this. And I think the task force that I mentioned, the legislative task force,

has particularly acknowledged the challenges and the complexities of the health independence accounts, the HSAs, and I think we can probably expect to see some changes there given that those accounts haven't worked out quite as they were expected to upon their implementation. So that's just sort of an overview of the Arkansas model and I am more than happy to answer questions if you have any. [LB1032]

SENATOR CAMPBELL: Ms. Boozang, I have a question. In our...the bill that's before us in LB1032, with the employer portion of it there's been question about, well, will employers just off-load employees on to that system. Has any state addressed that issue? [LB1032]

PATRICIA BOOZANG: So you know certainly states do think about that issue that...and I think that ESI premium assistance is one of the ways in which states tackle that. That there are many states that have small businesses that do have lower-income employees, and while they may have an offer of employer sponsored coverage, because they're lower income, they may not be able to afford that coverage. And I think ESI premium assistance, and certainly Arkansas is thinking about it this way, is a way for the state to come in and say we're going to leverage the fact that we have employers that want, as part of their compensation, to offer coverage to their employees. And doing that is a way to really try to preserve and sustain that employer sponsored market rather than just having those folks shift over to the Medicaid program. [LB1032]

SENATOR CAMPBELL: Should we look at some kind of an incentive? [LB1032]

PATRICIA BOOZANG: Yeah, there are some states, too, that as an incentive...you know, I think the concern you're talking about is, you know, do employers have an incentive to say, well, I'm not going to continue to offer because I used to have these folks going to Medicaid and now they're staying on my coverage. And there are several states, and Arkansas is also looking at getting federal authority to use Medicaid dollars to offer incentives to employers, so sort of a financial incentive to cover part of their portion of the premiums as an incentive to maintain or really even begin to offer coverage to their employees. [LB1032]

SENATOR CAMPBELL: When you were in Arkansas, you worked with Optumas, correct? [LB1032]

PATRICIA BOOZANG: Yes. [LB1032]

SENATOR CAMPBELL: What role did they play in relation to the role you played with Arkansas? [LB1032]

PATRICIA BOOZANG: Uh-huh. So we were primarily the policy and regulatory advisers, or are--I'm talking in the past tense--are primarily the policy and regulatory advisers to the state, really helping them understand, you know, what's within the realm of the possible as part of a demonstration program, what are other states doing, how can we be creative to create something that's really state specific, tailored to Arkansas. And Optumas was our counterpart in terms of the actuarial modeling. We aren't actuaries. We don't have that capacity within our firm. And so they really came in to take those ideas and helped to model them, both for the purposes of the waiver but also for the purposes of the fiscal note and understanding the impact to the state. [LB1032]

SENATOR CAMPBELL: I was somewhat surprised in the report to us, or at least that we received, that they had made ten-year projections. Did you make ten-year projections in Arkansas? [LB1032]

PATRICIA BOOZANG: We did not. [LB1032]

SENATOR CAMPBELL: Okay. I was somewhat surprised at that. Other questions? Senator Kolterman? [LB1032]

SENATOR KOLTERMAN: Thank you, Senator Campbell. And thank you for inviting her to come. Ms. Boozang, a couple questions. You've worked with the Arkansas model. How have projected costs that they had originally come out versus the actual costs, because they've had it now for, what, two years? [LB1032]

PATRICIA BOOZANG: They're in their third year. [LB1032]

SENATOR KOLTERMAN: Third year. [LB1032]

PATRICIA BOOZANG: Yeah. [LB1032]

SENATOR KOLTERMAN: Yeah. [LB1032]

PATRICIA BOOZANG: Yeah. [LB1032]

SENATOR KOLTERMAN: Do you know that? [LB1032]

PATRICIA BOOZANG: I do. So the...we think about this in the context of the budget neutrality of the waiver. So there's a budget neutrality cap that is set at the beginning of the waiver and the

state has to stay within that cap. In other words, it has to be budget neutral to the federal government. And if it exceeds that cap, those are costs to the state. Those are costs the state has to bear itself. And that's a three-year analysis, so it's over the life of the waiver, which is a three-year waiver. And in 2014, the first year of the waiver, the state was running slightly above that cap. That cap was $500 for 2014 and I think runs up to $530-ish, that's not...these aren't precise numbers but this is the range,... [LB1032]

SENATOR KOLTERMAN: That's okay. [LB1032]

PATRICIA BOOZANG: ...for 2016. For the first 11 months of 2015, the state, the private option program that the state has been running, the actual costs have been running below that cap. And the state projects now that for the life of the waiver for 2015 and 2016 they will remain below or at that cap level. [LB1032]

SENATOR KOLTERMAN: Okay. And then...can I keep going, Senator. Thank you. [LB1032]

SENATOR CAMPBELL: You can. [LB1032]

SENATOR KOLTERMAN: You talked about qualified health plans, which are what the federal government offers, the Gold, Silver, Bronze, Platinum, correct? [LB1032]

PATRICIA BOOZANG: Yes. [LB1032]

SENATOR KOLTERMAN: And you talked about most versus all. So you said 199,000 were in qualified health plans and 22,000 were in other traditional Medicaid. [LB1032]

PATRICIA BOOZANG: Yes. [LB1032]

SENATOR KOLTERMAN: How do you establish the difference between the two and how does that break out costwise? Do you know that? [LB1032]

PATRICIA BOOZANG: So states have the discretion to establish or determine who is medically frail through a process that they design. They have to have a process but it's left to the discretion of the state. In Arkansas, they've actually worked with some clinical folks in the state to develop a screener, so an actual screening tool so that when you're determined eligible for Medicaid in the state of Arkansas you go first to a portal where you take that screener. And based on how that screener is scored, you would be determined medically frail or not. [LB1032]

SENATOR KOLTERMAN: Okay. And then one...I guess one. I might have some more questions, but one last question. Well, I'll come back to that. I'll come back to that. [LB1032]

PATRICIA BOOZANG: Thank you. [LB1032]

SENATOR CAMPBELL: Senator Riepe. [LB1032]

SENATOR RIEPE: Thank you, Senator Campbell. Were you the...you or your organization responsible for the development, creation, implementation, enrollment of Arkansas Medicaid new program, the one that's currently functioning? [LB1032]

PATRICIA BOOZANG: We were part of the team of the consultants that worked with Arkansas to actually help to flesh out the details. They had state legislation. And so working with that legislation, we helped them to prepare an 1115 waiver application to CMS to get approval to implement that program. So, yes, we were part of the team that worked with them to do that. [LB1032]

SENATOR RIEPE: In terms of talking with some fellow senators that we know from Arkansas, they said that it was pretty wrought with problems as it started. That may not be atypical. Is that your experience? [LB1032]

PATRICIA BOOZANG: So one of the things you may be talking about in Arkansas is that they have had...and I say this because you mentioned the eligibility and enrollment systems and processes. Arkansas has, at the same time that they implemented their expansion, like many states, they had a major effort and project around replacing their eligibility and enrollment system and that project has in fact been fraught with many issues. And that has really created some real problems for the state in terms of having an efficient and effective eligibility and enrollment system. [LB1032]

SENATOR RIEPE: Uh-huh. We've also read some, and of course you're always trying to make sure that your information is caught up with what's currently going on, that at end of the year that the Arkansas program is going to be totally either reconstructed or that...and maybe that's just operational. And the other question I would have, if I might, is in terms of the private option, the stuff that I've read says that the cost to do private options is probably five times as expensive as if one was to expand Medicaid at the cost of Medicaid. [LB1032]

PATRICIA BOOZANG: Uh-huh. [LB1032]

SENATOR RIEPE: Is that...are we...am I off base on that or...? [LB1032]

PATRICIA BOOZANG: So I think you had two questions. [LB1032]

SENATOR RIEPE: Yes, I did. [LB1032]

PATRICIA BOOZANG: The first was about the sunset of the private option. So the original legislation authorizing...state legislation authorizing the private option does sunset the program at the end of 2016. So it requires the administration to do something to either end the program or to continue it or to change it. And Governor Hutchinson, which is who came into office this past year, formed a legislative task force to actually consider this question, you know, what should we do with Medicaid really more broadly in the state, not just about this expansion. And his...that task force is a bipartisan task force and at the beginning in the fall of this year actually had a bipartisan vote unanimously supporting continuing the expansion but, as you suggest, making some changes to it. So the proposal is to continue the QHP premium assistance aspect or feature of the expansion; to add this ESI premium assistance program feature, which is something your legislation considers; and has several other modifications to the program related to work referral and work training, really using Medicaid as a vehicle to help connect people to work; and then also some other features around program integrity. So the Legislature will have a special session and they'll be voting to do that definitively, but the proposal at this point that's been ratified by that task force is to amend the expansion to make some changes. [LB1032]

SENATOR RIEPE: Okay...I'm sorry. [LB1032]

PATRICIA BOOZANG: And your second question, do you want me to take the second one? I'm sorry I talk a lot. It's my mother's fault. [LB1032]

SENATOR RIEPE: If it's still on the tip of your tongue or I'll repeat it. [LB1032]

PATRICIA BOOZANG: The second question I think was about the cost... [LB1032]

SENATOR RIEPE: Yes. [LB1032]

PATRICIA BOOZANG: ...and is the cost of the program, I think you said... [LB1032]

SENATOR RIEPE: Compared to Medicaid. [LB1032]

PATRICIA BOOZANG: ...compare to Medicaid. So I don't think there is evidence that the private option is, at least in Arkansas, you know, many multiples more than it would have cost to pursue some other model. That said, I think that there are various models to implement expansion and they will have cost differentials. And I think you've considered some of them through other bills. I think you could consider doing it through a fee-for-service program, could consider doing it through a managed care expansion. I think a private option model is another option. And I think they all have differences, including differences in the cost of the program. [LB1032]

SENATOR RIEPE: We'd also like to welcome you to our nice cool weather here in Nebraska. [LB1032]

PATRICIA BOOZANG: Well, I'm from Boston so... [LB1032]

SENATOR RIEPE: Oh. [LB1032]

PATRICIA BOOZANG: ...I can take it. (Laughter) I can take it. [LB1032]

SENATOR RIEPE: You get no mercy. [LB1032]

SENATOR CAMPBELL: She's used to that. Senator Crawford. [LB1032]

SENATOR CRAWFORD: Thank you, Chairwoman Campbell. And thank you for being here and offering your expertise from your experience. I wondered, from your experience in working with the Arkansas program, if you care to comment. The cost estimates that we have, the analysis of the cost estimates, the estimate assumes that for the QHP that the cost would be $738 per member per month to help someone purchase those plans. And I wondered if you care to comment, if you know how that compares to what you've seen in your experience in Arkansas. [LB1032]

PATRICIA BOOZANG: So, you know, I haven't done an in-depth look at the methodology in the analysis. And in my experience, usually even when you do that those estimates are a bit of a black box and it helps to really have a conversation about what assumptions did you make, why did you make those assumptions. You know, my gut reaction to it is that it seems high. It certainly seems high as compared to Arkansas...the experience in Arkansas. But again, I...you know, without really digging in and trying to understand all the assumptions, it's difficult to say. I do know one of the places that there have to be a lot of assumptions, and sometimes those assumptions can be a little bit fluid, are around predicting, you know, who is this population and

how high risk are they, how sick are they, how alike or different are they from the population that we have enrolling in the marketplace today. I can say that in Arkansas that the population turned out to be less sick than we had anticipated early on in the process. And I think that other states have had this experience, too, where they anticipated these are super high-need folks; they haven't had access to insurance; they have a lot of, you know, unmet health needs. And that the actual experience has been somewhat less dire than what was predicted. [LB1032]

SENATOR CRAWFORD: Thank you. [LB1032]

SENATOR CAMPBELL: Senator Howard and then Senator Kolterman. [LB1032]

SENATOR HOWARD: Thank you for visiting us today. [LB1032]

PATRICIA BOOZANG: Thank you. [LB1032]

SENATOR HOWARD: I wanted to bring us back to the eligibility and enrollment system or the challenges with the enrollment system. What kind of system were they using? [LB1032]

PATRICIA BOOZANG: So they procured a new system and I think the vendor for that system was Carrum, was the vendor. And you know, beyond that I think they had some...a lot of challenges getting that system up to full functionality. And there's a lot of documentation out there. They had, again, the legislature, commissioned an independent report...an expert to come in and sort of do an analysis of that system and what the problems and challenges were. [LB1032]

SENATOR HOWARD: I think that just sort of brought to mind we've been focusing on ACCESSNebraska, which is our call center system for benefits, and on our Medicaid side they've really focused on improvements and streamlining enrollment for enrollees. And it's to a point where we almost don't need legislative oversight anymore and so it's actually kind of interesting to see that contrast between the state of Arkansas, which had some challenges in their enrollment processes, to Nebraska, which has really improved them on the Medicaid side. So thank you. [LB1032]

PATRICIA BOOZANG: Congratulations. It's not an easy thing to do. [LB1032]

SENATOR CAMPBELL: Senator Kolterman. [LB1032]

SENATOR KOLTERMAN: Thank you, Senator Campbell. The question I was going to ask you earlier deals with...now you were involved in Montana as well, I understand. [LB1032]

PATRICIA BOOZANG: Yes. [LB1032]

SENATOR KOLTERMAN: Were you involved in Iowa? [LB1032]

PATRICIA BOOZANG: No. [LB1032]

SENATOR KOLTERMAN: Okay. So let's focus on Montana and Arkansas. Does Montana use the qualified health plans as well, or do they do their own? [LB1032]

PATRICIA BOOZANG: They do not. They do not. [LB1032]

SENATOR KOLTERMAN: Okay. Let's go back to Arkansas (laughter) because that's more like what we're proposing here. So under the qualified health plans, you've got the Silver or Bronze all the way through. Did Arkansas offer all those different plans? [LB1032]

PATRICIA BOOZANG: No, they did not. [LB1032]

SENATOR KOLTERMAN: So where does the...you have an account that they can set up to put money into in Arkansas. So why would you need that if... [LB1032]

PATRICIA BOOZANG: Right. [LB1032]

SENATOR KOLTERMAN: ...if we're going to put everybody, if we do this bill, we're going to put everybody into a Silver Plan... [LB1032]

PATRICIA BOOZANG: Which is what Arkansas did as well. [LB1032]

SENATOR KOLTERMAN: ...which is...that's where you keep your most subsidies... [LB1032]

PATRICIA BOOZANG: Right. [LB1032]

SENATOR KOLTERMAN: ...as an employer, as an enrollee. [LB1032]

PATRICIA BOOZANG: Right. [LB1032]

SENATOR KOLTERMAN: So why do you have that other? [LB1032]

PATRICIA BOOZANG: Oh, the health...the independence account? [LB1032]

SENATOR KOLTERMAN: Yes. [LB1032]

PATRICIA BOOZANG: So just to validate, yes, the Arkansas model is focused on enrolling people in silver level plans for a few reasons. One is, you know, as folk's income changes, they're most likely, if they gain a new job or gain income and become over income for Medicaid, they're most likely still to be eligible for a silver level plan in the marketplace so that they can access the cost-sharing reductions, those additional federal subsidies. So I think it made good sense from that perspective. Additionally, the high value Silver Plan, so that 94 percent AV (actuarial value) plan where the sort of full benefit of cost-sharing reductions is very close in actuarial value to a Medicaid product with cost sharing. So it made sense from that perspective, too, so that's why Arkansas focused there. The health independence accounts were initially established to have people start to get into...it really...the goal was to help folks start to understand how traditional insurance works so that as you transition into the marketplace you have some experience with paying premiums on a monthly basis and having that monthly obligation. And the way it works is that if you make that contribution, if you're a person with income over 100 percent of the federal poverty level and you make that contribution, you're making that in lieu of your point of service cost sharing, so that your cost sharing is being drawn against those payments that you make to that account. You don't have that additional obligation. [LB1032]

SENATOR KOLTERMAN: Similar to an HSA type of an account? [LB1032]

PATRICIA BOOZANG: Sort of an HSA type model, yes. [LB1032]

SENATOR KOLTERMAN: Are all reimbursement accounts to a certain extent? [LB1032]

PATRICIA BOOZANG: Right. And really the goal, the policy goal was to sort of help people sort of move along in understanding how to be good healthcare consumers. [LB1032]

SENATOR KOLTERMAN: And then the final question would be, why is it...and apparently you deal with a lot of different states in a consulting role. Why is it that if the federal government...they could come into my office today and buy a policy if they're at 100 percent of poverty or greater. Why is it that we're designing all these Medicaid expansion to go from

zero...if we go to expansion, zero income up to 138 (percent)? Why wouldn't we just stop at the 100 (percent), because anybody that's over 100 percent would qualify under the Affordable Care Act right now? [LB1032]

PATRICIA BOOZANG: Uh-huh. [LB1032]

SENATOR KOLTERMAN: Is that not correct? [LB1032]

PATRICIA BOOZANG: Yes. Those people, yes. [LB1032]

SENATOR KOLTERMAN: So why are we going to pick up people that are already supposedly covered? Are they just not coming in and getting the coverage? [LB1032]

PATRICIA BOOZANG: So I don't think I can answer that question for you because that's federal statute. (Laugh) It's not...it's isn't even interpretation of statute. [LB1032]

SENATOR KOLTERMAN: Did that question ever come up in your own mind? [LB1032]

PATRICIA BOOZANG: It certainly is coming up and it is definitely being discussed, especially among states that are later to expansion. And I think you know it has to do with the fact that when the ACA was passed Medicaid expansion wasn't optional. It was the Supreme Court case that made Medicaid expansion optional and so it was never sort of conceived early on that you would have this environment in which people from 100 percent who would otherwise be eligible for Medicaid were enrolling in QHPs. So I do think it's a bit of an artifact of that change in how the ACA was implemented after the Supreme Court case. [LB1032]

SENATOR KOLTERMAN: Then one more question if I may. [LB1032]

SENATOR CAMPBELL: All right. Now you said final the second time. [LB1032]

SENATOR KOLTERMAN: Okay. I'll make this my final. [LB1032]

SENATOR CAMPBELL: Second final. [LB1032]

SENATOR KOLTERMAN: Second to the last. [LB1032]

PATRICIA BOOZANG: He really means it. (Laugh) [LB1032]

SENATOR KOLTERMAN: Sorry about that. So when somebody comes in and they want to buy a health insurance policy, as an agent they come to me and they say, what can I qualify for? And so to qualify them we look at their income, and so we look at...we ask them bring your tax statement with you so that we can put you where you actually belong... [LB1032]

PATRICIA BOOZANG: Uh-huh. [LB1032]

SENATOR KOLTERMAN: ...and make sure that our quote and our policy is as accurate as possible so they don't get caught next year with more income or less income and thrown out. How do you do that in the Medicaid situation, because many of the people on Medicaid or eligible don't file income taxes? So how do we...how do we qualify those people? [LB1032]

PATRICIA BOOZANG: Right. [LB1032]

SENATOR KOLTERMAN: W-2? 1099s? [LB1032]

PATRICIA BOOZANG: So there...so this is interesting and there may be things that you can do directly as a state to be more involved in that process. But I think if you have somebody who doesn't file a tax return or looks like they're...and I suspect you have navigators or assisters or other people who can speak to this question even better than I can. But I think, you know, you really want to get that person into the application through healthcare.gov where they can understand what tax...whether they're eligible for a tax credit or Medicaid. Or you want to get them to the Medicaid agency to make that assessment. I personally like the idea of when you've got somebody uninsured in front of you, really trying to help them on the spot understand what they might be eligible for. I also think there are calculators on healthcare.gov and there are some sort of private tools as well that you can use to work with somebody to understand what they're eligible for. [LB1032]

SENATOR KOLTERMAN: But what do the states do when people don't have a tax return? [LB1032]

SENATOR CAMPBELL: Third final. [LB1032]

SENATOR KOLTERMAN: Well, that's part of...that's what I asked the first time. [LB1032]

PATRICIA BOOZANG: Right. I think they probably direct them to healthcare.gov. [LB1032]

SENATOR KOLTERMAN: Okay. (Inaudible.) [LB1032]

SENATOR CAMPBELL: Did you have a question? [LB1032]

SENATOR HOWARD: I didn't have a question. I had a comment. We verify income eligibility for Medicaid in our social service programs through pay stubs, so it's not an income tax filing. [LB1032]

SENATOR KOLTERMAN: It's a W-2 type of thing. [LB1032]

SENATOR HOWARD: Kind of thing, yes, exactly. [LB1032]

SENATOR KOLTERMAN: Thank you. [LB1032]

PATRICIA BOOZANG: Oh, so it was more a technical question of how do you determine. [LB1032]

SENATOR HOWARD: (Inaudible.) [LB1032]

PATRICIA BOOZANG: I'm sorry, I was missing the point of the question. [LB1032]

SENATOR KOLTERMAN: That's where I was going with it. [LB1032]

PATRICIA BOOZANG: I'm sorry. Yeah. My apologies. [LB1032]

SENATOR CAMPBELL: And I'm sure one of the benefits, at least that we have seen, too, in looking at all of the different plans across the country, is that if you've got them in that Silver Plan there's a lot of what is called churning, where someone is eligible for Medicaid, then they aren't eligible, then they are. And we've spent a lot of money, publicly, every time they become eligible re-going through that process, whereas this is a way, in the Silver option plan, that they can go back and forth. It's just a matter of who's picking up the cost here. And it saves dollars on the churning, at least that's what we've seen in some other states. [LB1032]

PATRICIA BOOZANG: Yes. Yes. [LB1032]

SENATOR CAMPBELL: I'm assuming you'd see it in Arkansas. [LB1032]

PATRICIA BOOZANG: Yes, I think that that's true. And I think in Arkansas the other goal here was, you know, not just having...preventing the churning of coverage, you know, you'd lose your coverage because you're shifting between coverage programs, but also you know I can relate to the same plan and I have the same...I don't have to change my provider because I can keep seeing the person I was seeing when I was in the private option. I can keep seeing them now that I'm, you know, out of the private option and buying this plan directly. [LB1032]

SENATOR CAMPBELL: I want to thank you very much for coming and responding to our request. [LB1032]

PATRICIA BOOZANG: Oh, thank you. [LB1032]

SENATOR CAMPBELL: And if we have additional questions, we'll be in touch. [LB1032]

PATRICIA BOOZANG: Yes, I'd be happy to take any additional questions. [LB1032]

SENATOR CAMPBELL: Thank you very much. [LB1032]

PATRICIA BOOZANG: Thank you. [LB1032]

SENATOR CAMPBELL: Okay. We'll take our first proponent. [LB1032]

GWENDOLEN HINES: Good afternoon. My name is Gwendolen Hines, it's G-w-e-n-d-o-l-e-n H-i-n-e-s, and I represent the Unitarian Church of Lincoln, so I'm no expert but I have done my homework. And I'm sorry to push in here but I have chronic fatigue syndrome and so I'm way too tired to testify later on. The Declaration of Independence says that we have the right to life, liberty, and the pursuit of happiness and that to secure these rights governments are instituted among men. We believe these rights include the right to affordable, quality healthcare and that government has a role in providing that. Medicaid makes financial sense, too. It is sometimes difficult to make a cost-benefit analysis of things like Medicaid. For example, what is the cost of saving one critically ill infant? The immediate cost is high, but the benefits unfold throughout a lifetime. That person grows up, gets a job, spends money, which helps the local economy and increases sales tax income. She makes money, which increases income tax revenue for the state over the course of her life, and she contributes to the economy. We believe that the saving of that life is worth more than...is worth it. Here are some of the benefits of LB1032. It says that it will cover 77,000 Nebraskans that are uncovered. Currently, 11 percent of uncompromised care is

covered through higher premiums and higher copays for those that have insurance. This silent tax on Nebraskans, privately insured citizens, is $67 million a year in 2014 dollars. A higher rate of insured people in poor communities will encourage healthcare workers to work there, thus, increasing the quality of healthcare for these people. Figuring that all states would expand Medicaid, the federal government cut how much it pays to hospitals and physicians. Passing LB1032 would more than recoup these losses. In Nebraska, critical access hospitals, or CAHs, provide the foundation of local health services. Even not-for-profit hospitals need a total margin above 2 percent to cover uncompensated care, acquire new technology, and build a capital fund for long-term facility development. Currently, 15 to 23 Nebraska CAHs (out of 66) are operating under negative total margin or an unsustainable (inaudible) positive total margin of less than 2 percent. Financial losses have already caused the closure of one CAH in Nebraska in 2014; that was the Tilden Community Hospital. If we don't pass LB1032, we may see more CAHs closures, leaving people with no healthcare and leaving critically ill people to die. If you have a heart attack and you don't have a hospital, and the nearest hospital is 50 or 60 miles away, you're not going to make it. States that have expanded Medicaid by 2014 saw 48 to 72 percent decrease in uninsured hospital admissions. The uninsured have a higher mortality rate than the insured. The decision to opt out of Medicaid expansion will lead to 67 to 212 unnecessary deaths per year. I think that's just unforgivable. The lowest quintile of income in Nebraska spends $1,650 annually on healthcare. This is 7.5 percent of their income. With LB1032, we could drop this to 2.5 percent of their income, giving them an increase of $88 million in discretionary income as a group. This would create 800 jobs, creating $32 million in additional income that can be taxed. This would generate $4.9 million in state and local taxes. Not only will passing LB1032 increase discretionary income, it will increase spending on healthcare, which will create more healthcare jobs. The income from these new healthcare jobs will generate sales and income tax revenue. Under the Nebraska Advantage Tax Incentive Program, it costs $43,000 to $235,000, depending on how high you calculate it, to create one new job. Each increase of Medicaid funding of $46,500 will create one more job. So again, that's with the Nebraska Advantage Program, it costs $43,000 to $235,000 to create one job. But with expanding Medicaid it costs $46,000 to create one job. So why wouldn't we be willing to create jobs by expanding Medicaid and passing LB1032 if we are willing... [LB1032]

SENATOR CAMPBELL: Ms. Hines, we are at the red so... [LB1032]

GWENDOLEN HINES: Oh, I'm very sorry. I had a lot more to say. [LB1032]

SENATOR CAMPBELL: Could you possibly send it to us in e-mail and finish so we get the full text of it? [LB1032]

GWENDOLEN HINES: Yeah, sure. [LB1032]

SENATOR CAMPBELL: Okay. [LB1032]

GWENDOLEN HINES: I just didn't want...let me, just to finish up, Nebraska is a state that cares. We must pass LB1032 to help those in need to strengthen our communities, make our work force more productive, to help small businesses, and to save lives, and just because it is the right thing to do. Thank you for your time. [LB1032]

SENATOR CAMPBELL: Thank you. Our next proponent. [LB1032]

ROMA AMUNDSON: (Exhibits 2 and 3) Good afternoon, Senator Kathy Campbell and members of the Health and Human Services Committee. My name is Roma Amundson, spelled R-o-m-a A-m-u-n-d-s-o-n. I am here on behalf of the Lancaster County Board of Commissioners and as well as the Nebraska Association of County Officials to express our strong support for LB1032. During the last five fiscal years Lancaster County spent approximately $10 million on the medical needs of general assistance clients. Adopting the Transitional Health Insurance Program Act will eliminate virtually all general assistance medical costs for Lancaster County. That would create a potential annual savings of $2 million for our property taxpayers. Additionally, the Transitional Health Insurance Program Act will greatly improve the quality and the effectiveness of healthcare for our low-income citizens, as well as assist the Lincoln-Lancaster County community in meeting its goal of integrating primary care and behavioral health services. The results of the study conducted by the Tax Modernization Committee of 2013 indicate that there is too much reliance and pressure on the real property tax. Also, the citizens of our state have sent the message loud and clear that their number one concern is high property taxes. This bill provides an opportunity to help lower property taxes by maximizing the use of federal funds. Opponents of LB1032 argue that we cannot afford the Transitional Health Insurance Program Act. The truth is we cannot afford to miss this opportunity. Thank you, and I would be happy to answer any questions. [LB1032]

SENATOR CAMPBELL: Questions? Senator Riepe. [LB1032]

SENATOR RIEPE: Thank you, Senator Campbell. Thank you for being here. [LB1032]

ROMA AMUNDSON: Uh-huh. [LB1032]

SENATOR RIEPE: I guess my question would be is if the state of Nebraska takes on the expense, why should Lancaster County have a windfall of $2 million? In my way of thinking, if there's a savings there, that needs to come back to the state to offset the state. [LB1032]

ROMA AMUNDSON: Actually in that regard the $2 million, that this is money that has been raised by the property taxpayers. And we are mandated to provide services to people who cannot afford health insurance. Okay? [LB1032]

SENATOR RIEPE: I understand that. [LB1032]

ROMA AMUNDSON: Yes. And so that is money that we have taken from the property taxpayers to pay for this. This is a mandated service. As far as that is concerned, why it should not go back to the state, if we can lower our property tax dollars so that we do not have to pay that $2 million, then that is money that goes back to the state of Nebraska citizens in property tax savings. [LB1032]

SENATOR RIEPE: My counterpoint would be is I think the state will need that $2 million to help run the program. [LB1032]

ROMA AMUNDSON: That might be. I don't know all the particulars. [LB1032]

SENATOR RIEPE: Thank you. [LB1032]

ROMA AMUNDSON: Uh-huh. [LB1032]

SENATOR CAMPBELL: Any other questions, Senators? Thank you, Ms. Amundson. Our next proponent. Good afternoon. [LB1032]

MERLIN FRIESEN: Good afternoon. I'm Dr. Merlin Friesen, M-e-r-l-i-n F-r-i-e-s-e-n. I'm here representing both Nebraska Farmers Union and also as an active member of the practicing medical community. I am an active farmer and an active participant in Nebraska Farmers Union, and that participation nearly landed me in the emergency room this morning as I had a collision with a handle on a cattle chute as I was working cattle. So I try to wear both hats. This is a second appearance, a year apart, a second attempt at implementing a Medicaid expansion. Unfortunately, from my perspective as a physician, as a farmer, and as a human being, nothing has changed much. The cost of medical care remains the greatest threat of bankruptcy to Americans in general and to small family farmers in particular. This is a singularly cruel fact of life in Nebraska and some other states that when you come down with a major health condition you have to choose which is more worrisome: the health condition or the potential to be bankrupted by it? I'm appalled at that fact in our country. In my past experience in primary care, I chose to spend almost a decade of my career in dedicating services specifically to uninsured people. And in my current part-time emergency room work, I continue to see uninsured people

on a regular basis. And I can assure you all that uninsured people do not get primary healthcare in the emergency room. The subject of diabetes was briefly brought up, and if it's of interest, I'd be glad to entertain a question to that effect. But diabetes is a singularly good illustration of the way that emergency room care does not provide for the most fundamental healthcare need of a major common health condition, and can't provide for it. We in the emergency room frequently see people who can't afford follow-up. They can't afford a specialist visit or the cash up-front that will be required for that specialist. They can't afford the medications for their condition. And as a result, we might see them back again in the emergency room, even for the same condition. I digressed from a point that I thought was pretty salient from a standpoint of farmers. As a farmer and in talking with other farmers, we work in a high-risk occupation with a high rate of injury. And it's a striking fact that every small farmer who can't afford health insurance and, therefore, goes uninsured is only one major injury away from losing their farm because the costs of a major health condition are directly capable of doing that, of bankrupting them and causing them to lose their land, in fact. This is an amazing condition to observe year after year. I am, you know, somewhat frustrated to realize that many states have found a way to solve this riddle of how to provide healthcare insurance for their patients, for their people. And granted that we can't address all of the fine points up-front, those things have to be worked out on the road, nonetheless it feels to me, having observed this situation at least three years in a row, I believe, where attempts to achieve an expansion of Medicaid coverage funded almost entirely by the federal government have been stymied...stymied, in my view, by partisan politics. And I don't like the thought of seeing our citizens and our healthcare providers and our healthcare institutions in this state thrown under the bus for lack of doing something. There are multiple ways to crack this egg and it can be done and it is being done; it's just not being done in Nebraska. And if this is the good life, I think we should do it. [LB1032]

SENATOR CAMPBELL: Questions, Senators? Thank you, Dr. Friesen. [LB1032]

MERLIN FRIESEN: Yes. Thanks. [LB1032]

SENATOR CAMPBELL: Our next proponent. Good afternoon. [LB1032]

SARAH PARKER: Good afternoon. Thank you very much for having me here. My name is Sarah Parker, that's S-a-r-a-h P-a-r-k-e-r. I do want to thank you for hearing me speak today. I live here in Lincoln and I am one of the faces of the 77,000 people in this state that do not have health insurance. They can't afford health insurance under our current system. I think it's important that you know who the people are, who we are in this state that can't afford health insurance--you're going to meet some others later--and how much more we could give back to the state if we were healthy. Now for more than 20 years I've lived and worked in Nebraska. I graduated from Nebraska Wesleyan. I worked full time until 2011, when my father was

diagnosed with Parkinson's disease. My dad became ill and I cut back to part-time hours so I could stay home and take care of my father. I love my dad and I'm happy I was able to be there for him. But of course, not many part-time jobs offer benefits so I did lose my health insurance. I do have some health insurance...or some health conditions that need treatment and regular medications. Because I work temp jobs now, I don't have health insurance. That means I pick and choose which conditions I get treatment for. It depends on how much money I can pay on a particular day. I also have a large amount of medical bills because of a hospital stay last summer. And I am one of those people who have bills that are so great I'm probably going to have to declare bankruptcy because of them. Now I grew up in Iowa where people in my situation get health insurance coverage, but I've lived in Nebraska for over 20 years and like all of you I bleed Husker red. I consider myself a Nebraskan and a lot of people in Nebraska have stories like mine. If LB1032 were to be passed, we'd be able to get insurance. And we need to pay for the treatments...the insurance we need to pay for the treatments that we need and then we could get back to work. Now I know that the transitional plan is going to ask me to pay for stuff--for some of the coverage--and that's good. I'm all right with that. It's what I want because I want to get back to working on a full-time basis, giving back to society. I paid into the system most of my life and I want to get back to work, pay into the system again, so I can help other people. Now I'm asking you and all our state senators to give me this chance. Please afford me this chance. Please support LB1032 so people like me can have our best shot at a healthy life. Nebraskans are hardworking people and we have to be healthy to move forward. Please give us this chance. I do respectfully ask that you advance LB1032 and give it your full support. [LB1032]

SENATOR CAMPBELL: Thank you, Ms. Parker. Any questions from the senators? Okay, thank you for coming today. [LB1032]

SARAH PARKER: Uh-huh. [LB1032]

SENATOR CAMPBELL: Our next testifier. Thanks, Lynn. [LB1032]

CHRISTI CROSBY: (Exhibit 4) Good afternoon, Senators. [LB1032]

SENATOR CAMPBELL: Good afternoon. [LB1032]

CHRISTI CROSBY: My name is Christi Crosby, C-h-r-i-s-t-i C-r-o-s-b-y, and I am testifying in support of LB1032 on behalf of the Nebraska Planning Council on Developmental Disabilities. Although the council is appointed by the Governor and administered by the Department of Health and Human Services, the council operates independently and our comments do not necessarily reflect the views of the Governor's administration. We are a federally mandated independent council comprised of individuals and families of persons with developmental

disabilities, community providers, and agency representatives who advocate for system change and quality supports. Our council supports LB1032 which would provide health coverage for the 77,000 Nebraskans in the coverage gap. I myself own my own home in Omaha and am living independently. I strive to be self-sufficient. For example, I even mow my own lawn. I have worked at the same part-time job at the YMCA for many years and I would love to be able to work full-time and make more money. However, my employment opportunities are limited and access to transportation is limited. When my father passed away, I was immediately taken off Medicaid and put on Medicare since my survivor benefits were greater than the allotment that one is allowed on Medicaid. This was a great detriment to me. Medicare does not cover as much as Medicaid and supplemental insurance is an expense I cannot afford. As a result, I lack dental coverage, and we all have learned that dental care affects your overall health. I do not feel...I feel I am very fortunate to have at least Medicare when many Nebraskans do not have any coverage at all. I urge you to pass LB1032 on behalf of many Nebraskans who fall into the gap and lack medical coverage. Thank you for your consideration. [LB1032]

SENATOR CAMPBELL: Thank you, Ms. Crosby, and you are right within the time frame. That is impressive. (Laughter) [LB1032]

CHRISTI CROSBY: (Laugh) Thank you. [LB1032]

SENATOR CAMPBELL: It's always hard to go through your own personal story, so we really appreciate it. [LB1032]

CHRISTI CROSBY: Yeah. [LB1032]

SENATOR CAMPBELL: Thank you very much. [LB1032]

CHRISTI CROSBY: Yeah. Thank you. [LB1032]

SENATOR CAMPBELL: Dr. Rauner, maybe you could help Ms. Crosby. I think Ms. Rex is the next. Thank you very much. I wish I could say I mow my own lawn too, but I don't. [LB1032]

LYNN REX: Senator Campbell, members of the committee, my name is Lynn Rex, L-y-n-n R-e-x, representing the League of Nebraska Municipalities. [LB1032]

SENATOR CAMPBELL: Go right ahead. [LB1032]

LYNN REX: I wish my testimony would be as effective as hers. This is the first time that the League has ever taken a position on Medicaid or anything relating to Medicaid. This is also the first time I've ever teared up at a legislative hearing, as Senator Crawford unfortunately could attest, spending hours on end, including yesterday, from 1:30 to 8:30. That being said, let me just tell you that the League executive board voted, of those that were on the conference call, unanimously to support this effort and the reason is because this is the most effective and cost-effective way in which the state of Nebraska, we think, can address the issue of trying to provide healthcare coverage for 77,000 low-income individuals. These are our neighbors. These are people with whom we go to church. These are people that many of them would like to be back in the work force full time. You've heard from a couple of them this afternoon. In addition, I'd like to share with you that there's also a law enforcement component to this. I mean obviously the humanity of it is first and foremost, but the secondary issue for us, as representing municipalities, comes to the issue of law enforcement and many of the anecdotal issues that we would raise to you today of police officers that report to us that there are actually people out there committing not horrific crimes, certainly crimes that have a penalty, like shoplifting, in order to get healthcare because they, frankly, do not understand the current system. So their view is that this is a way that perhaps they could get coverage, they could, in fact, have some type of care, because they believe that that's the way that they can get care. And if you're not aware of it, one of the municipal issues that we've had over the years, I know Senator Crawford is well aware of this as are others of you, is that in fact in order for a police officer to take an individual and have him or her taken to county jail, the county requires that that police officer has already assured that that person does not need medical coverage. So what I'm reporting to you today is that this is the first time that our organization has ever engaged in this issue. We think it is critical. We think that when you're looking at the amount of federal dollars at stake, we as Nebraskans are paying into that federal system and we have 77,000 people who would benefit from that. I think this bill provides kind of a safe harbor, if you will. Senator McCollister's opening was outstanding in indicating to you that if those dollars go below 90 percent that this program, as I understand it then, would sunset, would stop. The Legislature would then have an opportunity to review it. It seems to me it's a win-win. You have nothing to lose and everything to gain, and 77 (thousand) Nebraskans that again we know we care about. Some of us may even have family members that can't get coverage. So with that, I would just close by saying we strongly encourage you to advance this bill out of committee. And we think that of the solutions that have been presented in previous years, this is by far the most superior recommendation that we've seen. I'm not an expert in Medicaid, actually, as you know, TEEOSA either (laugh), but what I can tell you is the importance of this is overwhelming. And we hope that you will take into consideration those individuals that simply need this assistance. And from a League standpoint, again, we have a law enforcement connection. We understand, as well, the implications of this on local government. The county official that testified before me also indicated to you the kind of cost implications that this has for counties across the state of

Nebraska. And counties and municipalities partner on so many issues as well. So with that, I'm happy to respond to any questions that you might have. [LB1032]

SENATOR CAMPBELL: Any questions for Ms. Rex? Thank you for coming and for your testimony. [LB1032]

LYNN REX: Thank you very much. [LB1032]

SENATOR CAMPBELL: Our next testifier. Good afternoon. [LB1032]

JESSICA METZLER: (Exhibit 5) Good afternoon, Senator Campbell and members of the Health and Human Services Committee. My name is Jessica Metzler, and that's J-e-s-s-i-c-a M-e-t-z-l-e-r. Thank you for allowing me to speak to you today. I live in Senator McCollister's district in Omaha and I am one of the 77,000 Nebraskans who currently fall in the coverage gap. I'm here today to urge you to pass LB1032 so that other Nebraskans like me can finally find health coverage that we can afford. I just recently graduated from college this month after working as both a full-time student and a full-time activities assistant at an assisted living facility in Omaha. I'm also a full-time mother to my son. I've been working hard to better our lives, following the rules to set an example for him. I hope to instill in him that hard work pays off and that education is important. However, when I tried to get health insurance, I realized my hard work meant that I fell through the cracks. I make too much money to qualify for Medicaid, but at the same time, I don't make enough to get subsidies in the marketplace to get affordable health insurance. The insurance my employer offers also is not affordable in my budget. I work hard to give my son a better life and to get ahead all on my own. But without insurance, being unable to take care of a small health problem could mean big trouble for me and my family. Health coverage would let me...to not worry about my son or myself getting sick. Healthy workers are productive workers and healthy parents are able to contribute more to their family. No one is immune to getting sick or injured. Being able to afford health coverage is important for everyone. Please support the Transitional Health Insurance Program so that Nebraskans like me can be the healthy parents and productive workers that we need to be. Thank you. And if you have any questions, I'm more than willing to answer. [LB1032]

SENATOR CAMPBELL: Thank you, Ms. Metzler. Any questions, Senators? Thank you for coming and telling us your story. [LB1032]

JESSICA METZLER: Thank you. [LB1032]

SENATOR CAMPBELL: Our next testifier. [LB1032]

VINCENT LITWINOWICZ: (Exhibit 6) Dear Senator Campbell and members of the Health and Human Services Committee, thank you for letting me speak. My name is Vincent Litwinowicz, V-i-n-c-e-n-t L-i-t-w-i-n-o-w-i-c-z. I'm here to speak in favor of LB1032 today based upon my personal story and the stories of many other Nebraskans in the state, especially those even that are in wheelchairs that don't get their chance; you know, for one reason or another, we're always not here. And so I would like to work. This bill would help people like me--and that's the important thing, like me--who are trying to reenter the work force in overcoming our health issues. So, you know, I'm college educated. I was pursuing a graduate degree when a series of physical and then realized cognitive symptoms hindered my abilities and I had to discontinue. But, you know, the cognitive issues and the fatigue, probably the most important of all, are the limiting factors of why I won't be able to get...I don't care. I just want to work at a nonprofit or something. But, I mean, it will...it derails me from getting a higher paying job, which is why I'm particularly concerned. So when I developed multiple sclerosis, you know, it was a pretty big setback in my life. But I'm also proud to say that I'm fighting my way through it after the pity party of a few years and then because of my mental diagnosis too. But I'm in vocational rehab right now which I'm trying to see, you know, hook me up with something permanent because I would like to, you know, get off of my disability. And so I get a six-hour assessment next Wednesday, in fact, so that will be neat. But I am not the same cognitive level, certainly not in an engineering/analytical way, but I still have a lot to offer. And as I see it, it kind of straightened me back on a course I should have been from the start. So right now I am covered by Medicaid, but I'm concerned that when I get a job I could lose my health coverage, well, at least in...I didn't even think about it in the first couple of years because of, you know, there were rumors about cap limitations and stuff and other things and I was still on my pity party probably too. But I want to get back to work, so you can understand why it's a big risk though if the health coverage isn't there, you know. And I can't live without the health coverage. And in the spirit of this bill, my intention is to leave Medicaid to enter the work force permanently and hopefully after, you know, the extended work term limits I can do that. So the safety net of LB1032 would make sure that I have the health coverage I need to...you know, I'd like, you know, a job in the low twenties and high teens or whatever, whatever that I can do to be a part of the solution. And to get the treatments I need, you know, that costs a lot of money, Tier 4 drugs and so forth. And so I need to be confident when I go back. And I'm not going to jump up to, you know, when I first got an engineering job, you know. I'm not going to come close to $60,000 a year. So I'd love to work with people, and that's what I've found, and do things to help people with cognitive mental and physical disabilities of any kind or a combination thereof and, you know, because I've had the same challenges and these barriers are not too big to overcome if people could have the feeling of security and knowing that they can afford the health coverage. And they can lead better lives because productive workers are better than worried, ulcer-ridden workers. They sleep better at night knowing, if they get sick, they're not going to go bankrupt and they are better at their jobs when they go to work healthy. And it's interesting, in the spirit of the Christian ethic, whether or not you're a Christian or not, I think it behooves us to help the least of us, those who are the

working poor and those that...you know, it's interesting in a spiritual sort of way. They don't get to do what they want to do. So the people that are...make more money...and I'm not...they get to do what they want. And so these are the lesser of us who really need...I'm not going to go all didactic right now. I'm just...the lesser of us really need this, you know, the lesser of us as a...anyway, so I ask you to please support LB1032, and this is the best chance that we have, and then to cover the people, the working poor in particular. Thank you very much for your time. [LB1032]

SENATOR CAMPBELL: Thank you, sir. Any questions, Senators? [LB1032]

VINCENT LITWINOWICZ: Oh, I'm sorry. Are there any questions? [LB1032]

SENATOR CAMPBELL: It's good to see you feeling better. [LB1032]

VINCENT LITWINOWICZ: You too. Thank you. [LB1032]

SENATOR CAMPBELL: Our next testifier. Good afternoon. [LB1032]

BOB RAUNER: (Exhibits 7 and 8) Good afternoon, Senator. I'm Dr. Bob Rauner, B-o-b R-a-u-n-e-r. I'm testifying on behalf of the Nebraska Academy of Family Physicians and the Nebraska Medical Association. I'm glad to be back here again arguing for this approach, and I think this is even better than the last one. We've been arguing for this type of expansion, using the Arkansas model, for the last several years, and I think this is even better. This is the best solution proposed to date to provide healthcare to a family of four making $25,000 a year. And for those who don't like it, I would say, okay, what's your solution? Okay? You know, to Senator Kolterman earlier, in that 130...338 percent of poverty rate level you'll be at about $32,000. And as you probably know, the cost of health insurance for a family is around $15,000 to $20,000. They can't spend 50 to 60 percent of their income on healthcare because they're already spending half on housing. There needs to be some source of access for them. Last year, my daughter, she was working as a hostess in a restaurant earning money for college and came home to me amazed that her colleague that she was working with, who was a teenager, was working not to save money for college but to have money to buy her mom's medicine, a big lesson for her to learn. I think a lot of us don't realize at this income level what they run through. As I spent my whole career taking care of people in this income, they need access to care. The number-one source of bankruptcy in this population is medical bankruptcy, unforeseen medical bills that they have no reserves for that come up. It's because they have no coverage. Because of that they delay access to care. Sometimes it results to suffering from illness they could have prevented; sometimes it results in death. And most of us in the medical community who have been at it for awhile have seen these cases. So this is something that can't just sit there and wait for another year and another two

years and another five years. We've had four to five years with no competing alternative. This is the best to date, and we really encourage you to enact this. I also want to address this report that came out yesterday from Optumas about the Medicaid expansion cost estimate. There are several concerns as I read through this. On page 4 it says, due to the compounding necessary to obtain 2027 projections, they may contain a reasonable amount of projection error. Reasonable is probably an underestimate. Most of these types of projections will have a midlevel and then a range of estimates. And lacking in this report, which is somewhat suspicious, is those range of estimates. Second issue that he uses is, through the middle of the report, they use assumptions of 6 to 9 percent inflation increase costs; that's a dire side. It's based on Medicaid alone. And as you've seen other people testify already, this, the expansion, seems to be less sick than the typical Medicaid. So it would make more sense to use less dire predictions. Last, a couple weeks ago...I actually have included the first page and I can provide you the full one that actually lists what it has been for the rest of the population. It's been about 3.5 to 5.5 percent the last six years. So these should be rerun considering that. Lastly, they say, due to the possibility of unforeseen reforms, they may not be representative. And we have a number of reforms coming up. We have a direct primary care bill. We know that actually people said, will there will be enough medical homes? A few years ago with our medical home bills they said, well, our insurers told us, well, not enough people want to do this. And as soon as we started doing this, within a year we had...went from a handful to dozens of medical homes. We're well over 100 this year. Same thing was mentioned about accountable care organizations. We already have five Medicare-certified ACOs in the state already. If this changes, we can adapt very quickly in the primary care environment, so I'm not worried about that. We've talked about, will there be access to primary care? We train more primary care docs in Nebraska than we need already. The problem is they leave Nebraska when they graduate. That's why we have a shortage. If we could retain more of them and quit exporting them to states like Arkansas...why don't we have the funding? Because we have not expanded and we don't...and so the unreimbursed payer has to come from somewhere and that's one of the things that prevents us from doing the loan repayment options that other surrounding states are using to attract away our healthcare providers. It assumes no improvements in public health. Well, we've got several amazing opportunities. We have Senator Gloor's tobacco tax bill next...or tomorrow actually. That actually has projections for what it would save Medicaid actually. Plus, the revenue it brings in would more than cover even the dire predictions here. So this would make a big difference. And that's also only looking at those Medicaid, not the expansion, projections. So actually the potential savings from the tobacco tax bill would be even better. Yesterday I testified in Appropriations. Senator Haar had a bill on the Nebraska Whole Child Project. If we could do obesity prevention projects like what have been done in Lincoln and Kearney across the state, again, that would lower costs over time. None of those are included. So in closing, I think this is the best solution proposed so far and I think it highlights as you...how it interacts with so many other things and it highlights why we in Nebraska need a strategic plan for improving health that Senator Campbell has been working on.

If you want a great example, John Kasich from Ohio did this recently and it's on the Web, a great example. Nebraska needs to do the same. Thanks. [LB1032]

SENATOR CAMPBELL: Dr. Rauner, you talk really fast. [LB1032]

BOB RAUNER: I'm watching that light. [LB1032]

SENATOR CAMPBELL: (Laughter) Thank you very much. And what's also interesting is that Chancellor Gold at UNMC worked with Governor Kasich on the plan for Ohio, and that's... [LB1032]

BOB RAUNER: Awesome. [LB1032]

SENATOR CAMPBELL: It's been interesting to watch that plan come to fruition, so thanks for mentioning it. Any questions? Senator Riepe. [LB1032]

SENATOR RIEPE: Thank you, Senator Campbell. Thank you, Doctor, and congratulations. Today you've made it up to the booth where you could testify (laugh). [LB1032]

BOB RAUNER: Yeah. [LB1032]

SENATOR RIEPE: A question I have has to do with rates. I don't know what it takes to...many physicians--I understand very much why--do not participate fully in Medicaid. Some limit 10 percent. [LB1032]

BOB RAUNER: Yes. [LB1032]

SENATOR RIEPE: You know more about that than I. [LB1032]

BOB RAUNER: Um-hum. [LB1032]

SENATOR RIEPE: What does it take then to get more physicians to fully participate? Does that take...I read something in some plan that talked about commercial rates. Is that... [LB1032]

BOB RAUNER: Yes. [LB1032]

SENATOR RIEPE: Is that what it takes? [LB1032]

BOB RAUNER: No. [LB1032]

SENATOR RIEPE: No? [LB1032]

BOB RAUNER: And I actually would...I would highlight... [LB1032]

SENATOR RIEPE: Can we negotiate here? [LB1032]

BOB RAUNER: I would actually give the Governor and Calder Lynch kudos because in the Heritage Health they've gone from Medicaid rates to Medicare rates to pay for primary care doctors. [LB1032]

SENATOR RIEPE: Yes. [LB1032]

BOB RAUNER: If you couple that with per-member-per-month payments, which many of our Medicare managed care plans are already doing, you can actually take care of Medicaid patients and make your costs. And the big thing that was limiting access to primary care is, frankly, if it costs you $50 to provide it and Medicaid was paying you $35, you can do the math. We're actually going to fix that now I think. I think, if you had Medicare rates for primary care plus the PMPM, which is happening with medical home, that is fixing it and that's why I think you're going to see access open up for Medicaid now. [LB1032]

SENATOR RIEPE: And that PMPM is $6, is it, per patient? Is that... [LB1032]

BOB RAUNER: It ranges. Most people, if you do the projections, the overhead for a practice is at least $4 to $5, so it has to be more than that. At $6 you can do it profitably. [LB1032]

SENATOR RIEPE: I've been known for being too generous. [LB1032]

BOB RAUNER: Yeah, well, that's okay. We'll put it to other good stuff, so. [LB1032]

SENATOR RIEPE: Thank you, Doctor. [LB1032]

BOB RAUNER: You're welcome. [LB1032]

SENATOR CAMPBELL: Any other questions, Senators? Oh, Senator Crawford. [LB1032]

SENATOR CRAWFORD: Thank you, Chairman Campbell. And thank you for being here and thank you also for your work on expanding patient-centered medical homes in the state of Nebraska. So you are part of a coalition of people who are all...who have been working with providers and with our insurance providers of the state to help one another expand patient-centered medical home access. So this bill, since it puts people...allows people to buy into private plans and also to buy into their employee plan, I wonder if you'd comment on your sense of the availability of patient-centered medical homes in those private plans that exist in Nebraska that they would be buying into. [LB1032]

BOB RAUNER: Yeah, it's actually several commercial payers are already doing this. And so you have Medicare is already doing this, commercial is doing it, and Nebraska Medicaid is doing it. And by putting that across all payers, that helps enormously. One of the benefits of this expansion is it also deals with this problem called churn. What happens is most people don't realize most people don't stay on Medicaid for life. They're most not lifers. Most people, it's a short term: months, a couple of years. So as they're going off Medicaid, on Medicaid, off Medicaid, if they have a coverage gap, that churn is causing problems with continuity and also the coverage of their medical care. And so you might get...we would see this all the time in the clinic I was at. You'd get their diabetes taken care of. It's finally doing well. Then they lose their coverage. Now they're off their meds and they come back uncontrolled again. And so one of the things is you may see an increase in the short term, which is also not addressed in this, is you...once you take care of that untaken care of, postponed medical care and get people tuned up, your costs are actually going to go down in a couple years, diabetics being the most common example. Another issue is I actually used to work at the general assistance clinic that Roma mentioned earlier. One of the problems again was it was a separate clinic. We had the churn problem again. There's no continuity. And I can tell you that the fact that those people are taken care of in a regular clinic and not the GA clinic, the care will be better, it'll be more efficient, and it'll overall be less costly. And so one of the biggest problems, this helps to address the continuity problem. [LB1032]

SENATOR CRAWFORD: As a follow-up, just to clarify, it helps to address continuity because you can buy into a private plan, so you can be in it. [LB1032]

BOB RAUNER: Um-hum, yeah. [LB1032]

SENATOR CRAWFORD: Even if you lose your eligibility and gain it later,... [LB1032]

BOB RAUNER: Right, yeah. [LB1032]

SENATOR CRAWFORD: ...you can stay in the same plan. [LB1032]

BOB RAUNER: And you pick that plan. [LB1032]

SENATOR CRAWFORD: Right. [LB1032]

BOB RAUNER: So if you're on Blue Cross through your employer, you lose your job, now you're on this, you can be on Blue Cross through the exchange and go right back to Blue Cross again. You don't have to churn from plan to plan, which means you don't have to change providers because your plan doesn't cover that provider. And that's what was happening in Lincoln. And you'd go to the GA clinic. They'd give them coverage. They'd go to the residency program clinic where I worked the rest of the time and then they'd have nothing and they'd be over to People's Health Center and back and they just kept being a big circle, so. [LB1032]

SENATOR CRAWFORD: Thank you. [LB1032]

SENATOR CAMPBELL: And every time that they were coming back on, we were paying for that whole process to get them eligible for Medicaid. [LB1032]

BOB RAUNER: Yep. [LB1032]

SENATOR CAMPBELL: Exactly. Any other questions or comments? Yes, Senator Fox. [LB1032]

SENATOR FOX: I have both a comment and a question. [LB1032]

BOB RAUNER: Sure. [LB1032]

SENATOR FOX: So first of all, as a dietician, I thank you for your comment here about, you know, ways to reduce healthcare costs, such as the public health arena. I agree, you know, if we could get coverage for childhood obesity, that would be great. But unfortunately we've had those discussions with insurance and they say that mandates will increase the cost of healthcare, which brings me to your bullet point here: uses a pessimistic assumption of medical inflation, 6-9 percent per year. I guess I'm kind of thinking that's an "underassumption" because for the second year in a row, I mean it's well documented, for the second year in a row healthcare costs or health insurance costs for someone like myself has increased by double digits two years in a row. [LB1032]

BOB RAUNER: That's probably because of the experience of your particular employer. I'm guessing you're in a shelf of a tiered plan, yeah. [LB1032]

SENATOR FOX: Well, it's a national trend. It's not just me. It's a lot of... [LB1032]

BOB RAUNER: Well, actually that's the whole national trend. Now, will there be isolated places where that's going to change? Yes, and it's usually because, if you're in a shelf-insured plan, you may have had a couple...you know, two people have a heart attack, one case of melanoma, and a preterm birth and that bumped the plan that year. And so when you spread it across the whole population, this is what the estimate is. Are there people who individually have 10 or 20 percent? Yes. Partly that's because we don't necessarily pool everything together the way we should. So there are individuals who have had an increase. Some of this reason also is because what happened is some people, frankly, had junk plans that didn't cover a lot. And when it covered stuff, guess what? It cost a little more. And so some plans were replaced, really an inadequate plan. But again, there are sometimes localized factor that may have caused your rates to go up. That doesn't mean the whole state will go up. And of course at the state you're looking at the state levels. And so just because Omaha went up doesn't mean Lincoln went up actually. And so that...so you're seeing the anecdotal "ours went up 10, 20, 30 percent," which is true for you but not for the state as a whole. And these are coming from the actuary. This is the rate for the country. And they do break it down in the full article on commercial versus Medicare versus Medicaid versus all that. And they're different, of course, between the three. [LB1032]

SENATOR CAMPBELL: Any other questions? Thank you, Dr. Rauner. [LB1032]

BOB RAUNER: Welcome. [LB1032]

SENATOR CAMPBELL: Our next testifier. Good afternoon. [LB1032]

PAULETTE JONES: (Exhibit 9) Good afternoon, members of the Health and Human Services Committee. My name is Paulette Jones, spelled P-a-u-l-e-t-t-e J-o-n-e-s. I am 1 of the 77,000 Nebraskans who fall in the Medicaid coverage gap. I have a four-year college degree and was employed for many years. When my five kids were growing up, my husband brought us to Nebraska. Within three months he left me as a single mom without looking back. I wanted to set an example of a strong ethic for my children, so I immediately went back to college to complete my degree. It took a while working and going to school, but I worked my family off the system and showed them the importance of self-reliance. Right now I receive a small check for Social Security retirement and a small check for child support. That small income puts me $42 over the line where I would qualify for Medicaid. To my dismay, I also found out that I do not make enough money to get subsidies to buy marketplace insurance. After years of hard work, I find

myself stuck with no way to afford insurance. I have several chronic health challenges, including insomnia and hypertension. I am able to get some generic medication but it's not enough. I need to see a specialist for a sleep study and other treatments. Last month, after going several days without sleep, I had to be hospitalized. I didn't want to go to the hospital because I had no insurance, but in the end I had to go. If I had insurance I could get proper care to prevent expensive hospital visits. I am currently applying and interviewing for jobs. I need to be healthy, and my insomnia and other illness need to be cared for, so I can once again be a productive worker. LB1032, the Transitional Health Insurance Plan (sic--Program), would finally let people like me get covered by insurance and get healthy. I ask you today to please support LB1032. I'm available to answer any questions. [LB1032]

SENATOR CAMPBELL: Thank you, Ms. Jones. Questions, Senators? Thank you for coming to tell your story. [LB1032]

PAULETTE JONES: Thank you very much for listening. [LB1032]

SENATOR CAMPBELL: Our next testifier. [LB1032]

LISA METZLER: Hi. [LB1032]

SENATOR CAMPBELL: Good afternoon. [LB1032]

LISA METZLER: (Exhibit 10) Good afternoon. My name is Lisa Metzler, L-i-s-a M-e-t-z-l-e-r. I'm here today to request that you support the Transitional Health Insurance Program Act. I want to tell you a little bit about my family's story and why I believe so strongly. My husband and I are now reaching our mid-50s. [LB1032]

SENATOR CAMPBELL: It's okay. Just take your time. [LB1032]

LISA METZLER: I said I wouldn't do this...with knowledge that we will not always be here to support our son Benjamin, who has end stage renal failure, looking to have a new kidney in the future. Ben has Medicaid, but the coverage gap limits his ability to work. In our family, Ben is one of four children. He was born with kidney failure and has had multiple surgeries after birth. At age three, he finally weighed enough to receive one of my kidneys, transplant for his survival. Because of his medical needs we were a one-income family. We managed to get by despite the incredible stress and medical expenses and always tried to set our kids up to live their best lives. Having health insurance is a necessity for Ben because he is disabled. However, that coverage gap limits his ability to work as much as he'd like. Ben has a wonderful soul and has a lot to offer

the community. He has worked at the same job for the last five years. He is fully capable of working more hours than he does currently right now if he didn't run the risk of falling over the Medicaid eligibility line and into the coverage gap; he would appreciate the opportunity after his transplant. In the past he has worked more hours in a given week trying to help a boss and earn some extra money. He almost lost his Medicaid by earning just a few dollars above the eligibility line. Ben believes that he is a contributing member to our community and wants to participate to his full capacity. LB1032 encourages work, allowing people with disabilities, like Ben, to work more and to help...helping people on Medicaid transition to private insurance. I want to empower those that are working and continue to support people who have the ability and, mostly, the desire to contribute. As a young adult man, Ben wants to be self-sufficient. That's Nebraska, the good life. That's what it's all about. We are strong, hardworking people. Let's help those who are working to help themselves. Please consider your support in LB1032. Do you have any questions for me? [LB1032]

SENATOR CAMPBELL: Any questions? Thank you, Ms. Metzler. [LB1032]

LISA METZLER: Thank you very much. [LB1032]

SENATOR CAMPBELL: It's always difficult to tell your story, I know. [LB1032]

LISA METZLER: I didn't think I'd do it, but I did it. Thank you. [LB1032]

SENATOR CAMPBELL: You did a great job. Thank you. Good afternoon. [LB1032]

ROWEN ZETTERMAN: (Exhibits 11 and 12) Good afternoon, Madam Chair. I'm Rowen Zetterman. I'm speaking on behalf of the Nebraska Medical Association testifying in support of LB1032. My first name is Rowen, R-o-w-e-n; last name is Zetterman, Z-e-t-t-e-r-m-a-n. The Nebraska Medical Association is the unifying organization of physicians for all primary care and specialty physicians in the state of Nebraska. Amongst the two things I gave you today is a 2002 task force report...I'm sorry, a 2007 task force report, written before ACA was even being considered by Congress, suggesting a way that Nebraska could insure all Nebraskans, something that the physicians of Nebraska feel strongly about. The preamble of that proposal stated that all Nebraskans should have access to needed healthcare and emphasized the role of good health habits, wellness, and prevention. As you've heard many times, there are at least 77,000 Nebraskans not currently receiving health coverage who would be eligible for coverage under LB1032. You may not understand, or know, that rural counties in Nebraska actually have a greater percentage of uninsured than do the urban counties, and this affects rural counties, therefore, more than urban counties when you talk about the uninsured. Poor health insurance coverage of rural Nebraskans results in weaker communities and a less healthy rural Nebraska.

Critical access hospitals in Nebraska are at risk of survival, just like they are in other states, because of the uninsured and the underinsured in their communities. And across the country other states have experienced the closing of critical access hospitals because of the poor health insurance coverage in their states. The Transitional Health Insurance Program can remove this threat. The benefits for Nebraska are many. Federal supplements will come in to help pay for this and will buy services, food, jobs, cars, etcetera, as it provides more healthcare coverage and that money is spent into the economy. THIP can provide up to 10,000 new jobs, according to the studies that have been done. THIP will expand rural economies. THIP will increase the income and sales tax base in Nebraska because we will have more money entering the system and with more new jobs there will be more opportunities for income tax. Perhaps equally important as any of these things, THIP will save at least 80 to 100 Nebraskans their life over the next ten years because they have health insurance coverage. I know that my commercial health insurance, about $1,000 of it, goes to help pay for the uninsured and underinsured in this state, so I would expect my commercial insurance premium to actually fall because of the ability of THIP to provide coverage for some of those uninsured. And this lowering of premiums would allow more discretionary income for various families. Access to healthcare provides social goods that contributes to the well-being of the state and all of its residents. LB1032 can help us meet that goal. And I'd be pleased to answer any questions you may have. [LB1032]

SENATOR CAMPBELL: Questions? Senator Riepe. [LB1032]

SENATOR RIEPE: Senator Campbell, thank you. Dr. Zetterman, good to see you again. [LB1032]

ROWEN ZETTERMAN: Nice to see you, too, sir. [LB1032]

SENATOR RIEPE: My question is, what's your take on what will it look like in a year with a new administration? [LB1032]

ROWEN ZETTERMAN: Well, I can tell you we don't know what's going to happen, obviously, in the new one. We can probably predict that the Congress won't change so that interest will still be there. What we don't know is who will be the President of the United States and what that President believes or desires. But I think, realistically, it will be extremely difficult to roll back what's already in place because of the many benefits that are out there. We can go to publication after publication to show the benefit and value of ACA. You can go to states that have expanded Medicaid and show the benefit and value of that Medicaid expansion in their economy, in their total expenses that are spent by the state in a variety of things. I think it would be very important for us to look at that logically and carefully and, perhaps most importantly, to fix the things that everybody agrees needs to be fixed if there are things that are important. And certainly we all

have a few things that we think might be better done. But I think it will be a tragic event if we roll back the insurance for a whole collection of insured Americans, which is now, as you know, very large. And we're at the lowest percentage of uninsured in this country that we've been in more than 25 years. [LB1032]

SENATOR RIEPE: Do you have a sense of how we get ahold of some of the spiraling healthcare costs? I mean we're in the double digits. [LB1032]

ROWEN ZETTERMAN: Well, I think that, you know, there's some... [LB1032]

SENATOR RIEPE: We're, you know,... [LB1032]

ROWEN ZETTERMAN: There's some very interesting things that are going on, looking at value-based reimbursement for healthcare. I do think, and I'm by no means an expert, I actually think that if value-based reimbursement rolls over to critical access hospitals instead of cost plus that they currently have for Medicare coverage, that might actually be bad. Not that they don't provide value in what they do, but they don't...it may not cover completely their costs. So I think there are some risks even in the future as we go forward, yet those things will help control the overall cost of healthcare in this country. [LB1032]

SENATOR RIEPE: Thank you. Thank you. [LB1032]

SENATOR CAMPBELL: Other questions? Dr. Zetterman, you once said to me we're not going to really lower the cost of healthcare until we get everybody in the system, and I assume that you still believe that statement. [LB1032]

ROWEN ZETTERMAN: Absolutely. I think there's no way to do it until you have everybody paid by some sort of system so that there's no cost shifting. We really don't know the cost of commercial insurance for most of the people because we're cost shifting more than a billion dollars in the state of Nebraska to cover the uninsured and the underinsured. So until we have all of those people covered with some sort of a fashion, we really can't even address how the money is moving around inside the system. [LB1032]

SENATOR CAMPBELL: Any other questions? Thank you, Dr. Zetterman. [LB1032]

ROWEN ZETTERMAN: Thank you, ma'am. [LB1032]

SENATOR CAMPBELL: Our next testifier. Good afternoon. [LB1032]

CORY SHAW: (Exhibit 13) Good afternoon, Senator. How are you? [LB1032]

SENATOR CAMPBELL: Very good. [LB1032]

CORY SHAW: My name is Cory Shaw, C-o-r-y S-h-a-w, and I'm here on behalf of Rosanna Morris, the chief executive officer for Nebraska Medicine, speaking in support of the Transitional Health Insurance Act, LB1032. We support LB1032's efforts to bridge the gap between Nebraskans eligible for Medicaid and individuals who can afford insurance. Per our most recent government-audited calculation of uncompensated care, Nebraska Medicine provided $52.5 million in uncompensated care. Nebraska Medicine receives funding from the Centers for Medicare and Medicaid Services, CMS, due to our above-average potion of services provided to individuals who meet CMS's Medicaid eligibility criteria. This funding, called disproportionate share or DSH funding, was changed and reduced significantly to help the federal government fund the expansion of insurance for uninsured individuals. The net result of this change is a loss of approximately $1 million for Nebraska Medicine for fiscal year ended June 30, 2015. The dollars available under the DSH program will continue to decrease over time. The majority of the uncompensated costs are currently passed on to privately insured policy holders. LB1032 provides a means for reducing uncompensated care which substantially reduces the burden for healthcare providers. Ultimately the reduction in cost can be passed on as savings to privately insured Nebraskans. We believe that this investment in Nebraskans pays off for all Nebraskans and encourages your support of this legislation. Thank you for your time on behalf of Nebraska Medicine and Ms. Morris. So I'd be happy to answer any questions. [LB1032]

SENATOR CAMPBELL: Questions, Senators? Senator Riepe. [LB1032]

SENATOR RIEPE: Thank you, Senator Campbell. Mr. Shaw, good to see you again. [LB1032]

CORY SHAW: Senator, how are you? [LB1032]

SENATOR RIEPE: Good. The question I had is Nebraska Medicine provides $52.5 million in uncompensated care. If we have a uniform health insurance across this state and we take away this uninsured, how do the tax-exempt organizations then justify being 501(c)(3) charitable organizations? Should we not take that away and then be able to tax and some of the counties could get some money in that way through property tax out in the smaller towns? [LB1032]

CORY SHAW: So I think, as you know, the federal IRS regulations have several qualifiers to satisfy 501(c)(3) status. Charitable purpose is one of them. I think it's important to note that the charitable purpose that we have, it's across not only uninsured but also individuals and other community good that we provide as healthcare organizations, whether they be hospitals or nonprofit healthcare organizations that aren't hospitals that provide that and meet that need. So I think it's one of those questions that needs to be evaluated and judged were we to reach a point where there was no uncompensated care provided by any of the members of the healthcare system. [LB1032]

SENATOR RIEPE: But it's my understanding in your community report that if you bill the patient it's no longer charity; it's now a bad debt. So there's differentiation there. And like every business, there will be some bad debt within an organization. [LB1032]

CORY SHAW: Sure. I believe the IRS guidelines that we use to report uncompensated care accounts for those patients that we've billed for service and expect payment, which, as you allude to, defines a bad debt, as opposed to a patient that we see and prospectively determine we're going to be unable to provide or collect any source of payment for those individuals, and those patients become eligible for charity care. [LB1032]

SENATOR RIEPE: Just a question. Thank you. Thank you very much. [LB1032]

CORY SHAW: You're welcome. [LB1032]

SENATOR CAMPBELL: Any other questions, Senators? Thank you, Mr. Shaw. [LB1032]

CORY SHAW: Thanks. [LB1032]

SENATOR CAMPBELL: Good afternoon. [LB1032]

ANDREA SKOLKIN: (Exhibit 14) Good afternoon, Senator Campbell, members of the committee. My name is Andrea Skolkin, A-n-d-r-e-a S-k-o-l-k-i-n, and I am the chief executive officer of OneWorld Community Health Centers in Omaha. And I'm here today representing the Health Center Association of Nebraska, which includes the seven federally qualified health centers. And I'm going to name them: OneWorld Community Health Center, Charles Drew Health Center, both in Omaha; People's Health Center in Lincoln; Good Neighbor Community Health Center in Columbus; Midtown Health Center in Norfolk; Heartland Community Health Center in Grand Island; and Community Action Partnership of Western Nebraska in Gering. Our health centers are nonprofit, community-based organizations that provide high-quality medical,

dental, behavioral health, pharmacy, and a number of support services to people of all ages. We are significant healthcare homes for Nebraska's low-income families. I am here today in support for LB1032. Right now our health centers serve about 70,000 patients, over half of which are uninsured. Sixty-eight percent are racial and ethnic minorities, 91 percent at or below 200 percent of poverty, which you know that threshold is $48,500 for a family of four. Overall, the seven health centers in Nebraska also serve 24 percent of the state's uninsured children. We are not free clinics. We have a sliding fee scale and we encourage everyone to contribute to the cost of care based on their household income and the number of people in their families. We are a safety net for low-income Nebraskans, but we are required by federal law to serve everyone who walks through our doors. LB1032 would allow the 77,000 eligible uninsured Nebraskans, and that is not all the uninsured Nebraskans, to access healthcare coverage. Moreover, LB1032 would allow us to continue to build capacity because we would have a source of reimbursement for their cost of care. Nationally, the average of the number of uninsured patients or percent across the country, and there are 1,300 health centers, the average is 28 percent. In Nebraska, our uninsured rate is 50 percent. This doesn't bode well for our long-term sustainability and ability to continue to provide care to the state's uninsured. Ignoring uninsured Nebraskans only will continue to overburden a fragile safety net system in our state. The Nebraska Legislature has generously supported us, in addition to our federal dollars, in the past. And you have seen what we can do to provide quality healthcare, including preventive support to Nebraska's health systems. But we cannot completely cover the cost of all these health services for all uninsured Nebraskans without reimbursement and our state support, as well as philanthropy. It must be a partnership among all health facilities and providers in our state to protect our most vulnerable Nebraskans while giving a leg up to working low-income families so they can access health insurance. I believe you've heard today and will continue to hear that this partnership among health providers is all in support of LB1032. Do not tie our hands when there is such a need. Thank you for the opportunity to speak today. [LB1032]

SENATOR CAMPBELL: Thank you, Ms. Skolkin. Questions from the senators? Senator Riepe. [LB1032]

SENATOR RIEPE: Thank you, Senator Campbell. Thank you for being here. [LB1032]

ANDREA SKOLKIN: Thank you. [LB1032]

SENATOR RIEPE: I've had the opportunity to visit your place several times and I know that you do an excellent job. I think yours is one model that has been talked about as an alternate model, maybe across the state, as opposed to being in the insurance business that we be in some kind of federally supported clinics types of things. And I know that the staff that you have there are

outstanding. So my question gets to be is, could we extrapolate and have centers like yours in other regions in the state of Nebraska to address our challenges? [LB1032]

ANDREA SKOLKIN: Senator Riepe, thank you for your question. And I would tell you it's not an either/or. We need both. We do need health centers across the state. But we provide primary care and we need the help of all the health systems in the state to provide that continuum of care. Right now we have seven health centers. We don't cover the whole state, nor all of the uninsured that need our care. And so for us it's really both. [LB1032]

SENATOR RIEPE: Are you reimbursed on a cost-plus basis? [LB1032]

ANDREA SKOLKIN: We are reimbursed, I guess you would call it a cost plus. We have a PPS rate that we are reimbursed by. [LB1032]

SENATOR RIEPE: Okay, thank you. Thank you very much. [LB1032]

SENATOR CAMPBELL: Any other questions, Senators? Senator Crawford. [LB1032]

SENATOR CRAWFORD: Thank you, Chairwoman Campbell. And thank you for your testimony. Just to follow up on that question then, I think what I'm hearing you say is you provide only primary care. And so someone who has cancer or someone who needs hospitalization, there's none of that kind of care available through expanding clinics like yours. Is that correct? [LB1032]

ANDREA SKOLKIN: Senator Crawford, that is correct. [LB1032]

SENATOR CRAWFORD: Thank you. [LB1032]

SENATOR CAMPBELL: Okay, anything else? Thank you very much. [LB1032]

ANDREA SKOLKIN: Thank you. [LB1032]

SENATOR CAMPBELL: Our next testifier. Good afternoon. [LB1032]

KEITH NELSON: (Exhibit 15) Good afternoon, Senator Crawford and all the members of the Health and Human Services Committee on this Ash Wednesday afternoon. I am Keith Nelson, a

pastor of the Lutheran church and a member of the clergy caucus of Omaha Together One Community. I am here... [LB1032]

SENATOR CAMPBELL: Could you spell your name, sir. I'm sorry, Pastor. [LB1032]

KEITH NELSON: I'm sorry. I should spell it. You're right. K-e-i-t-h N-e-l-s-o-n. [LB1032]

SENATOR CAMPBELL: Go right ahead. [LB1032]

KEITH NELSON: I apologize. I'm here to ask for your support to move LB1032 out of committee and into law. Many clergy and members of congregations across Nebraska urge you to see the Transitional Health Insurance Program Act as consistent with their faith. The U.S. Conference of Catholic Bishops in their statement endorsing Medicaid expansion said Catholic tradition upholds healthcare as a basic right flowing from the sanctity and dignity of human life. Well-designed public policy is ethical and promotes the common good guided by principles such as fairness and do no harm; Nebraska treats some of its citizens unfairly and causes harm. Arbitrary income thresholds are used to refuse healthcare insurance to all. Almost 500 people die unnecessarily each year. Others become disabled or chronically ill when tax dollars already paid by Nebraskans are left on the table. People without health insurance are harmed by delayed diagnosis and treatment, all totally unnecessary and very, very expensive. People such as hotel workers who clean and make the beds for guests to our state, many who serve us our fast-food hamburgers, care for our children in day-care centers, clean our houses, serve us coffees in the diner, stock shelves and bag groceries at the supermarket, are among those who get caught in the gap. For example, in Senator Fox's district alone, there are over 4,000 people, mostly working poor, who are only one serious health problem away from economic ruin. I did not appreciate the need for LB1032 until I preached in a south Omaha congregation. Following the service a parishioner asked me a startling question: How do I get insurance? Immediately I thought, well, you buy it. He asked, do you think I should buy that or cut back on food? He said, I need to have treatment that the community health center can't do but I can't figure out a way to pay for it. Perhaps you have had a similar experience. Maybe you see LB1032 as good public policy for our state or maybe you have never had a conversation with your server or the person who cares for your elderly relative about their circumstances. Some of us live comfortably, receive health insurance from our employers or Medicare, and can pay for our medical needs. We are insulated from the problem and the harm our decisions do to others. It is time to open our eyes and see, our ears to hear the cries of honest, often hardworking Nebraskans who, for reasons beyond their control, are in the gap. Etched on the pylons at the north entrance to this building in our state is our state motto, "Equality Before the Law." Presently we have an unnecessary and expensive form of diversity in our state. That is the diversity among our citizens in terms of their access to healthcare. Today, using a market-based, job growth, economic development approach, Nebraska

has the opportunity to redress this inequality. Passing LB1032 out of committee and into law is the right thing to do. Thank you. [LB1032]

SENATOR CAMPBELL: Thank you, Pastor. Are there any questions? Senator Riepe. [LB1032]

SENATOR RIEPE: Thank you, Senator Campbell. Pastor Nelson, good to see you again. [LB1032]

KEITH NELSON: Good to see you as well. [LB1032]

SENATOR RIEPE: You commented in here and as it's written it says, "consistent with their faith" in terms of talking with people. And you go on to talk about a quote from Catholic traditions. Then does this open the door for abortions or where...I mean, when we're using health insurance? [LB1032]

KEITH NELSON: That discussion is another item that I am not prepared to discuss. However,... [LB1032]

SENATOR RIEPE: I think it's very much a part of health insurance. [LB1032]

KEITH NELSON: However, I am ready to say that the basis upon which the national U.S.A. Catholic Bishops encourage the passage of expanded Medicaid was the sanctity of life. And I believe that that is what we're talking about, the sanctity of life. [LB1032]

SENATOR RIEPE: Okay, we'll see how it plays out. Thank you. [LB1032]

SENATOR CAMPBELL: Any other questions? Thank you, Pastor, for coming. Oh, sorry. [LB1032]

SENATOR FOX: Oh, that's okay. [LB1032]

KEITH NELSON: It's fine. [LB1032]

SENATOR FOX: I know you pointed out that I have...you know, I am the senator for the district for which you work and you mentioned the working poor. As a senator trying to weigh the pros and cons of this bill, my biggest concern is burdening those that are working and bringing home a paycheck and trying to maximize their take-home pay. If this model would not be sustainable

and the cost of this expanded coverage would fall on the working people of the state, as a state senator, what do I tell those people? [LB1032]

KEITH NELSON: If it's not sustainable? [LB1032]

SENATOR FOX: Um-hum, if the costs that are projected end up being more and we as a Legislature have to scramble to find ways to cover the cost. [LB1032]

KEITH NELSON: I don't know that the only answer to that question is cutting costs. I think there are other answers to address that issue, and then maybe revenue production and increasing revenue to offset the costs by the state in...as needed in the event that that should happen. So I, as a citizen, would be willing to increase my contribution through state taxes so that those persons in my state who are in desperate need and want to work could receive care. Remember, the story of the good Samaritan is very clear. Not only did they see the need, but the good Samaritan took resources of his own and placed them with the hand of the caregiver and said, care for this person at my expense. And if there's a need for more revenue to meet those needs and you need me to contribute more, just ask. [LB1032]

SENATOR FOX: (Inaudible)...and I understand that. But unfortunately, people in some parts of the state...District 7, don't have that luxury. They don't have the luxury of saying, I'm willing to have more taxes taken out of my paycheck. So that's my question to you is, what do I say to those constituents then? [LB1032]

KEITH NELSON: Well, that they would be the beneficiaries of this action and that many of them may...I'm not saying they are. [LB1032]

SENATOR FOX: The working poor, the working poor, not those that don't have health insurance. [LB1032]

KEITH NELSON: There are many people who are working poor that have very low tax rates if...are exempt from paying taxes. [LB1032]

SENATOR FOX: These are people that are working, that are living paycheck to paycheck and already struggling to afford housing and food. If you... [LB1032]

KEITH NELSON: Yep. And I'm not saying you would increase their taxes. [LB1032]

SENATOR FOX: They're going to...so, okay, so we're...okay. [LB1032]

KEITH NELSON: Ask me for more taxes. I'm not asking them. Ask me for this revenue so that they can receive the medical care that they are required. I'm not asking them to increase their taxes when they don't already pay taxes. [LB1032]

SENATOR FOX: But again, I'm just saying I don't know that everyone would be agreeable to that. [LB1032]

KEITH NELSON: Didn't say they would, I'm just asking. [LB1032]

SENATOR CAMPBELL: Thank you, Pastor. [LB1032]

KEITH NELSON: Thank you so much. [LB1032]

SENATOR CAMPBELL: Our next testifier. Senators, I am not going to take a break. So if you need a break, you're going to just have to one by one maybe disappear. Good afternoon. [LB1032]

EMMANUEL CHAVEZ: (Exhibit 16) Good afternoon, Senator Campbell, members of the Health and Human Services Committee. My name is Emmanuel Chavez, spelled E-m-m-a-n-u-e-l, last name C-h-a-v-e-z, and I work as a community organizer at the Heartland Workers Center. I am here to testify in support of LB1032. Last summer the Heartland Workers Center conducted a community assessment in eight precincts in south Omaha. Of the 630 surveys completed, over one third of respondents stated that they do not have health insurance. The families of many of these respondents also lacked any kind of medical insurance coverage. Lack of health insurance is clearly an issue that is affecting many poverty-stricken households in south Omaha. I remember speaking with families that could neither afford health insurance on the marketplace nor did they qualify for Medicaid. In some cases, the employers of the respondents did not offer them medical insurance. And we also surveyed many families who did not qualify for Medicaid by a very small margin. Before working at the Heartland Workers Center I had the opportunity to take the community assessment as a resident of south Omaha. When I was asked about health insurance I was caught off guard because it reminded me of my childhood. It reminded me of the times my parents would talk about not being able to afford doctor visits. My parents would always say that God was our health insurance and this meant that in times of poor health we depended very much on prayer. Unfortunately, modern medicine and prayer are two very different things. That said, I am thankful that my family and that I have been lucky enough to have avoided financial and health disaster that could have been caused due to our lack of health

insurance. From my experience, it would have been greatly reassuring to have had access to necessary medical treatment when my family needed it. Members of the Health and Human Services Committee, I have come before you today representing the Heartland Workers Center to ask you for your dedicated support for LB1032. I no longer wish for members of my community to fall into a state of despair in times when they require medical attention. It would be good to see more families in south Omaha with the option to access medical attention without having to stress over outrageous medical bills and without having to depend solely on prayer. Thank you, and I can take any questions. [LB1032]

SENATOR CAMPBELL: Questions? Senator Crawford. [LB1032]

SENATOR CRAWFORD: Thank you, Chairwoman Campbell, and thank you for being here and sharing these results. Now in your testimony you talk about speaking with families that couldn't afford health insurance on the marketplace and you said that in some cases the employers of the response didn't offer medical insurance. So I just wondered. I assume that when you've been talking to families who could not afford health insurance, is it the case that many of them are employed and working and cannot afford health insurance? Is that correct? [LB1032]

EMMANUEL CHAVEZ: That was the case in...with some of the families. Like one of the testifiers earlier said, she was $42 over, like, the being able to qualify for the Medicaid I think. It was cases like that. But they were working families, yeah. [LB1032]

SENATOR CRAWFORD: Thank you. [LB1032]

SENATOR CAMPBELL: Any other questions? Thank you very much for your testimony. [LB1032]

EMMANUEL CHAVEZ: Thank you. [LB1032]

SENATOR CAMPBELL: Our next testifier. Good afternoon. [LB1032]

MELISSA FLORELL: (Exhibit 17) Hello. My name is Melissa Florell, M-e-l-i-s-s-a F-l-o-r-e-l-l. I represent the Nebraska Nurses Association. NNA is the voice of registered nurses in Nebraska and I'm here today to testify in support of LB1032. I've submitted a letter written by our legislative chair that describes her experience in working with a patient with a preventative...preventable medical condition. And in my own practice prior to coming to NNA, there are countless times when I encountered patients who were working who would be classified either as the working poor or self-employed or own their own small business whose

health outcomes would have been vastly improved, if not completely cured, by having improved access to care in the form of health insurance. These patients had late-stage cancers, uncontrolled hypertension, poorly controlled diabetes, all things that reliable, dependable primary care would have prevented. LB1032 makes sense to the Nebraska Nurses Association. It supports working Nebraskans who fall in the coverage gap by allowing access to healthcare, especially preventative. It also brings $2 billion of our tax dollars back to Nebraska. You've heard from several members of Nebraska's healthcare work force who are ready to work with the Department of Health and Human Services and Nebraska's Legislature to find creative Nebraska-based solutions under LB1032 to meet the needs of these patients. This bill promotes personal responsibility while helping those who need it most. And NNA would like to thank Senator McCollister for introducing the bill and thank you for allowing me to testify in support. [LB1032]

SENATOR CAMPBELL: Are there any questions? [LB1032]

SENATOR RIEPE: I have a quick question. [LB1032]

SENATOR CAMPBELL: Senator Riepe. [LB1032]

SENATOR RIEPE: In parts of the country they're talking about...in terms of funding expanded Medicaid with a taxation on hospitals and physicians and other providers. Are you familiar with that? [LB1032]

MELISSA FLORELL: No, I'm not. I'm... [LB1032]

SENATOR RIEPE: Well, there's one state I know that's $4.2 million for a large hospital and it was $800 for every physician. Do you think your Nurses Association would be receptive to that, as we would call it, a Nebraska-based solution? [LB1032]

MELISSA FLORELL: I think that LB1032 does not introduce that opportunity in Nebraska. And I feel that Nebraska's hospitals right now and the hospital administrators and healthcare workers that I've spoken to are most concerned with providing dollars that will offset or take care of the uncompensated care that they currently are faced with. [LB1032]

SENATOR RIEPE: Would you oppose an amendment to that effect to allow that taxation back to hospitals and doctors and nurses? [LB1032]

MELISSA FLORELL: Our legislative committee reviews every amendment individually as it's introduced and would take a stance at that time. [LB1032]

SENATOR RIEPE: Okay, thank you. [LB1032]

SENATOR CAMPBELL: Any further questions? Thank you. Our next testifier. Good afternoon, Senator. [LB1032]

LOWEN KRUSE: Good afternoon, Senator Campbell. And hello to all the committee members, a personal hello. I am Lowen Kruse, L-o-w-e-n K-r-u-s-e, and I live in Omaha. I am here to support this bill. I'm impressed with it, with the tremendous amount of work that's gone into it on the part of people on all sides and the progress that's been made recently. I commend all who are working on it and I commend the bill to you because this is a very complex issue and it's dealing, from my perspective, with one of the most serious gaps in our system, in our policy, and that is how to provide preventive healthcare to a great mass of people. Its cost of not doing that is obvious from previous testimony. It's costing us billions of dollars over several years, and it's just an unacceptable way to go. I get to watch it close at hand. My neighbor died Friday. He had been in the hospital for two weeks and his physician said that it was all unnecessary. It was because of lack of preventive healthcare. His last week was in ICU. His bill was between $30,000 and $40,000 and we paid it. That's my point. We do pay these bills and the county pays for the emergency and the 911 calls that preceded. And those of us who have private health insurance, the hospital takes up a collection from all of us to pay the rest of the bill. It seems to me that if the public understood that we are refusing to use federal funds that we've already contributed, we've paid in the taxes, and if we don't want to use that when they would pay 90 percent of the cost, we had better hope that we don't meet any of them in a really grumpy mood because we're wasting money and that's not the way that we operate in Nebraska. I...my views are honed by the Appropriations Committee, eight years there; I watched Nebraska. We are a conservative state, supposedly. We are conservative, on the floor, about this year's budget. But in Appropriations Committee we had to look long term. There is a simple...you have to directly look at what's going to work over the long haul and, over the long haul, we've got some real problems to meet here. And I would urge that we get rid of deficit-minded approach to it. Those on the outside will say we're doing something nice for people. Well, from eight years on Appropriations watching every bill, we have not passed one single bill in Nebraska, in my observation, that was to be nice to somebody. We'd make all kinds of speeches like that, but we don't do that. We vote for dollars, and that's what we got to look at here. And that's not putting anybody down because we have a shortage of dollars. There are not enough dollars to hit all the necessities. We cannot be nice to everybody, but that's not going to carry the weight. I work also with ex-prisoners. That's a whole "nother" subject except that half of them are mentally ill and half of that group are in prison, basically, because they are mentally ill. We spend $35,000 a year for treatment for them that is the worst possible kind of treatment for a mentally ill person--and I've worked in a mental

hospital--yet when they get out the Medicaid gap is facing them because they cannot get treatment once they get out--good treatment. I have personally talked with persons who, if they'd have gotten decent treatment, would have been able to become employed again. They're very talented. They're skilled persons. They know how to do this. They could help us as a society. But I've traced some of them back ten years...unemployment because they didn't get the kind of help that would just be obvious necessity and in our benefit right off the bat. I have one final comment and that is a little different. It's pride. I am so proud of Nebraska. And I'd be more proud if we provided minimal health insurance or coverage for preemptive work. I think we can do it and I think we should get out of the negative deficit mind set. Thank you. [LB1032]

SENATOR CAMPBELL: Thank you, Senator. Any questions? Okay, thank you for coming, always good to see you, sir. Our next testifier. We must be getting pretty close to the end of the proponents. Can I see a show of hands? Not really (laughter). Well, we're going to be here until the last person has something to say, or at least the majority of us will be, so not to worry about that. Go right ahead and... [LB1032]

LAUREN KOLOJEJCHICK-KOTCH: (Exhibit 18) Senator Campbell and members of the Health and Human Services Committee, thank you for this opportunity. My name is Lauren Kolojejchick-Kotch, L-a-u-r-e-n K-o-l-o-j-e-j-c-h-i-c-k, hyphen, K-o-t-c-h. And I work for the Center For Rural Affairs, but I'm not here on behalf of the center today. I'm here to read testimony prepared by Deb Craig who lives in Hebron, Nebraska, and she was not able to make it today. I'm going to read an abbreviated version of what you have in front of you so hopefully you can follow along. My name is Deb Craig. I live in Hebron in Thayer County. My husband and I recently purchased an independent insurance and real estate business. This is a second-generation family business. We've had our own struggles with finding affordable insurance and, because we sell health insurance, regularly hear the stories of people who are caught in the coverage gap. I'm asking you to support LB1032. I agree that something needs to be done to make sure that everyone has access to health insurance that is affordable. I concede that not everything about the Affordable Care Act is perfect. But it has helped us, personally, to manage our own health insurance costs. When I lost my health insurance in 2009 due to my employer changing me to part-time status, our health premiums were over $1,500 a month, because my husband and son had to go to the health insurance pool and obtain individual policies due to preexisting conditions. Our premiums have become more affordable with a combined family deductible and coverage for preexisting conditions since implementation of the Affordable Care Act. One medication for my husband is over $5,000 a month. Without health insurance and the ability to purchase his medication, he would likely be disabled. With this medication he still works 40 to 50 hours per week. Health insurance makes a difference in an individual's ability to work and be a productive Nebraskan. As my husband is a licensed insurance agent, we attempt to help clients find health coverage that they can afford. We regularly encounter clients with garnishments for medical bills who cannot afford to buy medicine and pay premiums or the

medical bills incurred because of high-deductible plans. We have encountered couples who have gotten divorced to help a seriously ill spouse obtain Medicaid coverage so that they can afford to seek medical care. One of the spouses works full time and is barely above income guidelines, so divorce ended up being the only choice of last resort. Some individuals are on their third medical bankruptcy. These clients are what we deem the working poor. They are trying to stretch the paycheck that they earn and just don't have enough take-home pay to stop the vicious cycle of needing care and not being able to afford it. Many are embarrassed to ask for help and need help to get through a difficult time. As a small-town business it is important to us to help our clients find the most affordable coverage they can get. Prior to purchasing our business I worked for 25 years in healthcare and 7 years in assisting employees with health benefits. Uncompensated care is still a big problem for local healthcare providers in rural areas. Failing to expand access to health insurance forces healthcare providers to provide uncompensated care. By passing LB1032 and expanding access to coverage, you'll be providing support for our lower income workers. Our rural areas need healthy workers who are focused on their job, not the sad state of their financial affairs. Utilizing LB1032, you will be supporting low-income workers who are already very cost conscious to utilize an office setting rather than an emergency room. Expanding their ability to obtain primary care and medications with early intervention and follow-up stops, the vicious cycle our low-income workers are currently facing. In closing, LB1032 is a bill that can actually help someone like me and also the clients we serve. It would improve the health of my community and the financial well-being of our local health clinics and hospitals. This is a measure that will do tremendous good for good, hardworking Nebraskans that simply need some temporary help. I ask you today to please support LB1032. I am willing to take questions, but I also encourage you to direct any questions that you have to Ms. Craig. [LB1032]

SENATOR CAMPBELL: Please extend our thanks for her testimony and, no, I don't think we're going to question you because you can't answer for her, so. [LB1032]

LAUREN KOLOJEJCHICK-KOTCH: Yeah. Thank you. [LB1032]

SENATOR CAMPBELL: Our next testifier. Good afternoon. [LB1032]

ANDY HALE: (Exhibits 19 and 20) Good afternoon. Chairman Campbell, members of the HHS Committee, my name is Andy Hale, A-n-d-y H-a-l-e, and I'm vice president of advocacy for the Nebraska Hospital Association. What I have submitted are two letters, one...excuse me, both in support: one from Dr. Cliff Robertson who is CEO of CHI Health; and Mr. Stephen Goeser who is CEO and president of Methodist Health. It's the mission of the Nebraska Hospital Association to enhance the quality and delivery of patient care and services for our state's citizens. On behalf of our mission, our 90 member hospitals, and the 41,000 individuals that they employ, the NHA offers the following testimony in support of LB1032. People who do not have health insurance

still get sick and need medical care. Many uninsured consumers, particularly those with lower incomes, are not able to pay for the care they receive. Hospitals that care for uninsured patients end up providing significant amounts of what is called uncompensated care, care that patients cannot pay for because they have no insurance or have inadequate insurance. States that have expanded Medicaid are generally seeing larger increases in the percentage of residents with insurance and larger decreases in uncompensated care. Expansion states are also generally seeing a bigger increase in healthcare jobs than nonexpansion states and increased employment means a broader tax base, stronger local and state economies, and even a stronger overall national economy. The uninsured rate for low-wage workers dropped significantly in the states that expanded Medicaid compared to the states that did not. A study here from a Families USA found that states that expanded Medicaid in 2014 saw a 25 percent reduction in the number of uninsured workers. Expanding Medicaid is good for workers and their families and also good for businesses in the state economy. When working people have health insurance they are more productive, take fewer sick days, and report fewer instances of disability. A healthier, more productive work force helps strengthen the business and industries that we rely on every day as a state. Changes in Medicaid should be motivated by the needs of the patient, not by politics. The NHA wishes to thank Senator McCollister for introducing the bill, as well as Senator Campbell, Senator Mello, Senator Krist, and the other senators and, most importantly, the staff that I know have worked very hard. And we'd also like to extend another thank-you for Senator McCollister for including the NHA on his tour of the state last fall and last summer. In closing, I ask that the committee advance this proposal to General File and I thank you for your time. [LB1032]

SENATOR CAMPBELL: Thank you, Mr. Hale. Questions? Anyone have any questions? Okay, thank you very much. [LB1032]

ANDY HALE: Thank you. [LB1032]

SENATOR CAMPBELL: Good afternoon. [LB1032]

LaDONNA VanARSDALL: (Exhibit 21) Thank you. Senator Campbell and the Health and Human Services Committee, thank you for letting us speak today. My name is LaDonna VanArsdall; that's L-a-D-o-n-n-a. The last name is VanArsdall; it's V-a-n-A-r-s-d-a-l-l. I'd like to tell you a little bit about my healthcare situation and explain to you what it means to be part of a medically needed spend down category of Medicaid recipients. Many other Nebraskans in my situation would also be helped by passing LB1032. I'm sorry, I get nervous. [LB1032]

SENATOR CAMPBELL: You're fine. [LB1032]

LaDONNA VanARSDALL: I have worked hard all of my life and I've worked full time. I've been able to provide for my family and myself until I had surgery about eight years ago. That's when I...as a result from the surgery, I ended up having a severe infection. The medication shut down my kidneys and one time they kept me in the hospital for over two weeks because of that. I've had so many medical bills that I've had to file bankruptcy. After my surgeries, my job became very physically demanding and my medications made it very hard for me to concentrate. Needless to say, when the company laid off 50 people, I was one of them that was let go. There are medications and treatments I still need; however, I can only get healthcare coverage through what is called the Medicaid spend down. I receive an income from Social Security Disability, but my gross income is too high to qualify for Medicaid, but I still can't provide myself with private health insurance. However, I still need insurance so that I can...I'm sorry. I still need health insurance so I can spend down my income every month to the point where I qualify for Medicaid. This means I have to spend down a large chunk of my fixed income buying insurance policies that are not helpful for me. The only thing they are...the reason that they're needed is to help to reduce my income to be low enough to qualify and be eligible for these coverages that I do still need. I'm not alone in this. Many of us who have worked all of their lives hard in the past now have to spend a big chunk of our shoestring budgets just to get the healthcare we need. This seems like a wasteful practice. I would much rather spend my money on things I need and use, such as housing, food, and other bills. That's why the 2 percent income contribution from LB1032 makes sense to me right now. And I'm paying hundreds of dollars each month to buy these policies that don't actually help me. I would rather use part of that money for my 2 percent monthly contribution so that I am still doing part and being useful...I'm sorry, paying for useful coverage. Medicaid is necessary to get me the care I need, but my monthly spend down is not. LB1032 would eliminate the spend down category. The policy would let me spend my money more effectively while still being able to cover the important treatments. I ask you to please pass this bill of LB1032 which just makes perfectly good sense. And I thank you for your time. [LB1032]

SENATOR CAMPBELL: Thank you, Ms. VanArsdall. [LB1032]

LaDONNA VanARSDALL: I apologize for the errors. [LB1032]

SENATOR CAMPBELL: You're fine. Any questions, Senators? Okay, thank you very much. [LB1032]

LaDONNA VanARSDALL: Great, thank you so much. [LB1032]

SENATOR CAMPBELL: Our next testifier. Good afternoon. [LB1032]

SHAWN MURPHY: Good afternoon, Senator and committee. My name is Shawn Murphy; it's S-h-a-w-n, last name Murphy, M-u-r-p-h-y. I drove out here from western Hall County today to address you guys and share my story with you. I am first, a taxpayer; second, single parent; and third, a formerly convicted criminal. I did spend time incarcerated in prison and I do know one thing is that while I was there I never had an issue with being provided healthcare. I have since got out. I have completely changed my life around. I work in the community out there in Hall County, Grand Island area. I've done work with the police department, the State Patrol, Health and Human Services themselves, mentoring kids. I do youth programs and I run a football organization for kids. I did apply through the marketplace for medical insurance. I was denied that I was below poverty level. They referred me over to Health and Human Services, and I did apply through Health and Human Services, and I was denied because I was over the level. I did not know this term before recently, but I am in the gap, you know. I am a gap filler, as I've been calling it. My life changed when my son was dropped off. He was nine days old. Two weeks ago he turned nine years old. I've been working with my community, I've been working with my family, and I've been raising a child by myself. Over these years I have either had to go without medical attention or be heavily indebted for something. And I have also taken the same step other testifiers have taken, and I have had to file bankruptcy, and 90 percent of it was medical bills. I did contact the marketplace again and they did offer me insurance policies. They offered me a few policies that varied between 30 to 67 percent of my gross income. And even on the low end, I cannot expend 30 percent of my gross income trying to raise a child by myself, for anything. I've come here, you know, to see if we could get your support for LB1032 and let you know that there are working people out here. There are people that have changed their lives, that have been on both sides, that understand everything that's going on in this life situation. And I just hope that you guys could help support this bill and help me and 77,000 people not be gap fillers anymore. And I'm here to...any questions I will address with you. [LB1032]

SENATOR CAMPBELL: Thank you, Mr. Murphy. Any questions, Senators? Thank you very much for taking the time to come. [LB1032]

SHAWN MURPHY: Thank you. [LB1032]

SENATOR CAMPBELL: Our next testifier. Good afternoon. [LB1032]

AMANDA GERSHON: Good afternoon. Thanks for having me. My name is Amanda Gershon, A-m-a-n-d-a G-e-r-s-h-o-n. I've had health problems most of my adult life and, for the most part, have been uninsured. I was approved for disability in March of last year. It took me another nine months to get approved for Medicaid and then another five caseworkers to get my retro pay open to get medical bills paid. Our current system is so complicated and broken, the type and the amount of work for someone on disability to get all the paperwork together is unreal. The hours

of communication on my case alone had to be costly. Expanding the program helps simplify the process. There's so much misinformation out there about our current system and who qualifies. I even had a state senator last year crudely joke that I should spread my legs and have a baby to get on Medicaid. I'm not sure if his comments, or his ignorance of our current system, bothered me more. There are people who have had disabling health conditions who don't qualify for health with healthcare, working adults with minor problems that can be addressed before they get worse if they had access. I spent the first week of 2016 in the hospital. I had an outpatient exploratory procedure scheduled for the end of January for the problems I've been having for the last several years. But my body crashed before then. After waiting so long, simple issues had become much more complicated and much more costly. The procedure would have been about $2,000. My hospital bill alone is $44,000. There will be the ambulance, the doctor bills, pathology, many more coming in. I was not able to make it three more weeks to get to that because I had been hiding this for so many years. I now have Medicaid and I am so grateful. I cannot imagine the situation I would currently be in if I did not. I'm 33 and I'm starting to worry that I'm not going to get better because it has taken so long for me to get care, so long, and it's not right. There is so much more in me. I'm 33. I'm not even halfway through my life. I've got a lot more coming. I finally get the help and it's going to take awhile, but I see people going through this all the time. And being involved in this, I hear their stories all the time. This is a common thread and we've heard it over and over and over: medical bankruptcy, not being able to see specialists, get testing, get prescriptions. I cried the first time I went to the pharmacy with my Medicaid card because I had worked two jobs for so many years to pay for those medications. And being able to pick them up a whole month at a time and not have to worry about splitting them up and taking them occasionally, these aren't things working people should have to deal with--they aren't. And we have the opportunity to change this and make other people's lives better. Thank you. [LB1032]

SENATOR CAMPBELL: Questions or comments, Senators? Amanda, you've been here every year. [LB1032]

AMANDA GERSHON: And I'll keep coming. [LB1032]

SENATOR CAMPBELL: Are you better? [LB1032]

AMANDA GERSHON: I'm getting there. It's going to be a very long process. A lot of the stuff over the last several years has just kind of added up. But we're getting there so I'm grateful. [LB1032]

SENATOR CAMPBELL: Okay, thank you. Thank you for your testimony. [LB1032]

AMANDA GERSHON: Thank you. [LB1032]

SENATOR CAMPBELL: Our next proponent. Good afternoon. [LB1032]

NATHAN WILLIAMS: Good afternoon. My name is Nathan Williams. [LB1032]

SENATOR CAMPBELL: You need to spell the name, sir. [LB1032]

NATHAN WILLIAMS: Okay. I've never done this before. [LB1032]

SENATOR CAMPBELL: You're fine. [LB1032]

NATHAN WILLIAMS: So, N-a-t-h-a-n, Williams, W-i-l-l-i-a-m-s, but I am half Irish, so (inaudible)(laughter). Okay, so I've got two wonderful kids, got a 10-year-old and an 11-year-old, and my son has eagle eyes. I swear, this kid could see...he loves to collect rocks, pennies; you name it, this kid can spot it. But my son can find pennies all over parking lots. But he's ten years old and he knows this. He knows that if he saw a $100 bill, he'd chase the $100 bill down before he'd pick that penny up. So when we talk about $13 billion being able to come into the state versus $100 million that the state would incur in cost, my son is wise enough to know to chase after the $100 bill and leave the penny be. The expense that goes on doesn't show up in the budget of the state, but it does show up. These costs are spread out and they put strains on different communities because different communities have different demographics. I would like to say that when we look at this, we have communist power plants or communist power in the state of Nebraska. It's owned by the people and run by the people. It's the definition of communism. People love their Roosevelt care. That's socialism. That's Social Security. People love their Johnson care, their Medicare and Medicaid. People absolutely love, seniors love the fact that Obama closed the doughnut hole in Bush care which would have been the prescription drug. Nixon was for a universal healthcare. Truman was for a universal healthcare. This has spanned over close to 100 years from the time Roosevelt was in office with the New Deal. These ideas have been here. This is just completing the circle. Like the one gentleman who said he's a "gapper," you know, we have a sign that says this is the good life. We should say...it should actually mean it for all. I mean we're willing to take care of the poor. Those who are prolife...I'm prolife and I'm a Democrat and I'm prolife, but that doesn't stop when the child is born. That doesn't stop when somebody becomes 18. That doesn't stop because you're 45 years old, or like the gal is 33 years old. It's...this is something that should be inclusive for everyone. And if we look across, John Kasich, he's a...I'm a Democrat. I could vote for Kasich. But Kasich was wise enough to chase the $100 bill and walk over the penny because he did institute a form of Medicaid expansion, so has Branstad, so has Arkansas, so has Tennessee. As a matter of fact, the new Tennessee governor ran on the idea of getting rid of the "Kentuckycare" or however it's named. And as soon as he got in office, what did he do? He backed completely away from that promise that he ran on. And he ran as a Tea Party conservative. Once it's there, he couldn't touch

it. And I think that speaks volumes to once people actually are in office, once they see what it does for the communities, once it really hits home, for what it does for some people in the state that it's a good thing. So with that being said, my son, ten years old, has the knowledge to chase the $100 bill down, leave the penny. Thirteen billion dollars versus $100 million spread out over ten years and the loss, the hardship to families, for $10 million a year, I mean, for goodness' sakes, what were we willing to throw at ConAgra to stay? I mean the Governor ran down to ConAgra. He cares more about, you know, corporate than he does people. And if that's what this body wants to be known for, then so be it. Any questions? [LB1032]

SENATOR CAMPBELL: Any questions for Mr. Williams? Thank you for your testimony. [LB1032]

NATHAN WILLIAMS: Absolutely. Thank you. [LB1032]

SENATOR CAMPBELL: Our next proponent. Good afternoon. [LB1032]

JANET BONET: (Exhibits 22-26) Good afternoon. I'm Janet Bonet from south Omaha. My name is spelled J-a-n-e-t B-o-n-e-t. I want to say thank you to Senator McCollister for introducing this, for sponsoring LB1032. I'm here to speak in favor of it. I'm also pleased to see my new senator sitting on this very important committee. And I want to thank all of you for listening for as long as you have listened. I'm going to try and read this really fast. I appreciate the opportunity to be here to testify today. Statisticians say that one voice represents 500 to 1,000 silent people and I believe that. I'm here today to give voice to those who are like me but are not able to take the time from work or care-giving responsibilities to speak to you. In particular, I hope to give you some insight on the concerns of the self-employed and family members who are doing elder care. My story is not unique. I'm 60. I'm the tail end of the boomers. I was born and raised in south Omaha, which I feel is the best part of Omaha--and I think everybody should be able to say that about where they come from. I spent eight years studying in Mexico and that international experience taught me a lot about healthcare. For the last 35 years I've been back in Omaha in District 7's Spring Lake Neighborhood Association and I can tell you I'm a community activist. I'm a Nebraskan but I'm a Nebraskan who is tired of seeing and hearing about people falling through the cracks or being in that gap. Those cracks are not caused or legislated by the people who fall through them. Cracks in a foundation mean there's a fundamental weakness in it that endangers the structure it is meant to uphold. Cracks in our nation's healthcare system cannot be ignored and should never, ever be socially, morally, or politically acceptable. Cracks mean that something is wrong. You, the members of the Health and Human Services Committee, have in LB1032 an opportunity to put Nebraskans' healthcare on a firmer foundation. Senators, we cannot have any more cracks. The best national defense is to have a country filled with educated leaders and healthy workers. Where does Nebraska stand on that? An estimated 77,000

Nebraskans will benefit from the Transitional Health Care Program. To put that in perspective, did you know that the combined populations of Grand Island and Kearney equal about 77,000? Just add another 13,000, which could be the margin of error in that 77,000, and you have the number of people in Memorial Stadium for a Husker home game. Can you picture that? Now imagine that awesome stadium filled with Nebraskans without healthcare insurance--what a shame that would be. As uninsured, those Nebraskans are more likely to get sick and become unable to work, raise their children, care for elders, care for themselves, or fully participate in their communities and neighborhoods. My story is that in the years my husband Jaime was a corporate employee we had healthcare coverage, employer-provided healthcare, very minimal participation required. Over the years, our part of it increased, their part of it reduced, and the coverage reduced. Then, suddenly, that very large company fired hundreds of people. It had no concerns for the impact that action would have on employees' lives or Nebraska's economy. Hundreds lost healthcare insurance and so did their spouses and children. Our household was one of them. For the next seven years our family was without healthcare insurance. Disillusioned by the big corporation's lack of social conscience, my husband Jaime chose to join my small translation and interpretation business. Now we were both self-employed and we were both uninsured. We looked into health insurance for self-employed couples. In 2008 we were quoted $800 per month. And I have to add to my testimony that that was $800 per month per person, so it would have been $1,600 a month for us and we would have had to go to a limited preferred provider network and that's only if we took on high-end deductibles and copays that were only slightly lower than the full cost of office visits for uninsured patients. We could not afford the coverage so we did not go back to the doctor, dentist, or pharmacy for many years. In elder care, I took care of my father-in-law and my mother when they entered their 90s. I reduced my income capability, sacrificed my business. Jaime took over full time. As... [LB1032]

SENATOR CAMPBELL: Ms. Bonet, we're...I'm sorry, the light didn't go on, but you're at pretty much close to five (minutes), so can you kind of... [LB1032]

JANET BONET: I'll speed it up. Long story short, I was taking care of the elders. We were uninsured. Jaime did not take care of himself because he preferred to pay the bills for the household. We did not have health insurance. He did not get proper medical care and he died, and I believe it was during that time frame when we should have been covering people already with affordable healthcare that he suffered his death. I didn't qualify because I wasn't making enough money while I was taking care of my mother for the Affordable Health Care Act subsidies. My mother died. I still didn't qualify because I wasn't making enough money as a self-employed individual. Finally, at the end of 2014, I qualified for 2015 coverage. I have coverage again now. Had I had the coverage that we're talking about here now for prior years, as you can read in the longer version of my testimony, I would have had care for ear problems that were cutting my ability to work. Please take the information... [LB1032]

SENATOR CAMPBELL: And so I do think we need to... [LB1032]

JANET BONET: ...that I've given you about the self-employed numbers here in Nebraska, a study that was done by the University of Nebraska at Lincoln, and also the information about how self-employed individuals contribute hugely to the economy locally and nationally but we're not taken into consideration when it comes time for healthcare coverage that we are willing to pay as much as we can for. Thank you very much. [LB1032]

SENATOR CAMPBELL: Are there any questions? Thank you for the materials. Our next testifier. Okay, I'm going to ask one more time, how many proponents do I have left? One, two...two. Three, okay. Mr. Goddard. [LB1032]

JAMES GODDARD: (Exhibit 27) Good afternoon, almost evening. My name is James Goddard; that's J-a-m-e-s G-o-d-d-a-r-d, and I'm the director of the healthcare access program at Nebraska Appleseed here today to testify in support of LB1032. The testimony that's being handed around will walk you through some of the fine points of the bill, but I'd like to spend my time with you attempting to address some of the questions and comments that I've heard this afternoon. First, Senator Kolterman, you had a question about the job training program. There are two components of that within the bill. One is simply a referral program where anyone that is part of the enrollment will be given information about the employment programs, basic education, and other training, things like that, in the state. The vast majority of individuals who would be eligible are employed. But for those who are unemployed, they would get a referral to an education and skills program and that focuses on getting people skilled up to an in-demand industry using contextualized learning. It's a model that's been used in other states that's been very, very successful and in this way the bill focuses on trying to help folks transition from being on the program to off the program. Senator Riepe had some comments regarding the next administration. I just wanted to note that the waiver under the bill would not be submitted until mid- to late 2017, so this is going to be decided and judged by the next administration, whoever that is. It's not going to be something that's rushed through with the current administration. But to the larger point is that we can't wait for that to happen. We can't ultimately wait to move this forward. We've heard today from many people why that's important. There are 77,000 people that simply can no longer wait for health insurance and we've got to move this forward at this point in time. Senator Fox had mentioned the safety valve provision, which I wanted to briefly address. The first thing I would say regarding the match is that the federal government's obligation is mandatory, it is not discretionary, it's written into federal law. It would take an act of Congress to reduce that rate to below 90 percent where it is right now. And if Congress were to do that, we would obviously know about that and have a chance to react. In the event that that were to happen, however unlikely it is, the program under the bill would automatically terminate. It would take no action of the Legislature. It would happen automatically. What would then happen would be that the Department of Health and Human Services would be responsible for

that programmatic change. They would then have to send out notices to everybody on the program letting them know that the program is being terminated, which of course would not be a fun thing to do but there is history with that happening before. We...the state cut off 35,000 people from the Medicaid program in 2002 which the department had to implement. The other point on sustainability that I believe Senator Fox was talking about and what I really just wanted to say, at this point in time, is I think the intent and the goal of this legislation is long-term sustainability. And what I would urge the committee and the entire body to do is to reserve some judgment until we at least have a fiscal note. And we do not have that at this point in time. I think that there are ways and mechanisms for funding this program to make it sustainable and long term. And so to briefly move on from that, I was disheartened to see a report in the eleventh hour from the Department of Health and Human Services about the policy and fiscal implications of this bill. It's a report commissioned by the department, designed to thwart the solution that we have here to cover thousands of Nebraskans who are locked out of our system. And I'm sure that we'll hear more from them about why they oppose it. I'm sure after I sit down and the opponents get up we'll hear what they have to say. But I'd invite you to listen to them and listen to whether they offer a solution. Do they have a proposal and where is it? Academic reports are insufficient. What is the proposal that they have? And this situation underscores the decision that's before us. We are at a fork in the road on this issue. On the one hand, we have a positive health policy, LB1032. It would cover 77,000 people and it would utilize ideas that we continually hear are what need to be done: use of the private market; personal responsibility; improved employability; and innovation. LB1032 is a real solution and it is the only solution on the table. On the other hand, we don't see anything: no ideas, no legislation, no solutions. And what does that lack of vision mean? It means $2 billion of our tax dollars lost, uncompensated care that's passed onto everyone, avoidable medical bankruptcies, less healthy Nebraskans, lives lost, and 77,000 people with nowhere to turn. Looking at this contrast, the action before us is clear. We can't sit on our hands. That's simply not the Nebraska thing to do. We have to act to solve this problem now for our fellow friends and neighbors. And with that, I would respectfully urge this committee to advance LB1032. Thank you. [LB1032]

SENATOR CAMPBELL: Questions? Senator Fox. [LB1032]

SENATOR FOX: I have two questions, I'll confess up-front. [LB1032]

SENATOR CAMPBELL: Sure. [LB1032]

SENATOR FOX: Thank you for your testimony. You said that, or at least the impression I was getting is we should be less concerned about the sustainability, but I'm just going to say I am. And you said that you think that there are things that can be done to make this sustainable. Could you elaborate on what those specific things are? [LB1032]

JAMES GODDARD: Well, what I was intending to say is we haven't seen the fiscal note to see some of the huge savings in various areas that there are that we know simply from last year's version of the bill, savings in the state disability program, significant savings in behavioral health, savings to counties, savings to Corrections. But beyond that there is a component around the...I believe it's the Health Care Cash Fund in this bill. And there is the potential for dollars to be utilized from that fund. All I'm trying to say at this point is sustainability is a concern for me, for everyone who is working on this. I would just encourage the body to keep an open mind until we actually see a fiscal note and see where this is versus looking at a report that came out in the eleventh hour yesterday. [LB1032]

SENATOR FOX: Okay. And then my next question is, have you ever sued the state of Nebraska for anything? [LB1032]

JAMES GODDARD: Nebraska Appleseed has sued the state of Nebraska in the past. And I will say the times when we end up in litigation is after we have attempted every other means to redress the issue that our constituents, being low-income folks, are facing. And so that means we have spoken with the department, we have potentially attempted a piece of legislation to resolve the matter, and taken other actions. And there are times where all of those things don't lead to the remedy that our clients are legally able to have. And so the answer is yes, but with that explanation. [LB1032]

SENATOR FOX: So if let's say...I know you said it would take an act of Congress for this to...for the way the bill is written for this plan, to end. But you're saying that...is there any possibility that you would sue the state if this plan would terminate? [LB1032]

JAMES GODDARD: I'm not seeing what the basis would be to do that at this point. [LB1032]

SENATOR FOX: Okay. [LB1032]

JAMES GODDARD: You know, the law is clear on what, if X then Y, you know, what should happen. So I cannot see a basis for doing so at this point. [LB1032]

SENATOR FOX: Thank you. [LB1032]

SENATOR CAMPBELL: Any other questions? Senator Riepe. [LB1032]

SENATOR RIEPE: Thank you, Senator Campbell. And, Mr. Goddard, thank you for being here. I guess my question would be, as well, there's some rather sharp criticism for the Department of

HHS for having conducted some financial analysis. The criticism would have been even sharper had there not been anything done and they showed up here today empty-handed. And I think we all understand. I know certainly, legislatively, we deal a lot with eleventh-hour events: getting ready for hearings and getting ready for the floor. On top of that...that's a statement. On top of that, you know, I'm disappointed that you wouldn't give us some assurance that you wouldn't bring suit against the state or the department if we don't do it your way. [LB1032]

JAMES GODDARD: If that's how what I just said sounded, that is not what my intention was, Senator. [LB1032]

SENATOR RIEPE: (Inaudible.) [LB1032]

JAMES GODDARD: What I'm telling you is I see no legal basis for a lawsuit, therefore, a lawsuit would not be moving forward. So I can tell you I don't see...the first point is I don't see the federal government pulling out of this obligation in any event, so I don't see this even coming into play. But even if that were to happen, I don't see a legal basis for us to file a lawsuit and I would say we would not do so. [LB1032]

SENATOR RIEPE: I'll let it go at that. Thank you. [LB1032]

SENATOR CAMPBELL: Any other questions? Thank you, Mr. Goddard. [LB1032]

JAMES GODDARD: Thank you. [LB1032]

SENATOR CAMPBELL: Our next proponent. Good afternoon. [LB1032]

CAROL McSHANE: (Exhibit 28) Good afternoon. My name is Carol McShane, C-a-r-o-l M-c-S-h-a-n-e. I represent Nebraskans for Peace. Nebraskans for Peace is in support of LB1032. This bill is a priority bill for NFP, and well it should be. With this bill, 77,000 Nebraskans who would otherwise live on the edge of catastrophe can be covered with health insurance; 77,000 Nebraskans will not have to depend only on the ER for healthcare; 77,000 Nebraskans can see a primary care provider before their symptoms escalate. I thank the senators who have worked and reworked this bill. It is a reasonable bill. People have to pay a premium. There are provisions in place to thwart employers from opting out of existing coverage. And there's a solid financial incentive for this bill. But time is running out. Nebraskans for Peace urges you to vote this bill out of committee. The saying that applies here is this, "A rising tide lifts all boats." Let me add this saying, "The light that shines farthest shines brightest at home." We can take care of our own. Thank you. [LB1032]

SENATOR CAMPBELL: Thank you, Ms. McShane. Any questions? Our last proponent. No? I miscounted. [LB1032]

AMBER HANSEN: (Exhibits 29 and 30) I think I am second to last. Good evening, everybody, Senators. My name is Amber, A-m-b-e-r, Hansen, H-a-n-s-e-n, and I am the executive director for Community Action of Nebraska. Community Action is a national network of nonprofits dedicated to helping people achieve economic stability. There are over 1,000 Community Action agencies across the country. Nebraska is home to nine of those agencies. And in the report being distributed, you will see on page 17 a full map and the respective service areas of each. So you can hopefully see your district within there too. As the Community Action of Nebraska, my organization serves as the state association to those nine agencies. And one project we complete in support of the agencies is the statewide community assessment that I just handed out. For the past five years, Community Action of Nebraska has sent a survey pertaining to topics of economic stability to 10,000 randomly selected Nebraska households. Most recently our topic was on employment, which was one that we also conducted in 2012, with the goal of better understanding Nebraskans' employment challenges. So we asked Nebraskans about the barriers they face in getting employment or better employment. At this time, I want to point you to page 7, which is where you'll see the top ten barriers to employment cited by Nebraskans in both 2012 and 2015. And note that the number one answer cited by 38 percent of respondents was physical health. We also had 7 percent respond that mental health was a barrier to employment. So Nebraskans told us pretty loud and clear that health is a significant barrier to employment. In addition to providing Nebraskans employment supports, community action is also the...one of the state's navigator entities, meaning that we have people who are trained and certified to help people navigate the health insurance marketplace, including directly helping them enroll and obtain health insurance through it. And through this experience we have seen a number of people fall into this so-called Medicaid gap. And our experience is that the majority of them are working families, are working people. Also in this assessment we found that 38 percent of Nebraskans working at least full time are unable to meet their basic needs, and I point that out because one of a person's basic needs is healthcare. In the interest of time, I will kind of skip this personal story because I think you've heard a wealth of very good ones behind me today. But I just want to say that, on behalf of the nine community action agencies, we recognize the importance of healthcare as an important employment support, and it's for that reason that we are here to urge you to support or move forward with LB1032. I'd welcome any questions. [LB1032]

SENATOR CAMPBELL: Any questions for Ms. Hansen? Senator Howard. [LB1032]

SENATOR HOWARD: Thank you, Senator Campbell. Thank you for your testimony today. So Community Action Partnership was our navigator entity for the state, so you helped people enroll in the health insurance marketplace. [LB1032]

AMBER HANSEN: Uh-huh. [LB1032]

SENATOR HOWARD: Would you, if LB1032 passed, would you be willing to assist in the enrollment process for this program? [LB1032]

AMBER HANSEN: So it is a federal grant that enables us or, I should say, you know, requires that we provide completely unbiased and impartial information on the marketplace and what people's options are. That includes the penalty, should they choose that over obtaining health insurance. So if that was...Medicaid expansion would enable us to help anyone enrolling in the marketplace specifically or to help them know that they also can apply for Medicaid and then we can point them in that direction or refer them to the appropriate agency who can do that. [LB1032]

SENATOR HOWARD: Okay. Thank you. [LB1032]

SENATOR CAMPBELL: Any other questions? Thank you, Ms. Hansen. [LB1032]

SENATOR HANSEN: Thank you. [LB1032]

SENATOR CAMPBELL: Our last proponent. Good afternoon. [LB1032]

JOHN O'NEAL: (Exhibits 31 and 32) Good afternoon. Good afternoon. My name is John O'Neal, that's J-o-h-n O-'-N-e-a-l. I live in Omaha Nebraska, in Senator Riepe's district, and I'm 62 years old. I was diagnosed with multiple sclerosis in 1997. I'm a retired attorney and a volunteer member of the Government Relations Committee of the Mid America Chapter of the National Multiple Sclerosis Society. And I'm submitting written testimony on behalf of...on their behalf and I also have a few additional comments of my own. I have been one of the lucky people with MS. You saw that I was able to walk unassisted to the witness stand, and a lot of people with MS can't do that. What you cannot see is that physical activity fatigues me much more rapidly than is normal and I am no longer able to function mentally at levels I have been accustomed to for most of my life. In my nearly 20 years of living with MS, I have learned from medical experts that individuals with MS should be taking one of the MS drugs to reduce the possibility that they will have an attack that will make their condition worse. While there is no cure for MS at the present time, there are drugs available that reduce the number and severity of MS attacks in many, though not all, people with MS. These drugs are very expensive. The least expensive ones cost $50,000 per year. Some cost much more. Since the drugs have widely varying biologic ingredients, patients try different drugs until they find one that seems effective for them; that is, a drug that reduces the frequency and severity of attacks. In my case, I am still

using the first drug that I tried, and it has been effective for me. Because there is constantly...because MS is constantly active in the body, though, it can attack at any time. So it is unwise to stop taking the MS drug that works best for you. The need for uninterrupted treatment has clear consequences for people with MS who fall into the Medicaid gap. By definition, these individuals cannot afford private insurance either personally or through the Affordable Care Act, and they also can't get help through Medicaid. Their only option is to stop taking their medications. They face a greater risk of paralysis, loss of vision, and a wide variety of other debilitating consequences that can result from MS by not taking the medication. Almost certainly such individuals would end up on Medicaid in that event at an enormous long-term cost to the state of Nebraska for their care. Thank you for your attention, and I would be happy to answer any questions you may have. [LB1032]

SENATOR CAMPBELL: Any questions? Senator Riepe. [LB1032]

SENATOR RIEPE: Thank you. Mr. O'Neal, I have a question. First of all, it's always nice to see someone from District 12 with a smile on his face. A question that I have is...a question that I have, are many of the multiple sclerosis patients on Medicare disability? [LB1032]

JOHN O'NEAL: Well, I couldn't give you a number. [LB1032]

SENATOR RIEPE: Okay. [LB1032]

JOHN O'NEAL: I don't know the answer to that question. But there are certainly some that are, yes. [LB1032]

SENATOR RIEPE: Okay. The other question, and I'm going to...I see Senator McCollister back there. I'll give him a heads up. I don't know what this plan would propose for drug...you know, the pharmaceuticals. I don't know whether they're going to cover something like, you know, $50,000 a year, and higher, for some of these pharmacy drugs. I don't know what the formulary would be. But I'd be interested to learn. [LB1032]

JOHN O'NEAL: Yeah. Yeah. I'm just guessing that if it's like other insurance plans that it would have similar drug provisions like you have in Medicare. But I don't know. He can probably answer the question. [LB1032]

SENATOR RIEPE: We'll leave it up to him. Okay. Thank you, sir. [LB1032]

JOHN O'NEAL: Anything else? [LB1032]

SENATOR CAMPBELL: That's it. Thank you, sir. Thank you for your patience. Okay, our first opponent. Good afternoon. [LB1032]

BRYAN KING: (Exhibits 33 and 34) Good afternoon, Madam Chair and members of committee. Thank you for the opportunity to come speak. I was invited here by the Nebraska Americans for Prosperity to speak. I'm an Arkansas state senator. My name is Bryan King, B-r-y-a-n K-i-n-g. I was elected to the house in 2006. I then moved to the senate in 2013. And I know there's been a lot of talk about the Arkansas private option so I want to give you another perspective I think that sometimes you don't hear. And there's been some good questions about the problems in Arkansas. Now I did not vote for the Arkansas private option. There was two main reasons. One was long-term sustainability with the program with the federal government entering into that type of agreement. Some of the things was the concerns that we had about people that...the promises that were made. And I want to apologize. Like I said, as Nebraska is a citizen Legislature, we are too. I'm not a professional. It's kind of like my wife one time. You know, when you campaign, you learn a lot of things about yourself, and one of the rumors that was going around was I was an adulterer and I'd been married three times. And I went and spoke to this group and the...one guy asked about that. And my wife, who sometimes can say some things, said, I can assure you, he hasn't been married three times because if he had he'd be better trained than he is right now, so. (Laughter) But so as a legislator, we went through this process and when the bill was debated we had questions about it. And we didn't know what the long-term effects were going to be. Some of the promises that were made, you're talking about the economic impact and all the money coming in. If you look at this article that shows that Arkansas's economy in the southern state region, and we were the only state to expand Medicaid, we did not see the economic benefit. Other states around us did not see...have, you know, better growth than we are. So we're not seeing the economic benefit that was promised in the front end. And there's a few reasons why. One is if you look at the population, almost 40 percent earn zero dollar income. So what we saw in my rural communities--you know, in a rural community you know a lot of things going on--you saw people that had health insurance that all of a sudden were paying more for less coverage, just quit their jobs. You saw people that had saw advancements to (inaudible), and once they went over the cliff they would not take those jobs because they would lose health insure...they would have to pay for health insurance. So it's been extremely detrimental to the economy in a lot of areas because people are not...it disincentives people to work. And we have...the redetermination factor came up a while ago. We've seen that...we were promised this great verification system that just simply has not happened. In fact, in the Stephen report, when you look at it, there are over 100 people in Nebraska that are on Arkansas private option. We had somebody in every state in the Union. And when we talk about the cost factors, if you look at the outlying things, just much like somebody building a house, a lot of the questions you're seeing about the cap is like the living quarters of your house. Some of these outlying things, like we mentioned about the problems to get the verification, we were promised $60 million on a system that would do verification on these enrollees. That never happened. Now

we're at $200 million and there are no promises that it's going to work. So once you start a program like this, what we're seeing in Arkansas, it's almost a bottom pit whenever you start trying to implement it in the outlying areas just besides the cap. The original estimates that were given were not met. They were...had been all over, in enrollees, in the cost. And one of the things that we're seeing is that you take John Smith that would go on the insurance part on the exchange, he doesn't...they put him...he doesn't have high medical costs. In fact, I think almost half the people on the insurance card do not even use it at all. So if you have Joe Smith that has high medical bills, they're putting them on Medicaid fee-for-service. So some of these things, when the lady was talking about earlier, it's just a shell game on staying under the cost. The other thing is when you look at the money, you know, I think as state legislators now, we're seeing that the federal deficit is not just a Congressmen and Senators' problem. It's our problem, too, because we're voting to do this. At a time we're cutting military, one of the big questions that's been down there is we're creating the federal deficit. It's an all-time record high. And those solutions shouldn't be put on the next generation. And as I've said, and a lot of proponents don't even counter, is that a lot of these medical bills...and you hear the situations of the people that need it and health coverage, and I'm sympathetic to that. But a lot of times we're just sitting here with the Arkansas private option that somebody is incurring medical bills and when they walk out they're handing that newborn baby a bill to be paid someday. So with that, I mean I'd be happy to answer any questions of the committee. [LB1032]

SENATOR CAMPBELL: Welcome, Senator. We're glad to have you. [LB1032]

BRYAN KING: Thank you. [LB1032]

SENATOR CAMPBELL: I'm sorry, we didn't know you were here earlier. We certainly would have liked a chance to sit and visit with you about some other issues. [LB1032]

BRYAN KING: Well, I got to visit your beautiful State Capitol. It's really good. Now I've been and visited Nebraska numerous times over my lifetime. [LB1032]

SENATOR CAMPBELL: Senator, did you go to NCSL? Have you gone? [LB1032]

BRYAN KING: I have been to NCSL. I've been involved in their elections part some, but I've been to NCSL several times. [LB1032]

SENATOR CAMPBELL: When you came forward, you looked familiar and I thought maybe I'd met you at NCSL, because I've not been in the state of Arkansas. [LB1032]

BRYAN KING: Well, with my looks, I always say I, you know, I can be noticed, but it's not for a good reason, so. (Laughter) [LB1032]

SENATOR CAMPBELL: Questions, Senators? Senator Riepe. [LB1032]

SENATOR RIEPE: Thank you. Thank you for being here and enjoying our lovely weather. How did Arkansas move the medically frail to more traditional Medicaid? [LB1032]

BRYAN KING: Yeah, they're making determinations. And a lot of our enrollees, when they first started, were the big bulk of the 50,000-60,000 that were jumped out there, and originally we were promised that these people were going to have skin in the game. They were going to be making their own healthcare decisions. That didn't happen. Immediately after the bill was passed they started basically sending out cards to the food stamp enrollees saying, do you want free health insurance? Well, of course they'd check yes, and then they mail it back in. And if you don't respond within a certain amount of days, they pick the plan for you. So you have a government bureaucrat or agency person picking these plans. And what happened was that they take, as I said earlier, Joe Smith who may have high medical bills...and that's what they're trying to play games with this cap that they're staying under, which is not true when you look at the total cost. Because they take Joe Smith, who has high medical bills, fee-for-service, they're putting him on straight Medicaid. Those people that are not, they're putting them on the exchange with the health insurance. And as I stated earlier, I think Mr. Horton back here with the Foundation of Government Accountability, could get more in the details. I tell people, you know, I do deals, not details, and so. But almost half of them are not even using the card. So this has turned into an extreme boondoggle for the insurance companies and that's why they're sitting there in our campaigns now. They're, you know, a lot of these people that have voted for it, the insurance companies are very contributing to these campaigns. [LB1032]

SENATOR RIEPE: May I ask another question? [LB1032]

SENATOR CAMPBELL: Sure. [LB1032]

SENATOR RIEPE: Thank you. My other concern and question was...had to do with collections, because, and we're saying in this particular bill that's in front of us, we're talking about that liens could be placed. [LB1032]

BRYAN KING: Uh-huh. [LB1032]

SENATOR RIEPE: And it was one thing to talk about putting a lien on someone who's sick. It's another thing to have it in statute that that's your intent; that we'll then carry it out. That's a pretty harsh...pretty harsh. Well, how do you collect down there from people (inaudible)? [LB1032]

BRYAN KING: They're not collecting. [LB1032]

SENATOR RIEPE: You don't. [LB1032]

BRYAN KING: And to my knowledge, they're not. I mean they have, because they were supposed to do redetermination. That's why our DHS officials, you know, we can't trust their figures. They were supposed to do redeterminations within a year. We found out they were not doing it. And it goes back to the system requirements that they had: spent the $60 million, it didn't work, they didn't tell us. Now they're at $200 million, saying it won't work. So they're sitting here, they're not collecting. [LB1032]

SENATOR RIEPE: Did you have anyone that would take a job immediately after they were signed on because they didn't have a...the way I think I've heard this, is they'd have a year before they'd be reassessed. So... [LB1032]

BRYAN KING: Yeah. [LB1032]

SENATOR RIEPE: ...they'd get 11 months of ride. [LB1032]

BRYAN KING: Yeah. And that's what is happening here in Arkansas. I had a banker tell me that they knew somebody, and they're no asset test with the Medicaid expansion so, you know, you have people with half a million dollars in assets that are signed up on this program. And what happens is a lot of times...and this is what the detrimental part to our economy that's disenfranchising...or disincentivizing people to work, is that they go out there and some of...like in the rural community, we hear these stories that somebody, they signed up on the program, now they're going to get kicked off. They just go quit their job and then turn around and re-sign up again. [LB1032]

SENATOR RIEPE: Yeah. Okay. Thank you. Thank you very much. [LB1032]

SENATOR CAMPBELL: Other questions, Senators? Senator Howard. [LB1032]

SENATOR HOWARD: Thank you. Thank you for visiting us today. I have a lot of family in Arkansas,... [LB1032]

BRYAN KING: Okay. [LB1032]

SENATOR HOWARD: ...so it's nice to see Arkansas folks here. I wanted to ask you, have you...when the private option was first presented to you as a policymaker, were you an immediate opponent? Did you sort of hear the testimony and make a decision after that? [LB1032]

BRYAN KING: No, I mean I think we all campaign on issues and people know where we're at, you know? But when we stepped in the situation, it's much like, I think you would know, sometimes it's like being on a jury, you know, when you go in the jury box and you make a decision. So you know, we listened to it and there was a part of me that went, well, maybe, maybe this is going to work; okay, maybe we're not going to have these problems of the financial part. And so we listened to it and, you know, some of us voted against it, some of us. And I just felt like in the end we're talking about sustainability where we have to balance a budget too. And you look at 2020 with Congress with already voting to repeal it, I mean it's almost like buying a house. I mean if I could lock in an interest rate for several years, well, that would be great. But with this type of program, it's almost like putting it on a two-year balloon, where you're renegotiating all the time because this program is going to end in 2016. We have...we don't know if the 90/10 match, the federal government, their economy goes bad. The economy was bad in '09 and '10. You know, if the economy goes bad again then they're going to, the federal government, is going to look. What if they change our match rate from 90/10 to 70/30? We look at that, incarcerating people, education. All those areas are going to be hit because we put able-bodied, working-age adults on to our budget system. And I've been in the legislature now for 11 years and one of the things in looking back in the decisions I made in 2007, you get to see what happened over a period of longer than four years or two years when people were in office. In our term-limited environment, makes me unpopular with a lot of Tea Party conservative people when I talk against term limits is because we serve three two-year terms in the house. Well, a lot of those people quite simply were voting for it because they said, you know what, I'm not going to have to deal with that someday. But you know, our kids and grandkids and those babies that have to deal with the deficit are going to have to pay the bill on this someday. [LB1032]

SENATOR HOWARD: May I ask one of the hand...the first handout that we got from Ms. Boozang said in 2015 Arkansas estimated that its total savings in revenue gains resulting from expansion were $118.4 million. Is that an incorrect amount? [LB1032]

BRYAN KING: You know, I don't put any...to say there's savings in this is trying to say some things like tell us that they're taking somebody that was on traditional Medicaid, and some of them were maybe on AR Health Network, which was a 70/30 match, and then now they're moving them to 100 percent match and are having these savings. Well, you know, the federal government is still the federal government. I don't see we're having savings. But a lot of the figures that we've had to rely on DHS have been wrong, okay? They...there's even proponents that are saying if DHS comes up with a bill and their estimates--a help an old lady across the street bill--they're not going to put any faith into it. So you know, I don't know how we continue to spend more record amounts of money. We are spending record amounts on traditional Medicaid in Arkansas. We're spending record amounts on federal spending in Arkansas. I'm confused about how we have savings on that. [LB1032]

SENATOR HOWARD: And then this is my last one, I promise. [LB1032]

SENATOR CAMPBELL: That's fine. [LB1032]

SENATOR HOWARD: This is not your first visit to another state outside of Arkansas to argue against a private option. I believe you've also visited Utah? [LB1032]

BRYAN KING: No. I wrote an Op-Ed out there and I was on the radio, but I've never visited Utah. [LB1032]

SENATOR HOWARD: Okay. Great. Thank you. [LB1032]

BRYAN KING: Okay. [LB1032]

SENATOR CAMPBELL: Any other questions, Senators? Senator Crawford. [LB1032]

SENATOR CRAWFORD: Thank you, Chairwoman Campbell. And again, welcome to Nebraska. [LB1032]

BRYAN KING: Thank you. [LB1032]

SENATOR CRAWFORD: It's nice to have you here. So as I was listening, I think I heard two main concerns that you've raised of what you've seen in Arkansas. And one is costs and challenges that were created by the enrollment process. [LB1032]

BRYAN KING: Uh-huh. [LB1032]

SENATOR CRAWFORD: And that the estimate of the enrollment process was one amount and then when you got into it, it wasn't working so you had to change that, and that cost more. [LB1032]

BRYAN KING: Correct. [LB1032]

SENATOR CRAWFORD: So, thankfully, we've been working hard to improve our enrollments processes, so I think we have less of a risk of that happening here just because we've had that time and experience to work on that and to work on our navigators and the marketplace. Now the second thing I wanted to understand, you were talking about the cost shifting. So someone who would come in to the plan and then be a very high, medically needy person was then moved over to... [LB1032]

BRYAN KING: Traditional Medicaid. [LB1032]

SENATOR CRAWFORD: ...to traditional Medicaid, right? [LB1032]

BRYAN KING: Uh-huh. [LB1032]

SENATOR CRAWFORD: Now at least in our bill that we're looking at here would do that very intentionally with the sense that that person needs a different kind of medical treatment than most people in the insurance market. So we want to take the people who have the most vulnerability, you know, the highest medical need, and they would get a much more intensely managed kind of care to keep those costs down... [LB1032]

BRYAN KING: Uh-huh. [LB1032]

SENATOR CRAWFORD: ...and keep the people that are more appropriate for the private market in the private market. So I don't remember what the Arkansas intent was, but I think in our case we wouldn't consider...that's in many ways by design here to keep those, to keep that population treated in a different way. [LB1032]

BRYAN KING: Yeah, and that's a good point. But the problem is in our traditional Medicaid in Arkansas is, just like in my area, several doctors only take so many Medicaid patients. So you're almost, and our system right there needed to be reformed. That's part of what the Health Care

Task Force is looking at our overall Medicaid. But you're almost in some cases, and I say some and I may be underestimating it because I don't want to be like DHS and overestimate things and get back on me, like I do. But they're shoving them into the traditional Medicaid system. Those high-end users, those people that need the medical care, are shoved into the Medicaid side, which is not working efficiently for those people who are seeing them. I mean there's a local nurse that works at the school, for example, in my rural area, has a Medicaid situation, has called several doctors in trying to get care for that system. So you're almost shoving, in Arkansas, let me say this, we're shoving people into the same failing system that are high-end needing people. And you know, the other thing is on the cost part, to address part of your question, when we look at the Arkansas model, it's higher. It costs the federal government--us, you, Nebraskans--more money to do the Arkansas model than it would be to put them in traditional Medicaid. There's been several estimates that it's several...at least several hundred million dollars, and maybe Mr. Horton can testify earlier (sic). But we're trying to reform the existing Medicaid population. We also know that when we've expanded the private option, we've hurt the truly needy in Arkansas, serving them. That came up in a committee that I chair, and that's one reason why I'm here, because I have a niece with cerebral palsy so I'm close to that population...in Special Olympics, could, you know, participate in those. I probably get the same phone calls from the same truly needy that need help that many of you do. They sit there in Arkansas to keep the promises, and that's what's frustrated me about Arkansas that I feel like you guys need is both sides of the story in Arkansas, because it's really just been puppies and kittens sometimes that's come out of Arkansas on the private option. But in our committee hearing, it came out that the redetermination people, they hired...they put 200,000-plus people on the system to be redetermined and they didn't hire any more personnel. Now even though I was against the program, it wouldn't be any different than me putting 200,000 people on the highway system or doing something like that and not increasing personnel. And we heard story after story about how the truly needy are not getting approved, they're not getting the care they need. And I know that from personal calls in my district. So when you expand...when we have...let me say this. When we have expanded this program, we have hurt the truly needy in Arkansas. I can say that and I'm willing to back that up and they know that. [LB1032]

SENATOR CAMPBELL: Other questions? Senator Kolterman. [LB1032]

SENATOR KOLTERMAN: Yeah. Thank you for coming. Arkansas, what I've read about the Arkansas model is that you over expanded...I mean you took on a lot more than you anticipated. [LB1032]

BRYAN KING: Uh-huh. [LB1032]

SENATOR KOLTERMAN: In order to do...you're serving a lot more people than I think were originally projected to serve. [LB1032]

BRYAN KING: That's correct. [LB1032]

SENATOR KOLTERMAN: Would that be correct? So when you got to that situation, you started to feel it's...and you just alluded to the fact you didn't put a lot more people on as you... [LB1032]

BRYAN KING: Uh-huh. [LB1032]

SENATOR KOLTERMAN: ...enroll them. I'm interested in, you know, the demographics of how that came about. Did you have to go out and purchase a new software to accommodate that situation? Did you... [LB1032]

BRYAN KING: Yeah. [LB1032]

SENATOR KOLTERMAN: ...go through people that enroll through like... [LB1032]

BRYAN KING: Yeah, I think... [LB1032]

SENATOR KOLTERMAN: ...organizations or did you go to agents to do it? How did you do that, because you've already expanded it? [LB1032]

BRYAN KING: Yeah. There are agents. You have to remember earlier I talked about how the food stamp population, how they sent out the applications to be...and this is...this income group we found is very transient. I mean like I said, we have somebody in every state in the Union on the Arkansas private option. There's over 1,000 people, I believe, in California that are on the private option. We have people in prison that are on this. And so there are insurance agents helping with the sign-ups. They really went out there and tried to sign up too many people. Since I live in a border county, we know that since we were the only one expanded we've, in some sense, become a Medicaid magnet where you've seen high-end users that lived across the state of Missouri have now moved to Arkansas just to sign up on Medicaid. So they've lived their whole life...so this thing of the economic factor that's coming in, in Arkansas, I have not see it. I think some statistics show that it's actually made us...I'll compare us to Mississippi, because in Arkansas we try and say thank God for Mississippi sometimes or something like that. And so they have actually...are, you know, better economically than we are. And we have kind of similar economies with agriculture and those type things. So these sign-ups of people, we've seen, like I

said, high-end users actually come to the state of Arkansas to sign up. And so if you're surrounding states have not expanded, that's a cost factor of something that's going to come in that later on, you know, we're going to have to pay the bill on. Does that answer your question? [LB1032]

SENATOR KOLTERMAN: Yeah. But logistically...my colleague gave me (inaudible). [LB1032]

BRYAN KING: Okay. [LB1032]

SENATOR KOLTERMAN: Logistically, did you have to spend a lot of up-front money to accommodate what you were trying to do? [LB1032]

BRYAN KING: Did we spend a lot of up-front money? Now that's something Mr. Horton maybe could better answer. But there was the sign...the people out there, the navigators, those type things, the normal type situations that you saw out there. We did have insurance agents that were out there. Now they have not--and I'll have to look to get you the answer exactly--they have not signed up a substantial amount of people. They have in some areas, but it's not the big number of people. [LB1032]

SENATOR KOLTERMAN: And...can I ask him one? [LB1032]

SENATOR CAMPBELL: Uh-huh. [LB1032]

SENATOR KOLTERMAN: And how many providers are on the exchange in the state of Arkansas, because we have four right now? [LB1032]

BRYAN KING: Yeah, the lady earlier testified to six. I mean I knew that originally we were promised (inaudible). It wound up being two. I think Blue Cross Blue Shield has a substantial...I'm thinking...three-quarters of the sign-ups. So the competition part I question. In the future, even though we have more people there because you know, it's just like if you already have 75 percent of the business, the idea that you're going to lose 30-40 percent of the business is probably not realistic. So we're not having the competition. You know, some of the people were picking the more expensive plans. They've tried to do that and tried to get the costs down. But even on every plan, and Mr. Horton can testify later, you know, people are still not paying anything for their prescriptions. And you know it gets back to the economic factor. I think that's one thing that keeps getting talked about here. It's just like a pharmacist I go to local said, you know, I was kind of hard on you, Bryan, you didn't vote for it and I really wanted you to. And

now they've changed their mind and they said some of the people coming in to get prescriptions say, I can't afford to go get a job, so. [LB1032]

SENATOR CAMPBELL: Any other questions? Okay. Thank you, Senator King, very much. [LB1032]

BRYAN KING: All right. Thank you. [LB1032]

SENATOR CAMPBELL: Have a safe trip back to Arkansas. [LB1032]

BRYAN KING: All right. Thank you. [LB1032]

SENATOR CAMPBELL: Always good to see a fellow senator. Our next opponent. Good afternoon. [LB1032]

CALDER LYNCH: (Exhibits 35 and 36) Good afternoon, almost evening. Good afternoon, Senator Campbell, members of the Health and Human Services Committee. My name is Calder Lynch, for the record that's C-a-l-d-e-r L-y-n-c-h, and I'm the director of the Division of Medicaid and Long-Term Care within the Department of Health and Human Services. Before I begin my testimony, I want to take a moment to say that though I'm here to testify in opposition to this bill, I want to thank everyone that's come before us to testify, particularly those citizens. I think it takes a lot of courage to come before the committee and it's an important part of our democratic process. And so I certainly appreciate that. I'm here to testify in opposition to LB1032 that will require the department to submit a waiver to the Centers for Medicare and Medicaid Services greatly expanding the population covered by the Medicaid program. The state Medicaid program provides health coverage to the most vulnerable in Nebraska: children, pregnant women, elderly, and persons with disabilities. The Affordable Care Act allows states to expand coverage to adults up to 138 percent of the federal poverty level. I have serious concerns with the expansion of this program from both a fiscal and policy perspective. In 2000, Medicaid expenditures in Nebraska totaled $983 million. Today expenditures are over $2 billion annually. While it is very difficult to accurately determine the total cost of a Medicaid expansion due to many unknowns, Medicaid has worked with its actuary, Optumas, to develop a reasonable estimate of the cost to expand Medicaid in the manner outlined in LB1032. In addition to being our current actuary and, thus, deeply familiar with our current programs and costs, Optumas performed similar work for the state of Arkansas, whose expansion model serves as the basis for this proposal. Optumas, whose report is attached to my testimony and available on our Web site, estimates that the Medicaid expansion proposed in LB1032 would cost the state nearly $1 billion in new state spending during its first ten years, adding nearly 126,000 individuals to Medicaid or state support by 2019. An expansion as outlined in this bill will inherently be costly for

Nebraska, as insurance purchased through the exchange is significantly more expensive than traditional Medicaid coverage. The costs of this bill will not be borne by the state alone. In its actuarial analysis, Optumas projects that Nebraskans who purchase coverage through the exchange today will see their premiums rise by over 7 percent due to the introduction of the expansion population into the market. As you will see detailed in the report, the annual state share of costs will rise to nearly $80 million by 2021 and $181 million annually by 2027. But these costs could quickly reach over $600 million or more in new state spending annually should a future Congress decide to increase the state match to the state's historical contribution. There is no guarantee that Congress will keep its promise to maintain the enhanced matching rate for the expansion population. While the bill contains language to halt the program in this event, the reality of unwinding such a massive entitlement expansion is far more uncertain. As of January 2016 Nebraska Medicaid covered 231,000 individuals. Adding an additional 126,000 by June 2019, rising to 136,500 by 2027, will increase the total population supported through Medicaid by 50 percent, straining our state's existing provider networks and impacting our state's entire insurance market. The population covered by the expansion will not only include the uninsured, but also those currently covered by private insurance. Additionally, the influx of enrollees will potentially create new access challenges for the medically frail expansion population and our existing clients since it will be more lucrative for providers to see the newly eligible populations that are covered through private insurance with a higher reimbursement rate. The bill before you today proposes to expand Medicaid by having the state purchase client's private insurance, similar to what's been done in Arkansas and Iowa. Iowa has since eliminated this part of their expansion and Arkansas is proposing significant changes to their program. I have several operational concerns about the proposal. Due to the complexities of administering the program, it will require hiring at least 147 new state staff to perform functions, such as individual determinations of cost-effectiveness, determine program eligibility, and to process copayments. It is unclear how we would ensure private networks and meet the bill's requirements for patient-centered medical homes, or how Medicaid can guarantee that a client in a private health plan will make an appointment within 60 days of enrollment. It is also uncertain how the state practically would collect the 2 percent contribution required. Questions also remain regarding what services not covered through the exchange we'd be required to provide separately through Medicaid or how those necessary services will be determined for individuals supported through employer sponsored insurance. Due to the work required to enact the complexities of this legislation, our fiscal note reflects that the administrative costs for administering this program will reach over $11 million annually by 2027. I should note that, unlike the enhanced match for healthcare costs, the state's match for the majority of these costs is 50 percent. Lastly, it is important to note that federal officials originally stated that only a limited number of private option waivers would be approved. The Government Accountability Office issued a report in 2014 looking closely at the approval process for Arkansas and found serious issues with how CMS determined the waiver to be budget neutral, as required under federal law. Due to the upcoming change in the presidential administration and the criticism these waivers have received from entities like the GAO, it is

unknown if the waiver outlined in the bill would be approved. For all these reasons, I oppose LB1032. And before I take questions, I'd like the opportunity perhaps to address some of the concerns regarding the submission of the fiscal note. We worked very diligently with Optumas and our internal staff once the bill was filed three weeks ago, to prepare an accurate and, I think, comprehensive fiscal note for this committee and for this body to consider as part of the process. I, along with anyone else, would have liked to have submitted that with more advance in front of the hearing. We worked through the weekend to finalize that and I appreciate the work that Optumas did. And so I take responsibility for making the decision to start fresh, bring in a new consultant, someone that had deep experience with our program, with Arkansas, to do that analysis. I know that, you know, in the past we've done updates of previous reports. We really wanted to start from a fresh perspective. But I'll be happy to answer any questions about the process or about what's contained in the note as well. [LB1032]

SENATOR CAMPBELL: Questions? Senator Riepe. [LB1032]

SENATOR RIEPE: Thank you, Mr. Lynch, for being here. We talked earlier today or this afternoon about the...there were cuts in Medicaid in 2002. And if my memory serves me, that was the result of an audit, but then those were reinstated. Is that correct? [LB1032]

CALDER LYNCH: My understanding of that situation, there were cuts both to Medicaid eligibility for individuals whose income was rising and they were losing eligibility, as well as some childcare subsidies. There was a lawsuit filed by Nebraska Appleseed against the state, in which they were ultimately successful in, and the state was required then to reinstate many of those enrollees to coverage. [LB1032]

SENATOR RIEPE: Okay. Another concern that I have, if I may, is we, this last session, we talked a lot about cliffs. You know, whenever someone would get close to a cliff, we wanted to move the landscape, if you will. It's a concern of mine in this particular legislation too. The cliff, we've heard a couple testifiers talk about, $42, oh, you know, too much, people at the cliff. You know, there's going to be another large number that come in. Those are unintended consequences, if you will. I don't know whether you want to respond to that or do you have some experience from someplace else? If so... [LB1032]

CALDER LYNCH: I mean I think it's all...that's a good question, Senator. Thank you. I think it's always a concern. You know, when you determine the eligibility provisions for these programs, are you creating disincentives for people to be able to...and move off of that in terms of returning to employment or returning to some other type of assistance. And I think we have to consider those very carefully, making these decisions to avoid those unintended consequences. [LB1032]

SENATOR RIEPE: Okay. Thank you. [LB1032]

CALDER LYNCH: Thank you. [LB1032]

SENATOR RIEPE: Thank you. [LB1032]

SENATOR CAMPBELL: I'm going to Senator Fox and then Howard and we'll work around. [LB1032]

SENATOR FOX: Okay. Thank you very much for your testimony, Director Lynch. A couple of questions I have, again, I have more than one if that's okay, the first thing has to do with the government's contribution here. And do you feel that it's realistic that they'll hold true to their promise? [LB1032]

CALDER LYNCH: Thank you, Senator. I think it's a very excellent question for the committee to ponder. I, you know, it is in federal law and so it would take an act of Congress to change it. But if you look at the President's most recent budget proposal, he proposed changing it and maybe in the other direction, in terms of providing all states that expand with three years at 100 percent, no matter when they expand. I don't expect that to meet a warm reception in Congress and so I don't anticipate that coming into law. But I think it does demonstrate that there could be wills from future administrations or future Congresses to make changes to those matching rates. There is a history of that. I know that the Governor has talked about some of the concerns he's had with the drop in the support for educational funding. When I was in Louisiana, we saw our match rate change by Congressional action during one of the deficit deals. We had had a special provision for disaster-related assistance that protected our FMAP for some period of time, and almost overnight an act of Congress reduced that FMAP and we lost $1 billion of federal financing out of our program in the current fiscal year. So I think there are examples and there are legitimate concerns to be had about the sustainability of that funding over time and what that impact would look like. For Nebraska, in the first full year that we have 90 percent match, should that drop down to our historical rate which is about a little over 51 percent, it would mean about $600 million in additional state financing necessary to support the program. [LB1032]

SENATOR FOX: Thank you. My other question has to do with a question I asked earlier as well, and that has to do with rate increases for premiums. In your testimony, you quoted about a 7 percent increase. Could you expand on why? [LB1032]

CALDER LYNCH: Why. Absolutely. So when we began this process with Optumas and we were talking through, you know, the analysis, one of the things they told us was they weren't sure

what the influx of the expansion population would do in the exchange market in terms of an impact on premiums; that there would be pressures up and pressures down in terms of this would ultimately double the size of the current exchange market. And so the introduction of that population could help spread risk and potentially lower costs. But there also could be an inflection of some higher risk which could ultimately raise costs. So in their analysis they looked at the current premiums that are in effect today, projected those forward to the time line for implementation, which is 2018, and then they...what they expect to see based on historical trend. Then they looked at similar populations that we cover today, which would probably be the parent and caretaker population that would be most similar to the expansion, what those costs look like, trended those forward and made some adjustments based on the expected acuity of that population, and then made an adjustment for commercial reimbursement level. So you know, we pay Medicaid rates, which are significantly less, and so when they made the adjustment for commercial reimbursement levels to bring those rates up, it was I think about $835 per member per month. And then they average that, essentially, with what they expected to see on the commercial side and that's where we ended up with the $738 figure. So because the health plans are not able to differentiate the premium they charge in the exchange between traditional exchange enrollees and expansion enrollees, everyone would have to be charged the same rate essentially. So you would actually see those that are in the private market today subsidizing the cost of the expansion population by having their premiums increase while the premium for the Medicaid expansion would be less than the actual expected costs for them. [LB1032]

SENATOR FOX: Thank you. [LB1032]

CALDER LYNCH: You're welcome. [LB1032]

SENATOR CAMPBELL: Senator Baker. [LB1032]

SENATOR BAKER: Thank you. Mr. Lynch, I look in the back page there. It's somewhat self-explanatory, but would you walk me through it anyhow? [LB1032]

CALDER LYNCH: Of the Optumas report? [LB1032]

SENATOR BAKER: Yes. [LB1032]

CALDER LYNCH: Absolutely. [LB1032]

SENATOR CAMPBELL: Which page are you looking at? [LB1032]

CALDER LYNCH: Is that page 19? [LB1032]

SENATOR BAKER: The back page, page 19. [LB1032]

CALDER LYNCH: Oh, 18? [LB1032]

SENATOR BAKER: Nineteen. [LB1032]

CALDER LYNCH: Nineteen. Nineteen represents just the administrative component of our costs. These calculations were actually done by our state staff, not by Optumas, but we've supplied them to them to include in the report. In the fiscal note we submitted, we outlined the different components of this. The largest component really is, of course, staffing that would be necessary. In addition to the eligibility staff that would be necessary to process the applications and help individuals enroll, there's also a significant number of fiscal staff that would be necessary to do the cost-effectiveness determinations for individuals who we would be supplementing their employer sponsored insurance, as well as calculating the supplement for their copayments and the collection of their 2 percent premiums that's proposed in the legislation. So we outline a number of individuals: financial teams, some medical teams to do the medically frail population. We heard the lady from Arkansas testify that they had a process in place to screen those individuals. We would need medical professionals to do that, as well as just general increases in some of our other functionalities around program integrity, reporting, data analytics. There would ultimately be also some significant IT costs in the first two years. We have some pretty antiquated systems, which of course we've had many conversations about, and so there will be some significant costs to get those in alignment with the new eligibility categories and processes necessary. I will say most of those costs will be borne by the federal government as those costs are matched at 90/10. And then finally we would require some contract costs, too, for consulting services to develop the waiver, to administer the waiver, do the quality reporting and assurance, significantly obviously in the first two years more than anything else. And so those are the components of that chart. [LB1032]

SENATOR BAKER: So as I look at fiscal year '18, looks like about $8.5 million total funds for staffing. [LB1032]

CALDER LYNCH: Correct. [LB1032]

SENATOR BAKER: About $4.4 million would be state funds. [LB1032]

CALDER LYNCH: That's correct for the staffing. Traditional...staffing is traditionally matched at 50 percent. [LB1032]

SENATOR BAKER: This would be all new staff that you don't have right now. [LB1032]

CALDER LYNCH: Correct. I mean we looked at our current staffing levels in terms of caseloads and what would be required, and we tried to isolate those staff we felt we would need additionally. We anticipate we'd begin hiring some staff in July of 2017 to allow for time for ramp up and training prior to the launch of the program in January. And obviously, there would be some eligibility work that would occur before then. [LB1032]

SENATOR BAKER: Thank you. [LB1032]

CALDER LYNCH: You're welcome. [LB1032]

SENATOR CAMPBELL: Senator Howard. [LB1032]

SENATOR HOWARD: Thank you, Senator Campbell. I have more than one, but I'll be very quick, I promise. [LB1032]

SENATOR CAMPBELL: You don't have to be quick. [LB1032]

SENATOR HOWARD: So with 147 staff, would you say that this is now a jobs bill? (Laughter) [LB1032]

CALDER LYNCH: I mean I'll... [LB1032]

SENATOR HOWARD: That was a joke. [LB1032]

CALDER LYNCH: I know. [LB1032]

SENATOR HOWARD: Okay. So can you tell me how much the Optumas report cost? [LB1032]

CALDER LYNCH: Oh, $40,000. [LB1032]

SENATOR HOWARD: Okay. And when was it commissioned? [LB1032]

CALDER LYNCH: Well, we have an existing contract with them to do our rate setting for managed care and other services. So there's a provision in that contract that provides for special projects. [LB1032]

SENATOR HOWARD: Like ad hoc services? [LB1032]

CALDER LYNCH: Uh-huh. Yes, so... [LB1032]

SENATOR HOWARD: And when did you commission...? [LB1032]

CALDER LYNCH: We began conversations with them probably in early January when we knew, you know, this was coming and started having them prep some of the work when we had maybe a general idea of what the proposal might look like. And then when the bill was filed is when the work really began in earnest. [LB1032]

SENATOR HOWARD: Perfect. And then do you agree with the report? [LB1032]

CALDER LYNCH: You know, I'm not an actuary so I rely on our expertise, which we've contracted through Optumas. We've had many conversations with them, walking through assumptions, explaining where they were coming up with numbers and how we were calculating different figures. And we came to agreement on all of those pieces. [LB1032]

SENATOR HOWARD: So one of the things that I really enjoyed in the report was on page 13, paragraph 1, which Senator Fox has already brought up some challenges with increased premiums. But the language says, "Reductions in uncompensated care could result in less cost shifting towards commercial payors." And then later it says: The influx of a large number of lives into the health insurance exchange could help stabilize premiums by providing a larger base of lives, and could also entice additional carriers to compete for business in Nebraska. Is that something that you would agree with after saying that you agree with the full report? [LB1032]

CALDER LYNCH: Sure. I mean I think it could. There's unknowns and that's part of the challenge that we have. And we wanted to present a fair and balanced analysis and there are a lot of uncertainties here. And you know, as I said, when we began this process, we didn't really know what the impact was going to be on the exchange premiums as they exist today. And when they came back to us, that was their analysis. [LB1032]

SENATOR HOWARD: And then I just have one question about the fiscal note,... [LB1032]

CALDER LYNCH: Sure. [LB1032]

SENATOR HOWARD: ...page 4 if that's helpful. We've...you and I have talked a lot about waivers and state plan amendments. We've worked on some together. [LB1032]

CALDER LYNCH: Uh-huh. [LB1032]

SENATOR HOWARD: Is it...$1.2 million seems like a lot for a contractor. I may be in the wrong business and I should start helping you write waivers. [LB1032]

CALDER LYNCH: You and I both, yeah. [LB1032]

SENATOR HOWARD: But that seems like a lot of money to have somebody help us with a waiver that I believe we might be perfectly capable of doing in-house. [LB1032]

CALDER LYNCH: Well, the pieces that are really challenging for us are more to do with the actuarial development and some of that work. And I think that this was based off of looking at some other states' experiences, our own staff, you know, making some estimates. So you know, is it an estimate? Sure. And we wouldn't really know until we went out to bid, you know, what those costs would look like. But one of the things that's really complicated about an 1115 waiver is that they're very detailed, they're very lengthy documents, but you're also having to demonstrate through pretty...at a pretty detailed level what your expected costs look like and demonstrating budget neutrality. And that requires a lot of work and certification by actuaries and certainly something that would take longer than three weeks. [LB1032]

SENATOR HOWARD: Thank you. [LB1032]

SENATOR CAMPBELL: I'm just going to ask a couple quick questions before I go on down the line. Director Lynch, in the 231,302 individuals in the state, that includes children, does it not? [LB1032]

CALDER LYNCH: They're the majority. [LB1032]

SENATOR CAMPBELL: Of the 200,000. So when we start adding an additional 126,000, that's all adults. [LB1032]

CALDER LYNCH: Yes. [LB1032]

SENATOR CAMPBELL: Correct? [LB1032]

CALDER LYNCH: Correct. [LB1032]

SENATOR CAMPBELL: Okay. I want to make sure that I was reading that correctly. What's the percentage of people in the state of Nebraska right now who are eligible for Medicaid who don't take it? [LB1032]

CALDER LYNCH: So we estimated the woodwork population as part of this analysis. I'm not sure what that exact percentage is. But when Optumas looked--and they looked at two different state examples, one a mountain state and one a southern plains state--to see what their...that expanded in 2014, and looked at their historical enrollment growth rate and compared it to what they saw after 2014. And they saw both not significant but slight upticks in enrollment growth for those that were already eligible, not part of the expansion population. So what we did was we looked at one year and estimated that in the first six months we'd see a 1 percent increase over our traditional enrollment growth rate and in the second six months a .5 percent enrollment growth rate over the last six months. And then we cut off the woodwork because after a year it's really difficult to assign an individual coming in as saying that they wouldn't have done so had it not been for the impact of expansion and the publicity around it. So that came down to 2,970 individuals that would...we classified as part of that woodwork group that are currently eligible but not enrolled. [LB1032]

SENATOR CAMPBELL: Did they take a look at the woodwork projections that the Fiscal Office made ahead of the ACA (inaudible)? I mean because my... [LB1032]

CALDER LYNCH: Yeah. [LB1032]

SENATOR CAMPBELL: ...understanding is that Nebraska has not come close to it and people have not, quote, come out of the woodwork. And so I'm somewhat curious as to does that figure match what they looked at? [LB1032]

CALDER LYNCH: Uh-huh. I don't know if it matches. I know they looked at a number of data sources and they might have looked at that analysis. I will tell you that because of that experience, we actually had them lower their original estimate of woodwork population. They had originally estimated 1 percent over a full year and we had them lower that second half of the year to .5 percent, recognizing I think that that has been slower than we expected. [LB1032]

SENATOR CAMPBELL: What's our, in relation to the other states, how do we rank in terms of our Medicaid participation? [LB1032]

CALDER LYNCH: We have about 13 percent of our population that's enrolled in Medicaid. I would say that's probably in the mid to lower range. I don't know exactly where that falls and I can't tell you exactly what the number is offhand of those that we expect are eligible but not enrolled, but we can certainly get that figure for you. [LB1032]

SENATOR CAMPBELL: And I'll be glad to show the national chart I looked at. We ranked 51st because we've lost people. [LB1032]

CALDER LYNCH: Oh, in the growth, yes. [LB1032]

SENATOR CAMPBELL: We have not added people. In relation to other states, I mean people are saying you're going to add all these people. Nebraska has lost people. [LB1032]

CALDER LYNCH: No, in terms of actual enrollment growth you're correct, we are near the bottom, in fact have seen... [LB1032]

SENATOR CAMPBELL: We are 51st. [LB1032]

CALDER LYNCH: ...seen a decline. And I think that's attributable to a few things. One, the baseline that was used for that study was during...right before a period when responsibility for Medicaid eligibility determinations was shifted from the Division of Children and Family Services to Medicaid. And at that point, there was a significant effort undertaken to review the Medicaid rolls and clear off some of those that were no longer eligible, no longer living in the state. And that resulted in several thousand people coming off the Medicaid rolls. And since that time, we've continued to see very low unemployment in our state. And as we know, public assistance programs typically respond countercyclically to the performance of the economy. So we've seen our enrollment stay relatively flat in the last few years. [LB1032]

SENATOR CAMPBELL: And the 147 new state employees that would be needed, I have to say, this is just a statement, I'm going to go back and look at the budget, not this last biennium but the biennium before that, because I raised a lot of questions on the floor because we...the budget request was almost like we want 175 employees to be ready for the ACA. [LB1032]

CALDER LYNCH: Uh-huh. [LB1032]

SENATOR CAMPBELL: I know the budget committee came forward and granted a great number of those and so it's almost like we're going to double this because we think that this is as big as getting ready for the ACA. And I do not think we even used all of those employees. But I'm going to ask the budget Fiscal Office to take a look at that. [LB1032]

CALDER LYNCH: And we absolutely should, and I'll say that, you know, when we were do...those 147, that's over the course of that full implementation period. That would obviously be phased in at a slower rate than that. And to your point about the additional staffing that was provided to the department during that discussion, I will say, you know, while we haven't seen the woodworking effect that we did, that is not the only impact that the Affordable Care Act has had... [LB1032]

SENATOR CAMPBELL: Right. [LB1032]

CALDER LYNCH: ...on the department, of course: the implementation of MAGI, policy changes, systems changes that we've had to make, the RAC audit process that was mandated, the new provider screening enrollment process that we've implemented. So those staff have been used across the division to support a lot of those activities and probably to supplement what might have been some understaffing that was occurring in the ACCESSNebraska system that's helped us address some of those challenges that we've had in the past. [LB1032]

SENATOR CAMPBELL: Okay. Senator Crawford. [LB1032]

SENATOR CRAWFORD: Thank you. Thank you, Chairwoman Campbell, and thank you, Director Lynch. I guess I'm going to start with Senator Howard's favorite paragraph, (laugh) because I was interested in the sentence...the next sentence. So as she noted on page 13, it talks about the fact some impacts of expansion could include reductions in uncompensated care that will result in less cost shifting and this could, you know, lower premiums and stabilize premiums in the exchange. And the next sentence that she didn't read was, "Impacts such as these have not been incorporated as part of this analysis." Now you mentioned that you hired Optumas because they had experience in Arkansas. We heard earlier from someone that actually that is what they saw in Arkansas, was this reduction. So you would have had someone who would have access to an experience to be able to put that into the analysis, so why wasn't that included in the analysis? [LB1032]

CALDER LYNCH: Well, when we had the conversation with Optumas, they did highlight some of their actual experience in Arkansas, which we were able to benefit from. One of the big unknowns is, despite the realities that may be the case of the acuity of this population, you know, a lot of this will be driven by what the insurers that are participating in the exchange market

interpret as to what they expect the relative risk level of the population to be, so. And Arkansas saw a pretty...I think we heard testimony earlier that they saw perhaps a very small increase or a steady rate from year two to three. And really what they, Optumas, felt in our conversations that represented was more of a stabilization of the rate, that perhaps the insurers had overestimated the original risk level of that population. And so every state is different. And I think there is an uncertainty to that of what that...how the insurers would respond to the influx of that coming into the market. [LB1032]

SENATOR CRAWFORD: So saw a stabilization or maybe 2 percent growth, but yet the assumptions in here are much higher for growth rates across the years. So it's interesting that that would be the Arkansas experience, yet that wouldn't be a prediction here. Also, just in terms of building on experience, in the past years our Fiscal Office has worked very hard to analyze the ways in which putting this population into expansion pulls them out of some of those programs that we currently pay for in corrections and in behavioral health. And I didn't see that in this report and maybe I missed it in terms of how those costs shifts that now the state...that the state no longer pays for are included. I wonder if that's in here and I've just missed it. [LB1032]

CALDER LYNCH: Well, it is not in the Optumas report... [LB1032]

SENATOR CRAWFORD: Okay. [LB1032]

CALDER LYNCH: ...but it is in the fiscal note that we submitted. We included estimated savings for the majority of them coming from the pregnant women category, because we would expect pregnant women to enroll in the expansion population and then would be eligible for that enhanced match, whereas prior they would have been at the normal match. [LB1032]

SENATOR HOWARD: Where is that? [LB1032]

SENATOR CRAWFORD: Where is that? [LB1032]

CALDER LYNCH: It's at the bottom of page 4 of the fiscal note, starting there. [LB1032]

SENATOR CRAWFORD: Of the department. [LB1032]

CALDER LYNCH: I don't know if your page 4 is my page 4. It's the second to the last page of the department's fiscal note. [LB1032]

SENATOR CAMPBELL: I just want to see where you are. [LB1032]

SENATOR CRAWFORD: Okay. I think I have it. I think we're on the same page literally. [LB1032]

CALDER LYNCH: Okay, good. (Laugh) [LB1032]

SENATOR HOWARD: Literally. [LB1032]

SENATOR CAMPBELL: We're getting there. [LB1032]

CALDER LYNCH: It ranges from $32 (million) to $35 million a year in General Fund savings, is what we're estimating there, and that's made up again of the pregnant women, the state disability category, a small amount in the women with cancer category, an even smaller amount in the 599 CHIP, and then about $5 (million) to $5.5 million annually in behavioral health. [LB1032]

SENATOR CRAWFORD: Okay. [LB1032]

SENATOR HOWARD: And when you say behavioral health, are you including the regions? [LB1032]

CALDER LYNCH: That figure came from the Division of Behavioral Health. [LB1032]

SENATOR HOWARD: Oh, thank you. Sorry. [LB1032]

CALDER LYNCH: And I think the Department of Corrections may have submitted, I'm not sure, their own fiscal note. We did not include them as part of our analysis. [LB1032]

SENATOR CRAWFORD: So in that case, if I'm reading this correctly, the savings in '18 from those costs, it would save the state over $32 million. Is that...yeah. [LB1032]

CALDER LYNCH: And that's why you'll see, you know, in the net projections, we do project that one year of savings in 2018--about $14 million. But then, of course, the costs would grow. [LB1032]

SENATOR CRAWFORD: Thank you. [LB1032]

SENATOR CAMPBELL: Go right ahead. [LB1032]

SENATOR CRAWFORD: If you're sure. So coming back to the Optumas report, I also...I was a little confused. As I understand the bill, what we're going to do is pay to put people on to the exchange or, when it's cost-effective, to put them in the...and available, to put them in employer sponsored insurance. [LB1032]

CALDER LYNCH: Uh-huh. [LB1032]

SENATOR CRAWFORD: Most of the people will probably be in one of those two areas. [LB1032]

CALDER LYNCH: Uh-huh. [LB1032]

SENATOR CRAWFORD: So now if we are paying to put somebody in a qualified health plan, all we're responsible for, really, is the premium and then the wraparound, which you have a cost for that. So I don't understand why we're talking about increasing reimbursement--Medicaid reimbursement levels--because on...it's on page 6 in the report, talking about the cost that comes from increasing reimbursement levels, because actually we...one of the nice things is we no longer have that risk anymore. We're just paying that premium and the insurance company now has that risk of paying reimbursement, and we expect them to pay higher reimbursement. But we only are responsible for the premium. [LB1032]

CALDER LYNCH: Right. And so what Optumas, I think, was attempting to do there was try to project what the insure...the market's response would be to the influx of that population by taking a look at who are these folks, creating some proxy of costs based on our current Medicaid experience, and making those adjustments for reimbursement and for relative acuity in their health status to come up with what we expect would be their actual cost in terms of delivering them healthcare, to try to come up with an assessment of what the insurers would demand in terms of a premium to cover those folks. [LB1032]

SENATOR CRAWFORD: So, for example, in the executive summary, just trying to think through what we would expect to have to pay in premiums, it talks about a...for people on the qualified health plan, a $738 per member per month charge. Now if you just look at Kaiser Family Foundation benchmark Silver Plan in 2015, which I know we have to do premium, not benchmark, but is $264. So that's..$738 per member per month seems way out of line with

looking at what appears to be costs that would be in our marketplace now and far beyond. I mean that seems like a huge gap between $264 for sort of a benchmark kind of Silver Plan to $738 per month. [LB1032]

CALDER LYNCH: Well, one of the key differences is when you look at the actuarial value of a Silver Plan. You know, an individual is having to contribute a significant portion of costs through copays and deductibles, which brings that premium down. Under...we've had to make the adjustment of looking at the cost of that Silver Plan and then adjusting its actuarial value to 100 percent... [LB1032]

SENATOR CRAWFORD: Right. [LB1032]

CALDER LYNCH: ...since the state is now responsible for covering those costs. Then on the back end, of course, we do the revenue collections for the 2 percent premium for those over 50 percent. So that's going to be probably the largest driver of that difference plus the additional, of course, adjustments for what we expect to see in terms of medical acuity. [LB1032]

SENATOR CRAWFORD: Okay. And then in terms of the employer-sponsored insurance, I found it very unbelievable, I guess, that the assumption would be that none of the unemployed, none of the people who are uninsured would take up an employee-sponsored insurance plan. That it would seem...I hear people talking about, especially like when I talk to people who are involved in long-term care, and I had a few of these discussions last year, say...long-term care managers say we have these plans, we'd love to have employees pay into them, it would not only help our employees but it would also stabilize our plan. So it seems to me that there would be several people who would be in those kinds of situations where the employee...the employed offer plan would be an attractive option to them. [LB1032]

CALDER LYNCH: Uh-huh. [LB1032]

SENATOR CRAWFORD: So I wasn't...do I don't understand why the assumption would be that that would be zero percent uptake for the uninsured population. [LB1032]

CALDER LYNCH: And we can certainly say...and that's a very good question, Senator, and I think I'd like to maybe circle back with Optumas and have a little bit more conversation on that piece. I would suspect part of it might be driven by the determinations of cost-effectiveness: If they're not participating today is it really going to be cost-effective for the state? Versus also, you know, usually those employee plans, there's a limited window of time from which you can enroll.

And so if they're coming to Medicaid and it's outside of that window, that might not be an option. But I'll circle back and take a second look at that. [LB1032]

SENATOR CRAWFORD: And we currently have...I might as well turn it into a question. How many staff do we currently have engaged in cost-effective analysis for ESI with our existing small program that has to do that kind of work? [LB1032]

CALDER LYNCH: The HIPP Program. I don't know the exact staff number off my hand. It's much smaller than this. And the portion, of course, that...you know, who are doing that is a smaller share of that 147. But I will get that number for you. [LB1032]

SENATOR CRAWFORD: So but we do have staff who I'm sure have algorithms and programs to assess cost-effectiveness of programs compared to Medicaid right now. [LB1032]

CALDER LYNCH: Yes, there are, and... [LB1032]

SENATOR CRAWFORD: Yeah. And they have expertise and experience and are already working in the department. [LB1032]

CALDER LYNCH: And if I could give those folks a shout-out I will, because you'll know that we've had several, you know, pretty significant audits in that program in the past... [LB1032]

SENATOR CRAWFORD: Right. [LB1032]

CALDER LYNCH: ...that have found some pretty significant overpayments. And just I think a week or two ago the Legislative Performance Audit Committee announced that they were taking no further audits on that program; that they had found substantial improvements in compliance. So I didn't want to lose that opportunity to thank those staff... [LB1032]

SENATOR CRAWFORD: Right. [LB1032]

CALDER LYNCH: ...for all their hard work. [LB1032]

SENATOR CRAWFORD: Thank you. [LB1032]

SENATOR CAMPBELL: Okay. Senator Riepe, did you have a question? [LB1032]

SENATOR RIEPE: No. I'm okay. I'm okay. Thank you. [LB1032]

SENATOR CAMPBELL: You're okay? Senator Kolterman. [LB1032]

SENATOR KOLTERMAN: Thank you, Senator Campbell. Thank you, Mr. Lynch, for coming today. Just a couple questions that come to my mind. We talked about logistics. You talked a little bit about those. So let's say we pass this out and it goes through the Legislature and then we start implementing a program. What's our possibilities with the federal government of giving this kind of a...getting this kind of a waiver? This is a little different than what we've experienced in the past, I mean what most states have experienced. I'm just curious. And then I'd like to try to address Senator Crawford's question about the reason for the cost, because I work in that area and I'm very familiar with that. [LB1032]

CALDER LYNCH: Thank you, Senator. I think it's difficult for us to assess that. One of my concerns being, of course, some of the scrutiny that, you know, the GAO and others have placed on how CMS approved and determined the budget neutrality for the Arkansas provision. As mentioned in earlier testimony, we will most likely be facing a new administration, should this bill pass, by the time we submit the waiver. And so there are, I think, a lot of uncertainties as to, you know, what the reception to that could be as outlined in this legislation. So you know I think...and originally CMS did say that they would only approve a limited number of these types of waivers. [LB1032]

SENATOR KOLTERMAN: And then I also see in the report that the state would take on the wraparound benefits. [LB1032]

CALDER LYNCH: Uh-huh. [LB1032]

SENATOR KOLTERMAN: I assume you're talking about vision and dental. [LB1032]

CALDER LYNCH: We...actually, Optumas had originally included dental and we asked them to remove it. You know, there was no requirement that dental coverage be included so we were trying to produce, you know, a cost analysis of really what's required under the bill. But it does include nonemergency transportation services. It does include vision and it also includes EPSDT services for 19- and 20-year-olds that would be eligible, and these are more enhanced requirements for medically necessary services. It's a small amount. It's about $6 PMPM ultimately. We assume that same cost for the ESI population, even though there are some uncertainties as to the uniformity of the benefit packages that are going to be available in ESI plans, given that some of them may have been grandfathered in prior to the essential health

benefits requirements. But for purposes of the estimate, we've assumed $6 PMPM across all populations. [LB1032]

SENATOR KOLTERMAN: Okay. And to talk about what Senator Crawford was asking, what we're seeing, a lot of your employers, small employers as well as large, are going to a higher deductible, higher copays. And so I would assume that if somebody has this option available to them and they can get a silver benefit, that's a lot richer than most. And if you're going for the silver benefit, it's the highest benefit you can get your best reimbursements for. Why wouldn't you take that instead of going on the employer's plan where you've got, even though the state might be paying some of it, it's not as good of health insurance? [LB1032]

CALDER LYNCH: You're correct. And we assumed in the analysis that 65 percent of those would go on the ESI subsidy because there would be a number that would perhaps not want their insurance tied to their employment or maybe for the reasons you've outlined choose not to. And there is no provision in this bill or in really, I think more importantly, probably federal law that would allow us to mandate that they take the ESI assistance since it's less expensive for the state. Now I do know that's one of the changes that Arkansas is requesting from the federal government, so it will be interesting to see that they're successful in that regard. [LB1032]

SENATOR KOLTERMAN: Okay. Thank you. [LB1032]

SENATOR CAMPBELL: Okay. Coming back, Senator Fox. [LB1032]

SENATOR FOX: Looking at the Optumas report and just thinking about all that's going to go into implementing this legislation as far as staffing, as far as IT requirements, looking at the fact that we're talking about initially bringing on 70,000 or, you know, 70,000 people estimated to grow to almost double, to over 136,000, do you think that this is even doable by January 1 of 2018? [LB1032]

CALDER LYNCH: You know, I appreciate that the author recognized, in writing the legislation, that the work to create and negotiate and implement this type of program is not going to be quick. But I think even this amount of time is going to be a very heavy lift. And it's not so much the development of the waiver that concerns me. It is more to do with the operational issues in terms of the necessary systems changes and that they'll be ready. As we are also in the midst of two major system replacements, both our eligibility and enrollment system is scheduled...a new system is scheduled to go live next spring, and we're also in the midst of replacing of our MMIS. But I don't think we'll have it quite replaced fast enough (laugh) to make...we'd now have to make changes to it to accommodate the provisions of this law. So that is the area that probably gives me the most concern in terms of our ability to meet those time frames. [LB1032]

SENATOR FOX: Okay. [LB1032]

SENATOR CAMPBELL: Senator Howard? Senator Crawford. [LB1032]

SENATOR CRAWFORD: Thank you, Chairwoman Campbell. And if we could, Director Lynch, I'd like to just walk through some of the fiscal note from the department. [LB1032]

CALDER LYNCH: Absolutely. [LB1032]

SENATOR CRAWFORD: I've had a chance to see that before, the savings part. [LB1032]

CALDER LYNCH: Uh-huh. [LB1032]

SENATOR CRAWFORD: So it says that the state could see savings by moving certain categories, certain population categories to the expansion population. Then it talks about the women with cancer category, pregnant women category. Says these populations currently cost approximately $38 million in state funds annually. And then later it talks about the disability program, which costs $3 million. [LB1032]

CALDER LYNCH: Uh-huh. [LB1032]

SENATOR CRAWFORD: And then when I looked down here in fiscal year '18 savings, I only see $32 million, which is less than $38 (million) plus $3 (million). [LB1032]

CALDER LYNCH: Part of that has to do with the take-up rate of individuals as they enroll in the program. So there will be some individuals that are...one of...the pregnant women is probably the biggest attributable factor to that, to that math problem. They...the way CMS has answered questions to states on this issue is that if they apply and say they're pregnant, or they're pregnant...they're already enrolled in the pregnant category of assistance, we'll continue...we have to continue to claim the traditional match rate for them. But if they're already enrolled as an expansion enrollee and they don't request that we change them to the pregnant women category, then we could continue to claim the enhanced match rate for them. So if they were already enrolled prior to the expansion as a pregnant woman, we would continue to claim federal match...the normal match rate for them through the end of that pregnancy until they would then transition over to the expansion population. And then we would also expect that some women might still come in at the time of becoming pregnant and if they tell us they're pregnant and that's the reason they're applying, then we have to put them in the pregnant women eligibility category. [LB1032]

SENATOR CRAWFORD: So we will save on a proportion or a segment of this population and that's... [LB1032]

CALDER LYNCH: A growing proportion. I think eventually we would probably capture almost all those costs. [LB1032]

SENATOR CRAWFORD: Okay. Okay. And then this says the state disability program, $3 million. Just for the record, what we had calculated for...what the Fiscal Office had calculated for FY '17-18, the previous version of the bill, really talked about like $9 million in disabilities and $4 million in behavioral health and also some savings in AIDS drugs. So I think there are other savings that aren't yet reflected in the department fiscal note that we should work on to make sure we have an... [LB1032]

CALDER LYNCH: Sure. [LB1032]

SENATOR CRAWFORD: ...accurate representation of the savings that it will bring. [LB1032]

CALDER LYNCH: Absolutely. And I'll say that we've put forward some of the savings that have not been part of the department's fiscal note in the past and we really tried to make this comprehensive. But if there are things that were missed,... [LB1032]

SENATOR CRAWFORD: Thank you. [LB1032]

CALDER LYNCH: ...we're certainly happy to look at that. [LB1032]

SENATOR CRAWFORD: Excellent. Thank you. [LB1032]

SENATOR CAMPBELL: Director Lynch, I worked on four different versions of this, which everybody is well aware of. In the statement that you made, someone handed me the press release that came, that there would be more targeted solutions. What targeted solution should those of us who worked on this look at? [LB1032]

CALDER LYNCH: I think that when we look at the number of uninsured individuals in the state, of course, you know, our figures are pretty close to those that have been put forward, around the 77,000. Of course, we know that there's probably an equal number of individuals, or near equal to that amount, under...in under the threshold for eligibility that have some sort of insurance today, many of them probably getting subsidies on the exchange in that 100 to 138 (percent)

amount. You know, ultimately, you know, as we've heard the testimony today, the law and CMS's interpretation of the law hasn't provided states with that flexibility for a more targeted expansion. But I think more importantly than that, perhaps, looking beyond just Medicaid and the ACA, I think one of the biggest disappointments that I've had in how this conversation has evolved over the last few years is that through the ACA we've really focused this conversation on coverage and through Medicaid and through the exchanges, which are certainly...you know, I understand why that was done. But we've really not addressed one of the fundamental issues of healthcare in our country, which is cost. We look across the globe. You know, we're seeing healthcare as a percentage of GDP for this country well above any other industrialized country, yet our outcomes are near the bottom. And I think that that's unfortunate, that we're not...that we're focusing the conversation here and not on how we can use the dollars that we have in our system today to better address the needs of all of our citizens. And I think obviously we're not going to solve that problem here at the table today and it's bigger than perhaps just even Nebraska. But I think that, you know, trying to hopefully work with maybe a new administration federally or maybe working with other community partners, other private sector partners to try and better address those needs in a more sustainable way for us. [LB1032]

SENATOR CAMPBELL: Okay. Senator Howard. [LB1032]

SENATOR HOWARD: I'm so sorry. [LB1032]

SENATOR CAMPBELL: That's okay. I've got my questions written. [LB1032]

SENATOR HOWARD: That prompted another question. That, to me, didn't sound like a solution for all the proponents we heard today who need something yesterday. [LB1032]

CALDER LYNCH: Uh-huh. [LB1032]

SENATOR HOWARD: Do you have an idea of what a better solution would be that we could present today, yesterday, tomorrow? [LB1032]

CALDER LYNCH: You know, I don't know of a solution that is going to...you know, that I know that I feel comfortable today saying to the Governor, to the Legislature this is financially sustainable, it's approvable under federal law, we can put it forward and we can move it forward. You know, I think from my perspective, as the Medicaid director, what I have to balance is our responsibility to our program today and our enrollees in trying to deliver better quality services, more efficiency to the taxpayers of the state. And I can't say that this does that in terms of being able to sustain our operations going forward into the future. We're already being challenged by

that in terms of, you know, the dollars that we require in our budget every year are growing. And I want to be able to deliver a better value for the dollars that are invested in the program. We're working every day to do that. But I think that this solution is going to create some challenges for the state in the long term and perhaps some challenges for our ability to meet the needs of our current enrollees. And so I don't have a solution that I can put forward and say this is, you know, financially sustainable, approvable. But I'm hopeful we can keep that conversation going and maybe under a new administration have some additional flexibility to work with them on a proposal. [LB1032]

SENATOR HOWARD: So you don't think that this would be approvable. Is that what you're saying? [LB1032]

CALDER LYNCH: Well, I know that by the time we would submit the waiver, we'll be in a new administration. So I think there's a lot of uncertainty there. You know, I think it would be...I think there are elements of this that are going to require negotiation and I can't say for sure what the federal government would say. [LB1032]

SENATOR HOWARD: Are there any particular pieces that haven't been approved in other states? [LB1032]

CALDER LYNCH: The ESI might be a little different, but I don't know of any particular pieces. [LB1032]

SENATOR HOWARD: Okay. Thank you. [LB1032]

SENATOR CAMPBELL: Okay. We're back to me. Director Lynch, I just want to say that I can't speak for the 2002 cuts that were made because I wasn't here in the Legislature. But while I've been in the Legislature, we have cut it. We have cut it during...when Speaker Flood asked that all of the committees to meet over the summertime and look for it, and we did make cuts and we didn't restore them and we weren't sued. So I just wanted to say that for the record, why we've been doing that. One of the issues that I have, and I asked the woman about that, it just seems strange to me that we're going out to 2027. Is there some reason why the department asked the actuary people to look ten years? I mean do we normally do that? [LB1032]

CALDER LYNCH: Well, I haven't been here for the past analysis or what those decisions were. I wanted to present the committee with as much information as we could. And certainly I don't know where the Fiscal Office will put its projections. They may take a narrower time frame. And certainly they can do that from our report. The information is there at an annual level. And we

note in the report that there is some projection risk the further out you go that, you know, there are uncertainties about what future actions may bring. So I think that, you know, it's there as information for folks if they want to focus on the first few years. But this is a big commitment we're potentially placing the state in front of and so we should look into the future of what that could mean for us. [LB1032]

SENATOR CAMPBELL: And I have to say that I did say to the Fiscal Office, and I know they're working on this, I said do you normally go out, you know, to that amount? And they have said no. [LB1032]

CALDER LYNCH: Uh-huh. [LB1032]

SENATOR CAMPBELL: And in the eight years that I've been here, the only time I've been asked to go out ten years and look at anything was on ADC. So I want to just indicate that it just seems strange to me and that's why I asked the woman from Arkansas that question. Any other questions, Senators? Okay. Thank you, Director. [LB1032]

CALDER LYNCH: Thank you very much. I appreciate it. [LB1032]

SENATOR CAMPBELL: All right. We will go on to next opponent. [LB1032]

BRUCE RAMGE: (Exhibit 37) Chairperson Campbell 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 for the state of Nebraska. I'm here today to testify in opposition in to LB1032. As the chief financial regulator of Nebraska insurance companies, my opposition to this legislation comes from a couple of different angles. First, I'm concerned the federal government will not fulfill their financial obligations to the state of Nebraska. Second, I am concerned what the passage of this legislation will mean for the health insurance market in Nebraska. The Department of Insurance's experience with the federal government's implementation of the Affordable Care Act, or ACA, can be summed up with one word--frustration. The frustration comes from the failure to fulfill promises to both insurers and state regulators, and from the unpredictable decisions that the federal government is prone to make in the implementation of this law. Last year, in testifying in opposition on LB473, I shared with the committee the story of the failure and liquidation of CoOportunity, which was an Iowa-based health insurance co-op that was formed as one of the consumer-driven health insurance entities created by the ACA. The CoOportunity failure was the first of 12 co-ops that have failed since that hearing last year. Many of the reasons for the co-ops' failures stem from failed federal government promises. This year I would like to talk about the risk corridor payments from the federal government. Risk corridor payments were a major component of the ACA's premium stabilization programs, commonly

referred to as the 3-R programs. The risk corridor program is intended to induce insurers to participate on the exchanges by paying insurers whose claims significantly exceeded expectations and payments from premiums. After the completion of the first year of the exchange policies in 2014, insurers began to submit risk corridor claims, expecting payment in the fall of 2015. During this time, state regulators were reviewing plans and rates for exchange policies to be sold for the 2016 year. Prior to the public release of the 2016 rates in later summer of 2015 and announcement of the 2015 risk corridor payments, the federal government contacted state regulators and mentioned to the media that the proposed rates should be lowered because of upcoming risk corridor payments. Essentially, the federal government was using risk corridor payments to pressure state insurance commissioners to lower premium rates. Luckily, few, if any, commissioners succumbed to this pressure. The risk corridor payments in the end were 12.6 percent of what the insurers requested and expected. When these low risk corridor payments were announced, a number of the remaining co-ops that were still operating were placed in supervision by their respective insurance commissioners. This pennies-on-the-dollar payout is yet another example of a failed promise of the federal government in relation to the ACA. The federal government has promised to make up some of the difference next year, but few, if anyone, in the insurance industry actually expects that to occur. With that background, I hope you can understand my reluctance to have Nebraska health insurers accept another large group of risk with promises of federal assistance. Nebraska is fortunate right now to have four insurers participating on the exchange. However, concerns exist that Nebraska's market may look significantly different next year. Insurers are already reconsidering participation on the exchange, and passage of LB1032 may add to those concerns. The first challenge for insurers with LB1032 is the assumption of unknown risk. The unknown risk from the exchange has already led to considerable losses for insurers on the individual market. Additionally, while the front-end technology of the exchange has vastly improved from the failures of late 2013, back-end issues between the insurers and the federal government persist. The additional technology interfaces that the insurers, and presumably the federal government as well, will need to build for Medicaid will not improve this situation. Furthermore, LB1032 will impair the ability of insurers to utilize cost-saving measures for this population used in other insured populations. Specifically: the lack of strictly controlled open enrollment leads to adverse selection, when consumers buy plans only when needing medical care; network requirements that will force insurers into unfair bargaining positions with providers on reimbursement; and payment of copays, coinsurance, and deductibles by Medicaid eliminates the purpose of these tools insurers have created to keep utilization down. These are just a few of my concerns with LB1032. I appreciate the opportunity to come before the committee to discuss LB1032. Thank you. [LB1032]

SENATOR CAMPBELL: Questions? Senator Kolterman, do you have a question? [LB1032]

SENATOR KOLTERMAN: Yeah, I do have a question. I apologize but I'm going to have to leave. But thank you for your testimony, Mr. Ramge. [LB1032]

BRUCE RAMGE: You're welcome. [LB1032]

SENATOR KOLTERMAN: When we talk about the risk corridors, we're talking about...are we talking about how they're getting reimbursed? That's basically what we're talking about, isn't it? [LB1032]

BRUCE RAMGE: It's how the insurers, who took on unexpected risks, were supposed to be reimbursed to help cover those unexpected losses. [LB1032]

SENATOR KOLTERMAN: And we, we as consumers that are paying for monthly premiums, are paying a tax every month towards that, aren't we? [LB1032]

BRUCE RAMGE: Yes. [LB1032]

SENATOR KOLTERMAN: And every premium that we pay, it goes...a certain amount that the insurance companies collect, and they send that to the federal government. [LB1032]

BRUCE RAMGE: Yes. [LB1032]

SENATOR KOLTERMAN: And now you're telling me that they're not collecting that back that they're promised? [LB1032]

BRUCE RAMGE: That's correct. And this pennies-on-the-dollar reimbursement is going to ultimately lead to a substantial increase in next year's rates because the insurers could not rely on those payments to help temper their losses. [LB1032]

SENATOR KOLTERMAN: And from an insurance perspective, there's four on the marketplace today... [LB1032]

BRUCE RAMGE: Yes. [LB1032]

SENATOR KOLTERMAN: ...and it's my understanding that several have asked to come off but the federal government won't let them off the exchange. [LB1032]

BRUCE RAMGE: I...we've not been notified of anyone decidedly leaving Nebraska's market for next year. But in the press there has been two major insurers that have announced that they are

giving very strong considerations to not participating on the individual market exchange. [LB1032]

SENATOR KOLTERMAN: Okay. Appreciate that. [LB1032]

BRUCE RAMGE: You bet. [LB1032]

SENATOR KOLTERMAN: Thank you. [LB1032]

SENATOR CAMPBELL: Senator Howard. [LB1032]

SENATOR HOWARD: Thank you, Senator Campbell. Nice to see you, Director Ramge. [LB1032]

BRUCE RAMGE: Nice to see you. Thank you. [LB1032]

SENATOR HOWARD: I never see you anymore. I was wondering, have you read the Optumas report? [LB1032]

BRUCE RAMGE: I have not seen it yet. [LB1032]

SENATOR HOWARD: And you heard the quote that I shared from page 13 that indicated that if we moved...made a bigger pool on the health insurance exchange, we could stabilize premiums. [LB1032]

BRUCE RAMGE: If...that would depend on whether...what population was enrolled. If everyone were enrolled and we got both the healthy and the sick, then there would be a good chance that that could help stabilize. But even in the states that have adopted Medicaid expansion, there are still levels of uninsured that are equal to Nebraska. So we would need to find a way to get everyone in there. [LB1032]

SENATOR HOWARD: And so in that scenario, if we were removing the medically frail, so we were removing the very sick, presumably then only the people who were mostly healthy... [LB1032]

BRUCE RAMGE: Yes. [LB1032]

SENATOR HOWARD: ...would be going into the insurance exchange. [LB1032]

BRUCE RAMGE: Yes. [LB1032]

SENATOR HOWARD: Bigger pool, less uncompensated care, stabilizing premiums. [LB1032]

BRUCE RAMGE: Yes. The more healthy people you would get in the pool the... [LB1032]

SENATOR HOWARD: The better. [LB1032]

BRUCE RAMGE: ...the more healthy the insurance situation would be. [LB1032]

SENATOR HOWARD: Perfect. And then my other question was about your fiscal note. [LB1032]

BRUCE RAMGE: Okay. [LB1032]

SENATOR HOWARD: You indicated that you would need another claims investigator. [LB1032]

BRUCE RAMGE: Correct. [LB1032]

SENATOR HOWARD: How many consumer questions and complaints do you get now? [LB1032]

BRUCE RAMGE: We get roughly 2,000 a year on written complaints, and then probably twice that on phone calls. And with this, we expect it would probably increase the load by one person because, especially individuals who have not been insured before or if they have a lot of questions or don't understand the coverage, we want to be there to help with...as we always are. [LB1032]

SENATOR HOWARD: And you want that person to start in 2017, but the waiver won't be submitted. When will the waiver be submitted? [LB1032]

SENATOR CAMPBELL: The end of '17 I think. [LB1032]

SENATOR HOWARD: The end of '17? [LB1032]

SENATOR CAMPBELL: It has 14 months. [LB1032]

BRUCE RAMGE: Yeah. [LB1032]

SENATOR HOWARD: So you anticipate that you would start to receive questions at the beginning of the year in 2017? [LB1032]

BRUCE RAMGE: We would receive questions as soon as the program were implemented, so I don't know the timing. And we certainly wouldn't hire anyone before they are needed. [LB1032]

SENATOR HOWARD: Before they were needed, okay. Great. Thank you. [LB1032]

SENATOR CAMPBELL: Other questions? Senator Crawford. [LB1032]

SENATOR CRAWFORD: Thank you. And thank you, Director, for being here. [LB1032]

BRUCE RAMGE: You bet. [LB1032]

SENATOR CRAWFORD: I just wanted to walk through a few things in, well, this last paragraph of your testimony... [LB1032]

BRUCE RAMGE: Sure. [LB1032]

SENATOR CRAWFORD: ...just to understand how LB1032 impacts these concerns that you have. So it talks about the lack of a strictly controlled open enrollment leads to adverse selections. So can you just indicate what you mean by that in terms of how LB1032 doesn't...or what you would like to see changed in LB1032 to address that problem? [LB1032]

BRUCE RAMGE: I would be happy to. Currently there is an annual open enrollment period, but there are numerous different special enrollment periods that are available, and for good reasons, for like if you lose your job or you have a child or there's a disaster in the state. But what the insurance companies have told us is that they are not able to verify that people coming in these special enrollment periods have actually sustained that triggering event. And as a result, they feel that many people are using that when they decide they need a healthcare procedure and coming in under...claiming a special enrollment period, getting the health procedure, and then dropping off. And so they're getting just a little bit of premium rather than the full year. And so we would

like to see those insurers to have the ability to verify that when people come in with a special enrollment that they are actually eligible. [LB1032]

SENATOR CRAWFORD: Do you have any sense of what percent in Nebraska come in under those special periods? [LB1032]

BRUCE RAMGE: No. No, I don't. [LB1032]

SENATOR CRAWFORD: Okay. [LB1032]

BRUCE RAMGE: Yeah. Sorry. [LB1032]

SENATOR CRAWFORD: But there's nothing in LB1032 that creates an open window, is there, or...? [LB1032]

BRUCE RAMGE: It would just be upon their eligibility, upon their Medicaid eligibility. And I suspect that the Medicaid Division would then be responsible for verifying their eligibility. So it may be less of a problem for that issue. Now copays and coinsurance are another matter because we want people to be smart consumers and we want...you know, in a perfect world, people who participate in payment of the healthcare would look out there for costs and say, well, this hospital is more reasonable or has great outcomes and that's where I want to go. But if people don't have responsibility for a major part of that healthcare expense then there's not that incentive. [LB1032]

SENATOR CRAWFORD: Uh-huh, and I can understand your concern about that and how it connects to LB1032. [LB1032]

BRUCE RAMGE: Yes. [LB1032]

SENATOR CRAWFORD: The other one I have a question about is the requirements that force insurers into unfair bargaining positions with providers. [LB1032]

BRUCE RAMGE: Well, they would need to...in order to maintain the Medicaid population, they would have to maintain a network. And we saw here in recent years where sometimes the insurers and particular networks can't really come to an agreement on reimbursement rates. And if there was further requirement on an insurer that they couldn't have a gap in their network, then

the medical providers in that area would have the upper hand and they could charge more. [LB1032]

SENATOR CRAWFORD: But what in LB1032 impacts that? [LB1032]

BRUCE RAMGE: I believe just because of the Medicaid rules would require a...there to be a network throughout the state in order to obtain a waiver. Again, that might be something more that Calder could verify. [LB1032]

SENATOR CRAWFORD: Thank you. [LB1032]

BRUCE RAMGE: Yeah. Thank you. [LB1032]

SENATOR CAMPBELL: Other questions, Senators? Director, I just have one question. [LB1032]

BRUCE RAMGE: Sure. [LB1032]

SENATOR CAMPBELL: We've heard today that there are seven other states or eight other states...have you had an opportunity to look at those states? I mean is there some better way to do this? I guess I'm trying to figure out, after multiple times looking at this, what have we missed. Did you see something that we should have looked at? [LB1032]

BRUCE RAMGE: I have to be very honest that my scope is towards the...is not the Medicaid market. [LB1032]

SENATOR CAMPBELL: Good. [LB1032]

BRUCE RAMGE: I'm more focused on the commercial market, you know, the exchange market and how that operates. And so I don't have a good answer for you. I would say that, you know, Congress has kind of put us in the situation of having this gap. I really feel that there should be some pressure on Congress to fix it. But that's just my opinion. [LB1032]

SENATOR CAMPBELL: You mean in terms of the people who are in the gap...pressure? [LB1032]

BRUCE RAMGE: Yes. Yeah. [LB1032]

SENATOR CAMPBELL: Well, I think Congress figured all along that they would be covered,... [LB1032]

BRUCE RAMGE: Yeah. [LB1032]

SENATOR CAMPBELL: ...but the Supreme Court said, states have to opt into this. [LB1032]

BRUCE RAMGE: Yeah. [LB1032]

SENATOR CAMPBELL: And so to some extent I suppose we're here because of a decision of the Supreme Court,... [LB1032]

BRUCE RAMGE: Very well could be. [LB1032]

SENATOR CAMPBELL: ...when Congress thought it was going to be covered. [LB1032]

BRUCE RAMGE: Sure. Sure. [LB1032]

SENATOR CAMPBELL: Anything else? You can tell it's a long afternoon. I'm losing my voice. [LB1032]

BRUCE RAMGE: Yes. [LB1032]

SENATOR CAMPBELL: Thank you, Director. [LB1032]

BRUCE RAMGE: Thank you for allowing me to speak. [LB1032]

SENATOR CAMPBELL: Uh-huh. Our next opponent. [LB1032]

JIM VOKAL: (Exhibit 38) Thank you, Chairwoman Campbell and members of the Health and Human Services Committee. My name is Jim Vokal, J-i-m V-o-k-a-l, and I am the CEO of the Platte Institute for Economic Research. I'm grateful for this opportunity this evening to testify on LB1032. I've read the statement of intent and LB1032, and I believe my friend, Senator McCollister, provides a good example with this bill of how intentions can often conflict with results. There are three key promises this form of Medicaid expansion makes to differentiate itself from other attempts at expansion that it simply can't keep. The first promise it can't keep is

being a form of transitional premium support. In fact, it's an entitlement program that asks taxpayers to pay virtually all the cost of a silver level private insurance for participants. Transitional should mean that it has a codified end. Premium support means you are assisting people to make their own payments for insurance, as with ACA subsidies. But aside from language aspiring to that goal, the bill is very clear that premiums, copays, deductibles, and coinsurance are paid for by taxpayers. There are no teeth to the promise of transitioning people off the program or requiring meaningful cost-sharing on their part. There is no time limit, there's no work requirement, and the job program is entirely optional. And I understand why that is. It's very unlikely the current administration would approve of more stringent requirements. In theory, the Legislature can put anything it would like in this bill, but in practice LB1032 is just a dress rehearsal for a negotiation with the federal government over Section 1115 Medicaid waiver. In other states that tried this waiver, like Arkansas and Iowa, the federal government has applied terms and conditions that would have made cost-sharing more difficult and less meaningful than policymakers would hope. The second promise the bill can't keep is who it would serve. We would all like to close the coverage gap by offering more affordable options. And last year the Platte Institute discussed a potential waiver option we can pursue without expanding Medicaid eligibility to able-bodied, childless adults. But actuaries hired by DHHS have projected that 58 percent of the participants in this program will be among those currently insured or those currently eligible for ACA subsidies. We will be paying out more state tax dollars to fund insurance that was previously paid for with private money or for which there is already ACA funding available. The Congressional Budget Office and the National Bureau of Economic Research project a reduction of work force participation among able-bodied, childless adults under expansion, including nearly 14,000 Nebraskans who will drop out of the work force altogether and thousands more who will reduce work hours to become or remain eligible. The incentives of the Arkansas-style private entitlement will trap more Nebraskans in welfare dependency, through no fault of their own, simply because they want, like everyone else, to be able to afford health insurance. Finally, the third promise LB1032 can't keep is how much the program will cost state taxpayers. Now I know a lot has already been said about the federal government's 90 percent match rate, which reaches that point in 2020. But that rate changing is not the only danger. Of 17 states that made their expansion enrollment projections publicly available, all of them exceeded their annual projections in 2014. By 2015, they all exceeded their total maximum enrollment projections, meaning they enrolled more people than they ever thought they would throughout the entire history of their expansions. This is especially problematic for Nebraska's state budget because in Arkansas it was demonstrated that a private insurance entitlement costs even more per patient than regular Medicaid expansion. In fact, the original projections for average annual cost per person were off by more than 50 percent. Under LB1032, the total program cost in the next five fiscal years will be nearly $2 billion higher than Medicaid expansion...the regular Medicaid expansion I should say, and the state's share will be over $136 million higher. Every time projections for enrollment or costs exceed their targets, we're contributing to a budget crowd out that endangers funding for traditional Medicaid

populations and other state priorities. I would simply close by mentioning that the federal waiver process for Medicaid and the ACA may change considerably by next year when a new federal administration will come in. In the time window LB1032 suggests a waiver for an Arkansas-style Medicaid expansion could be submitted and approved, there may be other, better opportunities available, including a federal block grant of Medicaid dollars or an ACA waiver which enables Nebraska to design its own eligibility requirements for insurance subsidies. I'd be glad to answer any questions the committee may have. [LB1032]

SENATOR CAMPBELL: Thank you, Mr. Vokal. Questions, Senators? We're wearing them down. (Laughter) Mr. Vokal, would you just kind of briefly describe the option you had suggested, because I'm not going to do... [LB1032]

JIM VOKAL: Sure. [LB1032]

SENATOR CAMPBELL: ...I'm not going to do justice to it. [LB1032]

JIM VOKAL: And I will be as succinct and as good as I can about this. It's fully described in our study that we released last August. So it utilizes 1115 and a 1032, I believe,... [LB1032]

SENATOR CAMPBELL: Okay. [LB1032]

JIM VOKAL: ...a 1332 waiver. And so it accesses existing block grant funding under the current Medicaid program, also ACA funding, allowing the state to have more flexibility to determine not only eligibility but to transition, potentially, folks off of the program and use existing federal funding rather than create additional debt on the federal level. And we truly, and I don't mean to interrupt you, Senator, this isn't about not helping this coverage gap. We want to try to find a solution. But what concerns me and the Platte Institute is that where 58 percent of those folks estimated to come on already have that private insurance, and the crowd out that may exist obviously with those that are currently under the Medicaid program. [LB1032]

SENATOR CAMPBELL: And all I was going to say is, and I haven't looked recently so this is probably since this summer, but at that point nobody had applied for a 1332 yet. Some of them had 1115 waivers. When we were at NCSL this summer, they were talking about the fact that you would start with that step and then move to the 1332, and I don't know how you... [LB1032]

JIM VOKAL: Sure. [LB1032]

SENATOR CAMPBELL: ...think about that suggestion to us at all. [LB1032]

JIM VOKAL: No, I think that that's certainly a valid question to ask. I think that that alternative plan that we outlined has just as much chance of getting the waivers necessary that LB1032 does. But I caution, I think other folks have talked about and I think you'll all aware, that we have a new administration coming in towards the fall and so I think it's prudent, obviously, for the state to look at all the options that are on the table. And I'm committed, as the CEO of the Platte Institute, to help look through those options and work with the senators to find a plan that's tailored towards those...helping those that are currently those...are those that we're trying to help. [LB1032]

SENATOR CAMPBELL: Any questions? Oh, Senator Crawford. I'm sorry. [LB1032]

SENATOR CRAWFORD: That's fine, Madam Chair. And thank you for being here and thank you for bringing in the expert and having this discussion. I appreciate you being involved in thinking about solutions. And I was happy to have a chance to be there for that discussion as well. And I do recall part of the discussion at that session was about the challenge of being able to get these waivers and the difficulty of getting the waivers. Now I do also recall part of the discussion was that if you had those waivers and expansion that you could serve even more people with this kind of flexibility. So I think that was also something that was discussed was that it doesn't necessarily exclude the expansion as well. [LB1032]

JIM VOKAL: Correct. [LB1032]

SENATOR CRAWFORD: Thank you. [LB1032]

SENATOR CAMPBELL: Any other questions? I have to tell you, Mr. Vokal, there's just...I'm becoming cynical here because with every plan we've thrown out, somebody has said, now, if you'd just wait until the Supreme Court. I mean it's like every time somebody else saying you need to wait for the next step. So that's why I chuckled when you talked about (inaudible). [LB1032]

JIM VOKAL: Well, I appreciate your efforts to try to find a solution for Nebraska. [LB1032]

SENATOR CAMPBELL: We're looking. We continue to. [LB1032]

JIM VOKAL: Thank you very much. Have a good evening. [LB1032]

SENATOR CAMPBELL: And thank you. Our next proponent... [LB1032]

JOSELYN LUEDTKE: Opponent. [LB1032]

SENATOR HOWARD: Opponent. [LB1032]

SENATOR CAMPBELL: Or opponent. Sorry. Sorry. Sorry. You can tell they're paying very close attention to what I'm saying here. Good evening. [LB1032]

NIC HORTON: (Exhibit 39) Good evening. Thank you for having me. I want to say thank you to Senator Riepe, specifically, for inviting me to speak today. My name is Nic Horton, N-i-c H-o-r-t-o-n, and I'm a senior research fellow with the Foundation for Government Accountability where I specialize in healthcare and welfare reform. FGA is a multistate nonprofit research organization. We work exclusively on health and welfare reform with employees and offices in nine states across the country. We work at the state level in more than two dozen states. And our staff has testified before committees in 35 states, testified before Congress, and have decades of combined experience working with state legislatures, executive branches, and the private sector. I'm here today to discuss the experiences of Arkansas, my home state, as it has implemented the Medicaid expansion outlined in the Affordable Care Act, commonly known as "Obamacare." Before joining FGA I worked as a journalist chronicling the debate and the ongoing battle over Arkansas' so-called private-option version of Medicaid expansion. Your state is now considering going down the same path. But before you make such an enormous decision, I want to be sure you know the whole story. Chloe Jones is a 16-year-old girl from Walnut Ridge, Arkansas, who lives not too far from where I grew up. Chloe has cystic fibrosis and she depends on medication in order to survive. Without it, doctors say she won't live to the age of 40. Thankfully, Chloe has been able to receive her medication through the Medicaid program, that is, until 2012 when the state of Arkansas decided her medication was too expensive and they stopped paying for her life-saving treatments. I'm thankful to report that after years of costly litigation Chloe has finally had her benefits restored and is able to get the help that she desperately needs. But the broader point cannot be overlooked. While Chloe was engaged in this lengthy legal battle, taxpayers were spending billions of dollars to provide welfare benefits to able-bodied, mostly childless adults through our state's Medicaid expansion. This is wrong and, unfortunately, our state's approach to Medicaid expansion puts the truly needy patients like Chloe at even greater risk. Medicaid has traditionally been reserved for vulnerable Americans, including poor children, pregnant women, seniors, and those with disabilities. But opting into Obamacare's Medicaid expansion would change that focus. States opting into expansion give Medicaid benefits to an entirely new class of able-bodied, mostly childless adults, a group that traditionally does not qualify for other types of long-term welfare. Unfortunately, this policy change shifts limited taxpayer dollars away from the truly vulnerable, like Chloe, and gives it to these able-bodied adults who have no disabilities keeping them from meaningful employment. It also puts the truly needy first on the chopping block. Consider this: The federal government currently reimburses Nebraska for roughly 51 percent of the cost to provide Medicaid to the truly needy. But if Nebraska were to expand

Medicaid, the federal government says they would cover 95 percent of the cost of Medicaid to provide Medicaid to this new class of able-bodied adults in 2017 and that would ratchet down to 90 percent thereafter, of course assuming that the federal government keeps its funding promises. So what does this mean? It means that when this body is looking for needed savings in the Medicaid budget, Obamacare will put you in a very difficult position. You will be forced to choose between saving 5 cents out of every dollar cut from your Medicaid expansion program or 49 cents out of every dollar cut from services and benefits for the truly needy. And let's be clear, policy makers will need to find savings even without Medicaid expansion. Medicaid is one of the largest and fastest growing line items in the budget. In states that have expanded Medicaid under Obamacare, the cost of expansion has far exceeded original projections. Those states are now desperately looking for funding to pay their state share which they must begin paying in their next budgets. Arkansas' expansion model is also significantly more expensive than a conventional Medicaid expansion. In fact, the Government Accountability Office has said that Arkansas' model will cost nearly $1 billion more just over the first three years than if the state had implemented a regular expansion. Instead of delivering benefits directly through fee-for-service or managed care, as Nebraska does, Medicaid benefits in Arkansas' expansion are redirected through qualified health plans sold on the exchange. But the cost of expanding Medicaid through QHPs is far higher than the cost of traditional Medicaid. The state of Nebraska commissioned a study last year to see what this alternative model would cost for just a portion of the expansion population. That study concluded that doing that approach would increase per-person cost by 94 percent in the first year and eventually projected those increases would reach 150 percent. Based on the available data, we estimate that expanding Medicaid through an Arkansas model in Nebraska would increase costs by $1.9 billion over the next fiscal year. And I realize I'm out of time, so I'll be happy to stop and answer questions. [LB1032]

SENATOR CAMPBELL: Thank you, Mr. Horton. [LB1032]

NIC HORTON: Yes. [LB1032]

SENATOR CAMPBELL: You know, there...I don't have very many people that look at the red light and stop. [LB1032]

NIC HORTON: (Laugh) I was watching it the whole time. [LB1032]

SENATOR CAMPBELL: They always try to add just a little bit more. Questions, Senator? And thankfully you have...we have your document here that we can take a look at. [LB1032]

NIC HORTON: Sure, and there's a lot of it that I didn't get to, so. [LB1032]

SENATOR CAMPBELL: Right. Senator Riepe. [LB1032]

SENATOR RIEPE: Thank you. I would ask you to finish with your conclusion, if you would, please. [LB1032]

NIC HORTON: Okay, sure, absolutely. So my final point would be that the cost of this private-option approach to the Medicaid expansion is really unpredictable. According to our estimates, if Nebraska opted into Medicaid expansion through the Arkansas model, the state will face more than simply higher per-person costs. They'll also likely see more able-bodied adults enroll in the program than ever imagined. In our state, Arkansas officials initially predicted that no more than 215,000 adults would ever enroll in Medicaid expansion. But by the end of the first year we had already exceeded that limit with more than 230,000 people enrolling. Within 18 months, enrollment hit nearly 300,000 adults, far more than the state estimated would ever even be eligible. As a result, more than 41 percent of all Arkansans are now on Medicaid, making Arkansas one of the most Medicaid-dependent states in the nation. And Arkansas is not an outlier here. In fact, last year we reviewed, at the Foundation for Government Accountability, the experiences of every expansion state with available data. We found that states exceeded their enrollment projections by a whopping 91 percent on average just in the first year. And in fact, in every state we reviewed, more able-bodied adults signed up than the state predicted would ever enroll. In many states, more people enrolled than states thought would ever even be eligible. Nebraska's own estimates of predicted enrollment have significantly increased over the years. Even the most recent estimates rely on similar methods to projections that have proven to be unrealistic in other states. This means policy makers should prepare for enrollment and expenditures to be even higher than the amounts currently expected. In conclusion, Obamacare's Medicaid expansion puts the truly needy at risk and an Arkansas-style expansion hurts them even more. This approach is more expensive than a conventional expansion. Its costs are uncontrollable and it prioritizes welfare benefits for able-bodied adults over care for the truly needy. Given the problems that have stemmed from this model, it is perhaps unsurprising that your neighbors in Iowa, which sought to replicate this approach for a portion of their expansion enrollees, was forced to scrap the model altogether last year. And even in Arkansas, state law now terminates the expansion altogether at the end of this year and the state has begun sending termination notices to enrollees informing them that the program is ending. I do not believe that this current proposal is right for your state. I hope you will instead pursue policies that protect the most vulnerable citizens, protect taxpayers, and create opportunities for adults who ultimately need jobs, not welfare. So thank you for the committee for allowing me to speak. [LB1032]

SENATOR CAMPBELL: Questions? Senator Crawford. [LB1032]

SENATOR CRAWFORD: Thank you. And thank you for coming... [LB1032]

NIC HORTON: Yes, ma'am. [LB1032]

SENATOR CRAWFORD: ...and sharing your story and your experience in Arkansas. When did the Arkansas private option begin? [LB1032]

NIC HORTON: January 1, 2014, is when the benefits began, yes, ma'am. [LB1032]

SENATOR CRAWFORD: So it's hard for me to understand why the private-option benefit in Arkansas then is to blame for Chloe losing her medication in 2012. [LB1032]

NIC HORTON: Sure, that's a great question. The point of that story is not that the private option is necessarily to blame. The point of the story is that there are a lot of folks--in fact, we have 3,000 folks in Arkansas right now--who are on Medicaid waiting lists. And so while we have folks waiting for care, we're adding nearly 300,000 folks who are able-bodied who should be working, should be pursuing economic advancement for themselves and gaining that insurance in the private market. We're giving them insurance while folks like Chloe, who depend on these programs to survive, aren't getting the care that they need. So I hope that clarifies. [LB1032]

SENATOR CRAWFORD: What kind of waiting list? [LB1032]

NIC HORTON: Intellectual and developmental disabilities. [LB1032]

SENATOR CRAWFORD: Waiting list, all right, which we have one of those. [LB1032]

NIC HORTON: Yes, yes. [LB1032]

SENATOR CRAWFORD: So, and I...it is...we did have some discussions with providers because the question about the balance between the new people and existing very vulnerable people has been an issue raised before. And many of those discussions we've talked to...when I've talked to providers, I find that people like Chloe have a different kind of provider than this new population coming in is likely to have. So the new people will be coming in and the providers they need to see will not be the kinds of providers that people like Chloe see because it's very different needs. And I've even asked that even in our rural parts of the state where I know, you know, that healthcare looks different. [LB1032]

NIC HORTON: Sure. [LB1032]

SENATOR CRAWFORD: But I appreciate you raising that caution for us to consider. Thank you. [LB1032]

SENATOR CAMPBELL: Senator Baker. [LB1032]

SENATOR BAKER: Thank you. I'm intrigued by your statement that 41 percent of all Arkansanins (phonetically)...how do you say it? [LB1032]

NIC HORTON: Arkansans, yes, sir. [LB1032]

SENATOR BAKER: ...Arkansans are now on Medicaid. Do you have any breakdown on that, like how many of those are children? [LB1032]

NIC HORTON: A large portion of them will be children, but I believe the total number is 1.2 million. About 300,000 of those are in the expansion, so those would all be adults. I could definitely get you more information on that. Those statistics come from the federal government. [LB1032]

SENATOR BAKER: Okay, thank you. [LB1032]

SENATOR CAMPBELL: Any other questions? Senator Riepe. [LB1032]

SENATOR RIEPE: Question, and thank you for being here. [LB1032]

NIC HORTON: Yes, sir. [LB1032]

SENATOR RIEPE: At one time in the discussion sometime today there was some talk and it's my understanding, correct me where I'm wrong, that elective abortions are available through the Arkansas plan. [LB1032]

NIC HORTON: Yes, that is correct, elective abortions and also Plan B, often referred to as the morning-after pill, is also available through the plans that are sold on the exchange. [LB1032]

SENATOR CAMPBELL: It's available here. [LB1032]

SENATOR RIEPE: Okay, thank you. [LB1032]

NIC HORTON: Yes, sir. [LB1032]

SENATOR CAMPBELL: That's in our current Medicaid plan. [LB1032]

SENATOR HOWARD: Right. [LB1032]

NIC HORTON: Well, and... [LB1032]

SENATOR CAMPBELL: A lot of Nebraska people don't realize that but it is. [LB1032]

NIC HORTON: Right, right, so I would say the point...my response to that would be that what you're considering then is expanding that benefit to more people, so you'd be expanding taxpayer-funded access to those abortion services. [LB1032]

SENATOR CAMPBELL: Any other questions? Thank you, Mr. Horton. [LB1032]

SENATOR FOX: I... [LB1032]

SENATOR CAMPBELL: Oh, I'm sorry. [LB1032]

SENATOR FOX: Sorry. [LB1032]

SENATOR CAMPBELL: Senator Fox, you're going to have to really get your hand out here. I need to... [LB1032]

SENATOR FOX: I'll have to jump up on the table next time. Again I'm going to ask you, just because I am concerned about sustainability... [LB1032]

NIC HORTON: Sure. [LB1032]

SENATOR FOX: And, you know, in your testimony you indicate here about, let me see here, yeah, the cost of expansion has far exceeded original projections, those states are now desperately looking for funding to pay the state share. And, you know, you've also mentioned the

fact that enrollment has far exceeded projections. I mean, yeah, I want to hear from you on your thoughts about the federal government's promise to be able to fund this. [LB1032]

NIC HORTON: Sure, that's a great question. We have actually an entire paper where we've outlined multiple instances of the federal government breaking their funding promises to states. But more specifically to this program, President Obama himself has specifically proposed in his budgets multiple times to reduce the funding rate back to the traditional match rate. And it's also something that Speaker Paul Ryan has shown support for. Even as recently as December, both chambers of Congress passed a bill that would have repealed all of the expansion funding and all of Obamacare and sent that bill to the President's desk. So it's something that I think is simply a matter of time before that funding goes away. [LB1032]

SENATOR FOX: I have another... [LB1032]

SENATOR CAMPBELL: What we're trying to determine here is, in Arkansas, is this for elective abortions? [LB1032]

NIC HORTON: Yes, elective abortions and for Plan B abortion drugs. [LB1032]

SENATOR CAMPBELL: Okay. Hmm. I'm curious. Senator Crawford and I are curious about this. [LB1032]

SENATOR CRAWFORD: So it was my...when you talk about so they mean elective abortion, are you talking about in the case of rape, incest, and the health of the mother? [LB1032]

NIC HORTON: Correct. [LB1032]

SENATOR CRAWFORD: You're calling that elective. [LB1032]

SENATOR HOWARD: Oh. [LB1032]

NIC HORTON: Correct. [LB1032]

SENATOR CAMPBELL: Oh. [LB1032]

SENATOR CRAWFORD: Yes. [LB1032]

SENATOR HOWARD: Oh. [LB1032]

SENATOR CRAWFORD: Okay, I just wanted to clarify that. [LB1032]

SENATOR HOWARD: Okay. [LB1032]

SENATOR CRAWFORD: So the federal Medicaid only allows the money to be spent if it is those conditions. So we're not talking elective--I would just like an abortion--we're talking only abortion in those instances, the rape, incest, or the health of the mother. [LB1032]

NIC HORTON: Yes, yeah, and I don't know if I used the word "elective," I'm sorry, but, yes, rape... [LB1032]

SENATOR CRAWFORD: Yes, you did use the word "elective." [LB1032]

SENATOR CAMPBELL: You did. [LB1032]

SENATOR HOWARD: You did. [LB1032]

NIC HORTON: Okay, I apologize...rape, incest, and life of the mother, and then Plan B, yes, ma'am. [LB1032]

SENATOR CAMPBELL: Thanks for clarifying that. [LB1032]

NIC HORTON: Sure. [LB1032]

SENATOR BAKER: A good distinction. [LB1032]

SENATOR CAMPBELL: All right. Thank you. [LB1032]

SENATOR RIEPE: I have a question. [LB1032]

SENATOR CAMPBELL: Oh, sorry, Senator Riepe. [LB1032]

SENATOR RIEPE: Thank you, Senator Campbell. Over the past few months or so we've been told that Medicaid expansion under ACA would create jobs. What's been your experience there in Arkansas? [LB1032]

NIC HORTON: Sure, that's something we hear a lot. Specifically in Arkansas, a firm that was hired by the hospital association predicted that there would be over 8,000 new jobs created just in the first year of the expansion. But in the first year of the expansion we actually saw about 650 hospital jobs lost and... [LB1032]

SENATOR RIEPE: Lost? [LB1032]

NIC HORTON: Yes, sir. And by June of 2015 that total number exceeded 800. So we went from being promised about 8,600 to in the hole about 800. So it's just something we see in a lot of states that I think there's an assumption that, well, all this federal money is going to start just flowing into the state and that's going to create an economic stimulus in a lot of states. And even in Iowa, as well, they promised about 2,400 jobs by this time and right now they've lost about 1,600. So it's something that we hear a lot but when you look at the data from the federal government, we just don't see those jobs coming to fruition. [LB1032]

SENATOR CAMPBELL: Okay. [LB1032]

SENATOR RIEPE: Okay, thank you very much. [LB1032]

SENATOR CAMPBELL: Thank you, Mr. Horton. [LB1032]

SENATOR FOX: I have a... [LB1032]

NIC HORTON: Thank you. [LB1032]

SENATOR CAMPBELL: Oh, sorry. [LB1032]

NIC HORTON: Oh. [LB1032]

SENATOR FOX: I guess I was supposed to jump up like I said I would last time. And in hearing about, again, all these increased costs, you know, the states that have implemented expanded Medicaid, and again going back to the federal government and sustainability, I'm trying to envision this pool of money, because that's always the selling point is that it's...you know, this is

money that we the taxpayers have already paid and the federal government has this money. But I'm thinking, well, if all these other states that have already expanded Medicaid, the costs are far exceeding the projections, what's happening to this pool? [LB1032]

NIC HORTON: Sure. Well, and actually all of the money that the federal government is spending on Medicaid expansion is derived from national debt. That's something that the Congressional Research Service has said. There's not just a pot of money sitting in Washington that's being divvied out and if Nebraska doesn't expand then all of a sudden Arkansas is going to get more. That's not really the way that it works. All of that money is being added to the national debt. [LB1032]

SENATOR FOX: Thank you. [LB1032]

SENATOR CAMPBELL: Okay, once again, any other questions here? [LB1032]

SENATOR FOX: I promise I'm done. [LB1032]

SENATOR CAMPBELL: Thank you, Mr. Horton. [LB1032]

NIC HORTON: Thank you. Thanks for having me. [LB1032]

SENATOR RIEPE: Thank you. [LB1032]

SENATOR CAMPBELL: Our next opponent. Okay, before we start, Elice, how are you doing? Okay. [LB1032]

MATT LITT: I was going to say it's...the marathon is very impressive (inaudible). [LB1032]

SENATOR CAMPBELL: I'm sorry? [LB1032]

MATT LITT: Oh, I'm just saying your...this committee's stamina is impressive. [LB1032]

SENATOR CAMPBELL: You should have been here on child welfare. We used to have hearings until 10:30 at night. [LB1032]

SENATOR BAKER: Okay, this is two nights in a row for me. [LB1032]

SENATOR CAMPBELL: See? Look at that. [LB1032]

MATT LITT: (Laugh) Yeah. Well, good evening, Chairwoman Campbell and members of Health and Human Services Committee. Thank you for the opportunity to speak. My name is Matt Litt, M-a-t-t L-i-t-t. I'm the Nebraska director of Americans for Prosperity, the nation's foremost free-market, grassroots advocacy group. Let me start by saying, as I've said in the past, that we all want Nebraskans to have more affordable and greater access to healthcare, yet we oppose the latest iteration of Obamacare's Medicaid expansion for the same reasons we have for the last three years. Our organization believes the Affordable Care Act was the wrong approach to healthcare reform. We should not further entrench and expand a law a majority of Nebraskans would rather see repealed. Proponents of the bill have publicly stated through articles and op-eds about this new, unique approach to Medicaid expansion. However, the problem is this is Medicaid expansion through and through. From the bill itself, in Section 4, the Transitional Health Insurance Premium Assistance Fund (sic--Program), or THIP, structure is created and gives away the secret that this program is not a unique Nebraska approach. The program hinges on a waiver, just as it has in every other state, and with it the same issues. The language of the bill itself makes clear we're not in the driver's seat and the program may not exist if the Legislature adopts the bill. THIP is at the discretion of the Centers for Medicare and Medicaid Services and only exists if the federal government allows it to. To say this is a unique, Nebraska-centric program ignores the reality that our state is not in control of healthcare reform under the ACA or the Medicaid expansion. Washington, D.C., is and this bill doesn't change the fact. In order to be in compliance with the federal ACA, as LB1032 prescribes in Section 3, mainly that expansion would offer minimum silver-tiered healthcare benefits...health coverage benefits to all newly eligible in the same exact manner that newly eligible would have been offered the same in LB577, LB887, and LB472, and now in this bill. Not Nebraska, nor any other state, has authority to change basics under Obamacare's Medicaid expansion (inaudible) who qualifies. These changes...excuse me, cannot change who qualifies. We cannot change the essential health benefit rules and we cannot change the funding sources. Proponents of the bill have focused on THIP's premium assistance fund for newly eligible with access to employer sponsored insurance. This in our view has created a false idea that THIP is simply a program to expand workplace insurance coverage when that is not the reality of the situation. There are no work requirements for Medicaid expansion under Obamacare and states aren't allowed to create them. In May 2015 a policy brief from the Center on Budget and Policy Priorities states, "Some state policymakers continue to propose linking Medicaid coverage to work or work-search requirements despite recent statements from administration officials that these requirements don’t belong in Medicaid. As we’ve explained, work requirements conflict with Medicaid’s purpose for (sic--of) providing...care to people who can’t otherwise afford it. In fact, work isn’t a requirement in any other health coverage program--individuals who get tax credits to help buy health coverage through the marketplace don’t have to work, nor do people who enroll in health coverage that their spouse’s employer offers." LB1032 constitutes...does not constitute a meaningful difference

from the expansion bills in the past and the Legislature has ultimately defeated the past three years. This is not intended to be a rebuke of Senator McCollister's good intentions. It is, instead, a rebuke of the system where the federal government has taken any meaningful role from states, local communities, and individuals to make real progress towards healthcare reform. See, there's not a role for the committee or Legislature or state to make actual plan that would be unique in Nebraska, and that's the problem and the disappointing aspect of what Obamacare has done to healthcare. It has taken the option of well-intended and innovative reform out of our hands. These other optional benefits, namely the employer-based coverage and assistance, and then the wraparound benefits prescribed in Section 3 will certainly come with increased costs. These increases in optional expenses are above and beyond what is required by straight expansion. These programs are, indeed, optional, thus the need for the CMS waiver, and will increase costs beyond the required federal benefits of straight expansion under the bill. Obamacare...oops. With Medicaid expansion the costs are not outweighed by the benefits, which are few. In state after state, Medicaid expansion has led to skyrocketing costs and has overwhelmed state budgets. States like Ohio and Illinois have expanded Medicaid and run millions of dollars in debts. State after state is seeing higher than expected enrollments. This bill is not a new approach to expansion. Obamacare clearly does not allow for new approaches to healthcare reform other than the top-down, D.C.-centric approach that has failed to control costs and offer innovative approaches to improve quality of care. We encourage this committee to oppose LB1032. [LB1032]

SENATOR CAMPBELL: Questions, Senators? Questions? Questions? Mr. Litt,... [LB1032]

MATT LITT: Yes. [LB1032]

SENATOR CAMPBELL: ...I just have one question. [LB1032]

MATT LITT: Yes. [LB1032]

SENATOR CAMPBELL: What suggestion would you make to serve the population that's in the gap? What should we do for them? [LB1032]

MATT LITT: Yeah. So one of the...a larger...a large issue is the requirements under Obamacare that force insurance plans who have grown in cost and what's been provided. We've said throughout, since the beginning of ACA, that we needed more market forces injected in there. We also look to our partners such as Platte Institute, think tanks around the country to develop those policies for us to advocate on. [LB1032]

SENATOR CAMPBELL: Okay. Senator Crawford. [LB1032]

SENATOR CRAWFORD: Yes, thank you. So do you have evidence that the insurance rate for this gap population was higher before Medicaid expansion options opened? [LB1032]

MATT LITT: The cost of insurance or the population... [LB1032]

SENATOR CRAWFORD: No, no, no, the insurance rate for this gap population... [LB1032]

MATT LITT: I'm sorry, I'm not clear on your question. [LB1032]

SENATOR CRAWFORD: So I think that what you said was that your...what should we do about the gap population. [LB1032]

MATT LITT: Um-hum. [LB1032]

SENATOR CRAWFORD: And what I'm hearing you say is reverse changes that were made in the Affordable Care Act. So I'm just trying to understand if we have any evidence that the rate, the insurance rate for this population, was higher. [LB1032]

MATT LITT: I don't have that off the top of my head. [LB1032]

SENATOR CRAWFORD: All right. [LB1032]

MATT LITT: I can get that and I can get that to you. [LB1032]

SENATOR CRAWFORD: I appreciate that. [LB1032]

MATT LITT: Yeah. [LB1032]

SENATOR CRAWFORD: Thank you. [LB1032]

SENATOR CAMPBELL: Anything else? Thank you, Mr. Litt. [LB1032]

MATT LITT: Thank you so much. [LB1032]

SENATOR CAMPBELL: Our next opponent, the patient man in the front row. Hi, Doctor. How are you? [LB1032]

EDWARD TRUEMPER: Fine. It's a pleasure to see all of you all. Some of you are personal friends; all of you are acquaintances. Anyway, thank you very much, Senator Campbell and the rest of you, for being so patient. I'm patient because I've wanted to hear what everybody else said before I fully gave my opinion. You didn't have a mix category, so I want to say that the senator... [LB1032]

SENATOR CAMPBELL: I'm sorry, sir. You need to state your name for the record. [LB1032]

EDWARD TRUEMPER: Oh, I'm very sorry, I'm very sorry. My name is Dr. Edward Truemper, E-d-w-a-r-d T-r-u-e-m-p-e-r. I'm a pediatrician practicing in Omaha and a pediatric critical care specialist. I am a faculty member at both medical universities. I'm also a professor at UNL. My opinions here are based solely on my own experience being on 23 different Medicaid programs, having practiced in five different states, and what I have seen over 30 years of practice. What I've heard today, almost 98, 99 percent has been based on care coverage and the illusion that care coverage actually leads to quality of care. And what I would like to talk about is a specific instance related to our current healthcare system with insurance and Medicaid. And this involves a family who has two children. They're both working. They have insurance. They have two kids. They have a third child--mother is taking care of herself very well through the pregnancy--and at birth is discovered to have multiple congenital anomalies, a number of them quite life threatening. Admitted to our hospital, admitted to my pediatric ICU, which is where I practice, and over the next three months we are dealing with these. The insurance carrier is absolutely fantastic through all of this. But we're still left with one remaining problem which, if not corrected, is going to kill the child. There's where the insurance became a problem. It took nearly ten months to get the treatment approved and it was a transplant. And the transplant that was needed was not out of the realm of what this insurance plan had done before. It had approved lots of different transplants before. It had given experimental...given coverage for hundreds of experimental treatments. In fact, it was an exceptionally good plan. It took ten months to get approval, ten months. On top of that, once we got approval, then there was six weeks of haggling over transport of the child by our care team to the other facility to get the transport...I mean to get the transplant. The equivalent of care per week, we could have rented a small passenger jet and taken that child as the sole passenger every week at the expense. The child, indeed, did get the transplant two weeks after arrival. Now, during the time that we waited for this child to get a transplant, the child developed an immune problem which led to us having to give treatment to try to correct that, which led to infections which were very difficult to abate. This child still got the transplant, came back, spent six months in our hospital, and subsequently died. The transplant, we found at autopsy, never took. I was outraged because what we found was the delay in getting approval led to this child's demise. Now you would say, wow, that insurance group was

very unfeeling. Well, that was Nebraska Medicaid. I see this all the time with our current Nebraska Medicaid where, for every person who was here who talked about needing healthcare coverage, I can point to one death for every person in here where there was a delay in care coverage. I can also point to it more often with private insurance. I can also point to situations where patients who are covered under Medicaid or private insurance who end up getting...who end up having a catastrophe and there's no knowledge to the healthcare...to the Medicaid system or to you all. We've got to improve the quality of care. And one of the problems I have with the current plan that is being proposed is we are going to glom on what I think is actually a quite effective program but with hundreds of new interrelationships. And in the process of doing these new interrelationships, we have no way of tracking the effectiveness of the care that we are purchasing. Last year we spent $1.83 billion to cover 254,000 people. When I looked at the 2014 plan, I mean the report, I find almost no metrics about the quality of the service. That's what the taxpayers in Nebraska are paying for. That's what's needed to be developed. You develop this plan, you get it approved, you high-five over it, and I will tell you this: Lives will still be lost, lives will still be in trouble, because within our current Medicaid system we have no way of tracking the effectiveness of that care or the lack of. Thank you. [LB1032]

SENATOR CAMPBELL: Senator Riepe. [LB1032]

SENATOR RIEPE: Dr. Truemper, thank you for being here and thank you for your patience. I'd like to have you expound a little bit more on what you visualize---obviously, you've done a lot of thinking about this--because I don't think there's anyone in here that wants to see anyone get damaged, get hurt, not get access. It's just trying to figure out the deal. Trying to listen to some ideas can be maybe helpful. [LB1032]

EDWARD TRUEMPER: I have one. Intermountain Healthcare, and I think most of you are familiar with Intermountain Healthcare, is a program in Utah. It's actually an affiliated group of 24, 26 hospitals, 325 clinics. It actually stretches about the same distance across the state of Utah as the entire state of Nebraska, 1.1 million covered lives. They have developed a program in which they have full coverage. They're spending $2,500 per individual covered life, saving 1,000 lives additionally because of their ability to access and look at data and then come up with best practices which are then disseminated to hospitals as small as 14 beds all the way up to the state teaching facility of 468 beds, including Primary Children's Hospital which is one of the best children's hospitals in the United States. I have talked to the director of that institution. They'd be more than happy to help us. They would love the opportunity to take on a state Medicaid program and be able to completely reform it based on the model that we have for our Medicaid. Why Utah's Medicaid hasn't bought into it? Actually they have. They're getting the indirect benefit of all of the improvements in their healthcare system because they're built into almost every hospital in the state. And so if you look at the aggregate for the entire state--the nation spends about $6,000 per individual for healthcare--in Utah, $2,650. [LB1032]

SENATOR RIEPE: How much? [LB1032]

EDWARD TRUEMPER: Twenty-six hundred and fifty dollars. We spend, if you look at Medicaid and the number of covered lives, it's about $6,500 a year. Now I would submit the reason that we spend more is because...several problems. The first one is the two biggest causes--morbidity and mortality--have nothing to do with a disease. It has to do with health illiteracy and noncompliance; and the root cause of those is situational. People assume that they are, because they feel well, that they are healthy. When I look at the medically fragile definition in this bill, it was a real eyeopener. I think it was in last year's bill as well, or one of your bills. I actually...I qualify as medically fragile. That's a real eyeopener. In my mind, if we were able to reduce what we expend on our current Medicaid population, could we actually cover all of these other lives? It doesn't address the issue of what do we do today, which is what you brought up, Senator Howard. But the way that we keep going is we just keep throwing more money, more money, more programs, and we never look at quality. And I do think that Senator McCollister, I am very happy he instituted this bill because I saw something in that...two things in that bill which I thought were fundamentally important. The initial preamble is the finest one--on the first page--of any healthcare bill I've ever read. The second was the next to the last page in which it talks about metrics and all those metrics are very basic. But they're there. The problem is closing the loop on those to turn around, to drill down, so we know what to do with each and every patient. One of the reasons I moved to Nebraska was because I found Nebraskans to be really smart people on average. And I think we can fundamentally solve this problem. But what we're going to need to do is drive the politics out of this and actually, fundamentally, look at what is it that actually gives us health. And I can tell you that I thought about bringing one of my textbooks in and saying, okay, I've got 6,200 diseases I have to treat with these medical treatments, not a single one says, "money." But what they do require is a system of care. It also requires knowledge by the individual. And as Senator McCollister mentioned many hours ago, a real important point is folks taking responsibility of their care. We've got issues, which you are trying to address I think, in H.R. 185, which is the issues of mental health, and I congratulate you on that. But that's been a problem for how many decades and now we're just getting to this? Nah, I shouldn't say just getting to this, but I've seen a lot of talk and doggone little action. Okay. The other problem is we're talking about building these patient-centered medical homes and it's for this group, mandating for this group, and yet the 77,000 covered lives that you have are going to be the minority in any practice yet you're going to completely change people's practices. I can tell you right now one in two physicians suffers burnout. They're not performing optimally. We need to figure out a way to get the regulatory burden off of these folks and let them practice. I'm sorry for the very long-winded answer because it's a very problematic issue. And as one of my professors once said, Ed, you never say anything in a sentence when a paragraph will do (laughter). [LB1032]

SENATOR CAMPBELL: Anything else? Senator Crawford. [LB1032]

SENATOR CRAWFORD: Thank you, Chairwoman Campbell, and thank you for being here, Doctor. And I would say you're singing to the choir in terms of wanting metrics and data to help us make better decisions. And we've argued for that. Senator Gloor, who has been on this committee, has long been arguing for that. I am excited we're hearing for it from Director Lynch that he's hired somebody to help in that capacity. And so we're looking forward to hopefully seeing some improvement there, but absolutely critical that we have better data to help us drive these decisions. And I say amen to that. [LB1032]

SENATOR CAMPBELL: Senator Riepe. Oh, sorry, you had a question. [LB1032]

SENATOR CRAWFORD: But, okay, sorry. Oh, that's all right. I did have a question. So is your...when you look at use of data and use of data to improve care, are you seeing that in the private-sector health plans that you work with? Are you seeing data and results back from them to help you feel... [LB1032]

EDWARD TRUEMPER: No. [LB1032]

SENATOR CRAWFORD: ...any more confident that they're using that? [LB1032]

EDWARD TRUEMPER: No. [LB1032]

SENATOR CRAWFORD: Okay. [LB1032]

EDWARD TRUEMPER: No, I'm not. We're driving that ourselves. I will tell you the one thing to address that on a side issue. Medicaid, Medicare was paying for complications and they said, oh, hey, we're not going to pay for central line infections, hospital-acquired infections. And suddenly hospitals said, oh, my gosh, we've got to set up programs to help prevent that because it's costing us money. I was involved in one of those. Boy, it's amazing what hospitals will do when you stop paying them for things. [LB1032]

SENATOR CRAWFORD: Thank you. [LB1032]

SENATOR CAMPBELL: Senator Riepe. [LB1032]

SENATOR RIEPE: I think he's picking on hospital administrators, but thank you very much. [LB1032]

EDWARD TRUEMPER: Not yet. [LB1032]

SENATOR RIEPE: Not yet. The question that I have...I think we're going into seven-year agreements on managed care organizations. My question gets to be is, I'm not that patient so that if you looked at an Intermountain pilot model, you know, and we...there's a lot of dialogue between now and then of trying to look to getting out of the sick side of the business and getting into the...on the positive side of it best we can, what's the option and not waiting until it's all run out? Could we start a pilot? [LB1032]

EDWARD TRUEMPER: What I would do is I would ask Senator Crawford to pick up the phone tomorrow and call. You're one of the leaders of this. Why not pick up the phone--you, too--why not this entire committee commit to that and get that program here next year? I would be happy to help you all write that bill. [LB1032]

SENATOR RIEPE: I suppose we start with unified education, you know. I mean there's...I'm not looking to go to Utah, but I'm saying, can we bring other people in to talk with us? I don't know. That's probably something that, not during this session, no, I'm not going to do it. [LB1032]

EDWARD TRUEMPER: President Obama, on March 1, 2009, in a speech to the nation said that Intermountain Healthcare was the model that we should go to, or Mayo Clinic or Geisinger Clinic (sic--Medical Center). And the reason I liked Intermountain Healthcare was, before I busted my knee, I used to like to ski. But I'd been there the most. I'd seen their program in action. And they were doing systems care, protocolized care to that gauge before anyone else was doing it meaningfully. They've figured it out. We don't have to redevelop the wheel. We don't have to redevelop the machine. It's all there and we could bring everybody...now I'm delving into politics. I'm on the edge of the cliff now. But why can't we adopt a model like this, get a Medicaid waiver, and actually cover everybody? We could have universal coverage and guess what? We would save money and we'd save a lot of lives too. [LB1032]

SENATOR CAMPBELL: Doctor, I'm going to... [LB1032]

SENATOR RIEPE: Okay, thank you. [LB1032]

SENATOR CAMPBELL: We're drifting here. [LB1032]

EDWARD TRUEMPER: I'm sorry. [LB1032]

SENATOR CAMPBELL: It's quite all right. [LB1032]

SENATOR RIEPE: Yes, we are. [LB1032]

SENATOR CAMPBELL: Thank you for your testimony today. [LB1032]

EDWARD TRUEMPER: Thank you. [LB1032]

SENATOR CAMPBELL: Do you want to be listed as an opponent or neutral? That was the question from legal counsel. [LB1032]

EDWARD TRUEMPER: Well, the question is, I was pro, I was con, and I was neutral, so... [LB1032]

SENATOR CAMPBELL: It's your choice. [LB1032]

EDWARD TRUEMPER: Well, let's just say neutral because mixed would be the most accurate one. [LB1032]

SENATOR CAMPBELL: Thank you, Doctor, appreciate it very much. [LB1032]

EDWARD TRUEMPER: Thank you all for your time and I appreciate you all's patience with me. [LB1032]

SENATOR CAMPBELL: Always good to see you. [LB1032]

SENATOR RIEPE: Thank you. [LB1032]

SENATOR CAMPBELL: Okay, I'm going to ask whether there is an opponent or neutral. All right, Senator McCollister, we are back to you. Elice, do you want to read the letters for the record while Senator McCollister is coming forward? [LB1032]

ELICE HUBBERT: (Exhibits 40-81) I have quite a number of them. A list of organizations or associations who sent letters of support: the AARP; the American Cancer Society; the American Heart Association; Brain Injury Association of Nebraska; Center for Rural Affairs; Children and Family Coalition of Nebraska; the city of Lincoln; the League of Women Voters of Lincoln-Lancaster County; the March of Dimes; the National Multiple Sclerosis Society; Nebraska Aids Project; Nebraska Association of Behavioral Health Organizations; the National Association of Social Workers, Nebraska Chapter; Nebraska Child Healthcare Alliance; Nebraska Restaurant

Association; Nebraska Retail Federation; Nebraska Rural Health Association; Nebraska Speech-Language-Hearing Association; Nebraska State AFL-CIO; Nebraska State Education Association; the Public Health Association of Nebraska; Together Omaha; Voices for Children; The Arc; Nebraska Pharmacists Association; Disability Rights Nebraska. A number of individuals sent letters of support: Dr. Brady Beecham of Lexington; Paula Cellar of Omaha; Denise Dickeson of Lincoln; Ruth Firley of Lincoln; Erica Harder of North Platte; Michael Johnson of Grand Island; Tim Kolb, Franklin; Marti Manley, Milford; Kristi Martin, Omaha; Vicky McKimmey, Grand Island; Dan Mostek, Boelus; Ashley Oviatt, Nickerson; Vickie Young, Omaha; Donald Zebolsky, Omaha; Patty Clark, North Platte. And I had a neutral letter from Steve Bowen of the Nebraska Occupational Therapy Association. [LB1032]

SENATOR CAMPBELL: Thank you, Elice. Senator McCollister. [LB1032]

SENATOR McCOLLISTER: Chairwoman Campbell and members of the committee, thank you for your patience and diligence. I am quite impressed; in fact, your reputation is well earned as a hardworking committee. Want to thank my good friend Ed Truemper for the few compliments that I got today (laughter). We've heard about McCollister's good intentions gone awry. But I must say that some of the best minds in Nebraska have helped with this project. A few of the members of this committee were involved, AARP, Appleseed, and this effort is a result of their hard work. So I'm grateful to them. Senator Fox, I need to give you a better answer with regard to your sustainability question. When the ACA was passed it was budget neutral, which means that they increased taxes and reduced reimbursement rates for hospitals in order to finance this. So, yeah, this is budget neutral. It didn't add to the deficit so, you know, with that remark I think we can hopefully settle your mind on that one. And the fact that we're sending money to Washington with our taxes and reduced reimbursements, that was the business case that most of the business leaders in Omaha said we need to bring this $2.1 billion back to the state where it can do some good, so. And we've found some...a good reception for that argument. Second, there is a state and federal partnership that I think most of us are aware of. The state currently gets 25 percent of its budget from the federal government. Nebraska's budget is approximately $4 billion a year. That's a billion dollars. Fifty percent--50 percent--of the HHS budget comes from the federal government. So, yeah, we have a pretty established partnership. When the tough times came in 2008, federal government came through with $500 million for the stimulus. So I'd love to have that kind of partnership. They're good partners and I think we can depend on them. In my opening comments I said it's not enough to be critical of our bill, LB1032. If you don't...if you want to criticize it, fine, but come up with alternatives that are better and cheaper, and I have yet to see anybody do that. So this alternative is the best option standing and we need to continue that, although I have to say I found some of the constructive comments from the Governor, Director Lynch, even Jim Vokal, my friend Jim Vokal at the Platte Institute, we are all searching for ways to deal with this Medicaid gap, the 77,000 poor working Nebraskans that don't have any coverage. Finally, we heard some poignant, heartfelt testimony today, people whose lives are

impacted by the fact that they don't have healthcare coverage. We can make a difference in the lives of those people and 49 state senators can make that happen. So I would encourage you to move this through committee and we can get it on the floor and get it passed. And with that, I'm very grateful and would be happy to answer to any questions you may have. [LB1032]

SENATOR CAMPBELL: Thank you, Senator McCollister. Questions? Oh, they're just worn down. [LB1032]

SENATOR McCOLLISTER: Go home. [LB1032]

SENATOR HOWARD: Oh, no, not yet. [LB1032]

SENATOR CAMPBELL: No, we cannot go home (laughter), because we have another bill. [LB1032]

SENATOR CRAWFORD: Another bill. [LB1032]

SENATOR McCOLLISTER: You are kidding. [LB1032]

SENATOR CAMPBELL: No. [LB1032]

SENATOR HOWARD: Step aside, McCollister. [LB1032]

SENATOR McCOLLISTER: I know where I'm going. [LB1032]

SENATOR CRAWFORD: I didn't think you were really happy to answer more questions. [LB1032]

SENATOR CAMPBELL: I don't think we have any testifiers for this bill but we have another bill. [LB1032]

SENATOR McCOLLISTER: No, no. [LB1032]

SENATOR RIEPE: Is he welcome to stay if he wants to? [LB1032]

SENATOR HOWARD: Yeah, you can stay if you want to. [LB1032]

SENATOR CAMPBELL: My daughter is trying to call me. Okay. [LB1032]

SENATOR HOWARD: This is going to be so fast. [LB1032]

SENATOR CAMPBELL: I'm hopeful. [LB1032]

SENATOR HOWARD: Wonderful. [LB1032]

SENATOR CAMPBELL: All right, that concludes the public hearing on LB1032 and we'll open the hearing. If you are leaving, please leave as quietly as you can. We'll open the hearing on LB696, Senator Howard's bill to provide for a Medicaid state plan waiver to provide coverage for treatment of opioid abuse. Senator Howard. [LB1032]

SENATOR HOWARD: (Exhibits 1 and 2) Thank you, Senator Campbell, and good evening. I had to cross off "good afternoon." I am Senator Sara Howard. For the record, that is spelled S-a-r-a H-o-w-a-r-d, and I represent District 9 in midtown Omaha. Today I'm here to present you with LB696, a bill that would instruct the Department of Health and Human Services to apply for a federal waiver to provide treatment for opioid addiction to Medicaid recipients. I would like to note that I have not invited any testifiers because, for me, when I started the conversation about prescription drug monitoring and really figuring out a way to help providers deal with individuals who are addicted to opioids, I got a lot of feedback that said, that's great but now we also need to talk about substance abuse and rehabilitation services. And so this is the beginning of a larger conversation that serves as a follow-up to prescription drug monitoring. You know, as we identify individuals who have opioid addiction, we also need to make sure that there are some resources in our state for them to receive rehabilitative services. And the idea of this bill actually came from a Medicaid boot camp that I went to that was sponsored by the Council of State Governments. And the suggestion for the waiver came from...Vikki Wahcheeno (phonetically), Wakeeno (phonetically) (sic--Wachino)? I don't know how to pronounce her name, but she's the director of CMS and she said we have this waiver out here that only one state has taken us up on and it really looks to provide a holistic view of substance abuse specific to opioid addiction. And I think all of us in the room know about opioid addiction and overdoses. We've been there, done that, so I won't go too much into that. California is the only state that's taken them up on this waiver. They're also an expansion state. And so when you look at the population that we would be covering with a rehabilitation waiver, it would predominantly be low-income pregnant women. And what's concerning is that we're seeing a rise in babies who are born already addicted to opioid and narcotic medications. If you Google it, it's pretty terrifying, but there are pictures of babies who are literally going through withdrawal and they're shaking because they were born already addicted to opioids. What they have is called NAS, or neonatal abstinence syndrome. It's a condition where they're already born addicted and it causes uncoordinated

sucking reflexes making feeding difficult, extreme hyperactivity of the central nervous system. And symptoms of withdrawal can begin any time in the first two weeks but usually within 72 hours after they're born. According to the National Institute on Drug Abuse in 2012, newborns with neonatal abstinence syndrome stayed in the hospital an average of 19 days compared to 2.1 for a normal newborn, costing hospitals about $1.5 billion. The majority of these charges, 81 percent of them, were paid by Medicaid. And so if we consider rehabilitation as a preventive measure for the population that we currently serve, that's what we're looking at. Around-the-clock care for an infant with neonatal abstinence syndrome can cost between $39,000 to $53,000. And this can be a problem for an already addicted mother, especially since addiction may have already caused her financial hardship, the reason why she's on Medicaid in the first place. So what's interesting is that in bringing this bill I got to have a chance to work with our good friend Calder Lynch. And the great news is that, while there are three components to opioid and substance abuse rehabilitation, two of them are already covered or going to be covered, which is really exciting. So the first is medication assistance. That includes administration of methadone, byoo (phonetically)--I can't pronounce this one, so--byooproneph...norphine (phonetically) (sic--buprenorphine)--where is Dr. Truemper?--naloxone, or injectable naltrexone. So we cover naloxone and injectable naltrexone. But for methadone we only cover it for a diagnosis of pain, not a diagnosis of opioid addiction, so we would need to change that diagnosis code. The second component is substance abuse counseling. That is completely covered in our Medicaid system. And the third component is peer support services, and I would direct you to the technical letter that we received from the department where they write in the third paragraph that they are planning on submitting a state plan amendment for peer support services in the near future. They told us they were trying to aim for fall of this year. So the third component of this would be completely covered, which is very exciting. I've read the fiscal note. As usual, some of our fiscal notes are a little bit challenging for us. The challenge with the fiscal note in this instance is that they don't note the number of people who they think would benefit from this service or the cost of, specifically, the methadone. So they're already on the path to peer services. They already have substance abuse counseling. Really what we need is the diagnosis code for methadone. And so I appreciate your time and consideration. It's a really long day. We've passed out a few handouts about neonatal abstinence syndrome and the importance for the specific Medicaid population that we cover to receive robust opioid and substance abuse rehabilitation treatment. And with that, I will close. I am happy to answer any questions you may have. [LB696]

SENATOR CAMPBELL: Any questions? Senator Riepe. [LB696]

SENATOR RIEPE: Thank you, Senator Campbell. Thank you, Senator Howard. I may be the only one. I don't think I have a fiscal note encased in the information that I received. That could be my problem because there's a lot of things going on. [LB696]

SENATOR HOWARD: I can give you mine. [LB696]

SENATOR CAMPBELL: Yeah, I've got one too. [LB696]

SENATOR RIEPE: Okay, I'm...I don't know why I missed it. Did I take your last one? [LB696]

SENATOR HOWARD: Oh, it's okay. [LB696]

SENATOR RIEPE: Okay, thank you. Thanks. Okay. My other question, and it's in Calder Lynch's letter, it says, and maybe I'm just reading part of this, it says, "Because certain components of treatment of opioid abuse are currently covered under Medicaid and the additional components could be covered under the state plan, a demonstration project would not be necessary." Is he saying that this is simply taking, like, the existing program that they've got for some of these addictions and just, you know, instead of a special program it's just an expansion? I don't know enough about this particular bill. [LB696]

SENATOR HOWARD: Sure. So the department interpreted the waiver that was proposed in the bill as an 1115. But what Vikki Wachino recommended was an 1113, which is a slightly different waiver. That's more of a supplemental service type of waiver. And in California they were doing it to really make some robust changes to their substance abuse and rehabilitation services, which is not something that we would necessarily need to do. [LB696]

SENATOR RIEPE: Okay. I know we're always talking that, you know, like, while everybody else is doing it we should do it. Sounds like nobody else is doing it and we should do it, so. [LB696]

SENATOR HOWARD: I actually think it's because nobody knows that it's out there. [LB696]

SENATOR RIEPE: Oh, really. Is this a grant or is this... [LB696]

SENATOR HOWARD: It's... [LB696]

SENATOR RIEPE: Is there any grant money? [LB696]

SENATOR HOWARD: It's not a grant because it's a waiver, so there would be a different type of match for this service. [LB696]

SENATOR RIEPE: Yeah, so it's our real money. [LB696]

SENATOR HOWARD: It's real money, yes. [LB696]

SENATOR CAMPBELL: Yeah, it's real money. [LB696]

SENATOR RIEPE: Thank you. [LB696]

SENATOR CAMPBELL: There's an article, and I'll try to find it for you, Senator Howard, because I sent it to Calder Lynch and asked him to outline what was covered, and it had to do with opioid but it wasn't with pregnant or young mothers. [LB696]

SENATOR HOWARD: Yeah. [LB696]

SENATOR CAMPBELL: It was something else. And he said that he would be looking at your bill and working with you. So I'll get you that article because it would be nice for your files to have. [LB696]

SENATOR HOWARD: Thank you. [LB696]

SENATOR CAMPBELL: Anything else? Senator Crawford. [LB696]

SENATOR CRAWFORD: Thank you, Chairwoman Campbell. You had mentioned the newborn challenge. Now is there a part of the waiver that stresses that population? [LB696]

SENATOR HOWARD: You know, newborns would already be covered. [LB696]

SENATOR CRAWFORD: Okay. [LB696]

SENATOR HOWARD: And so that type of service would already be covered for them. This type of service is really geared towards the adult population. [LB696]

SENATOR CRAWFORD: Okay. [LB696]

SENATOR HOWARD: And because we have such a small adult population, we wouldn't see it impacting the newborns so much unless it was geared towards prevention for pregnant mothers. [LB696]

SENATOR CRAWFORD: Just one other follow-up question. [LB696]

SENATOR CAMPBELL: Sure. [LB696]

SENATOR CRAWFORD: Is this something like fetal alcohol syndrome where if there's exposure in the womb it has consequences later on? [LB696]

SENATOR HOWARD: Absolutely, yes. [LB696]

SENATOR CRAWFORD: So is there any part of this waiver or what you're envisioning that has some kind of a screening or a component? [LB696]

SENATOR HOWARD: You know, there has been a shift in the medical community towards more screenings during prenatal care visits around not just elicit drug abuse but also what other medications are you taking. But we're starting to see that...and that type of screen is more of a formality. It's not really a billable the way that you would think of one. [LB696]

SENATOR CRAWFORD: Okay. [LB696]

SENATOR HOWARD: It's more like an SBIRT, like a brief intervention type of model that's not really billed. Does that make sense? [LB696]

SENATOR CRAWFORD: Yeah, thank you. [LB696]

SENATOR HOWARD: Okay, sorry. [LB696]

SENATOR CAMPBELL: Senator Riepe. [LB696]

SENATOR RIEPE: Thank you, Senator Campbell. Can you help me a little bit just in terms of because this went to a pretty steep fiscal note real fast. [LB696]

SENATOR HOWARD: Oh, I know. [LB696]

SENATOR RIEPE: So, okay, like what...does it entail a building? [LB696]

SENATOR HOWARD: Yeah, I couldn't say. My guess is that the predominant amount in the fiscal note is for that peer support service that is...that they're already planning on putting into a state plan amendment without any sort of legislative work. [LB696]

SENATOR RIEPE: A peer support group? [LB696]

SENATOR HOWARD: Well, it's...peer support counseling is part of a robust substance abuse and rehabilitation program. [LB696]

SENATOR RIEPE: Aren't those volunteers? [LB696]

SENATOR CAMPBELL: No. [LB696]

SENATOR HOWARD: No, I believe they can bill out... [LB696]

SENATOR CAMPBELL: (Inaudible). [LB696]

SENATOR HOWARD: The regions have been doing some peer work as well, which the fiscal note doesn't reflect any type of savings in the regions as well. So really, when you drill down to the only thing that we're missing is being able to pay for methadone with a diagnosis of opioid addiction, that's the only thing we're missing--pretty good! [LB696]

SENATOR CAMPBELL: But Senator Howard is not planning to go forward with the bill. [LB696]

SENATOR HOWARD: No, I am not planning on going forward with this bill. [LB696]

SENATOR RIEPE: Oh. [LB696]

SENATOR HOWARD: I wanted to get a feel for the cost. Next year we'll try again with a much more tailored approach because truthfully I didn't know anything about opioid rehabilitation because we never got there with my sister so we never really knew what the components were. But this is a conversation that we'll have to have now that prescription drug monitoring has moved forward. [LB696]

SENATOR CAMPBELL: Yeah. [LB696]

SENATOR RIEPE: Okay. I'll be quiet. [LB696]

SENATOR HOWARD: Oh, it's...ask away. [LB696]

SENATOR CAMPBELL: No, I mean it's just a step-by-step process of it's also what they do on the state plan amendment. So we'll see what the department does also. [LB696]

SENATOR HOWARD: Exactly. [LB696]

SENATOR CAMPBELL: But, yeah, it's a bill for 2017... [LB696]

SENATOR HOWARD: Um-hum, um-hum. Any other questions? [LB696]

SENATOR CAMPBELL: ...coming back. All right, going, going, gone. [LB696]

SENATOR HOWARD: I'm surprised I got any. Okay. [LB696]

SENATOR CAMPBELL: Seeing no one else in the hearing room to testify, and Senator Howard wisely waives closing, we are done. [LB696]

ELICE HUBBERT: I do have some letters. [LB696]

SENATOR HOWARD: Oh, there are letters. [LB696]

SENATOR CAMPBELL: Oh, letters! [LB696]

SENATOR HOWARD: Oh, people like it (laughter). [LB696]

ELICE HUBBERT: (Exhibits 3-8) We do have letters. We have lots of letters. Today for LB696 we have letters of support from: the Children and Family Coalition of Nebraska; the National Association of Social Workers, the Nebraska Chapter; the National Medical Association; Nebraska Pharmacists Association; Donald Zebolsky of Omaha; and a neutral letter from Calder Lynch, director of DHHS Division of Medicaid and Long-Term Care. [LB696]

SENATOR CAMPBELL: All right, trust me, anything else? Okay, we're done. We will Exec tomorrow afternoon. Be sure you take a look at the bills that were sent out in the e-mail. All right? [LB696]