MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON HEALTH AND HUMAN SERVICES

Seventy-Seventh Session
February 6, 2013

The Committee on Health and Human Services was called to order by Chair Marilyn Dondero Loop at 1:33 p.m. on Wednesday, February 6, 2013, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at nelis.leg.state.nv.us/77th2013. In addition, copies of the audio record may be purchased through the Legislative Counsel Bureau's Publications Office (email: publications@lcb.state.nv.us; telephone: 775-684-6835).

COMMITTEE MEMBERS PRESENT:

Assemblywoman Marilyn Dondero Loop, Chair
Assemblywoman Ellen B. Spiegel, Vice Chair
Assemblywoman Teresa Benitez-Thompson
Assemblyman Steven Brooks
Assemblyman Wesley Duncan
Assemblyman Andy Eisen
Assemblywoman Michele Fiore
Assemblyman John Hambrick
Assemblyman Pat Hickey
Assemblyman Joseph M. Hogan
Assemblyman Andrew Martin
Assemblyman James Oscarson
Assemblywoman Peggy Pierce
Assemblyman Michael Sprinkle

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

None

STAFF MEMBERS PRESENT:

Kirsten Bugenig, Committee Policy Analyst
Risa Lang, Committee Counsel
Harle Glover, Committee Manager
Janel Davis, Committee Secretary
Terry Horgan, Committee Secretary
Macy Young, Committee Assistant

OTHERS PRESENT:

Michael J. Willden, Director, Department of Health and Human Services
Jon Hager, Executive Director, Silver State Health Insurance Exchange

Chair Dondero Loop:
[Roll was called. Rules and protocol were stated.] Welcome to the first meeting of the Assembly Committee on Health and Human Services. The Assembly will use the web-based system called Nevada Electronic Legislative Information System (NELIS) to make the exhibits more accessible during our meetings. We require all exhibits to be submitted in an electronic format no later than 5:00 p.m. the day before the meeting. These can be submitted to the Committee Manager or the Committee Policy Analyst. This is important to me because our staff works very hard to prepare these documents in time for our meetings.

I would like to start with introductions of our Committee members. I am Assemblywoman Marilyn Dondero Loop representing Assembly District 5 in Clark County. This is my first time as Chair of this Committee and my third legislative session. I am honored to serve as Chair of this Committee and look forward to learning more about a variety of topics that encompass health and human services. I would like to recognize my Vice Chair, Assemblywoman Ellen Spiegel, who is serving her second session, both in the Legislature and on this Committee. There are five other returning members who have also served on this Committee: Assemblywoman Teresa Benitez-Thompson, Chair of the Assembly Committee on Government Affairs; Assemblywoman Peggy Pierce, Chief Deputy Majority Whip, who has the longest tenure on this Committee; Assemblyman Steven Brooks, Assemblyman John Hambrick, and Assemblyman Pat Hickey, the Minority Floor Leader. Please join me in welcoming our seven new Committee members: Assemblyman Andy Eisen, Assemblyman Andrew Martin, Assemblyman Michael Sprinkle, Assemblywoman Michele Fiore, Assemblyman Wesley Duncan, and Assemblyman James Oscarson, all of whom are freshman legislators, and Assemblyman Joseph Hogan who has served five legislative sessions.

Next, I would like to introduce our Committee staff who are invaluable in helping us process all the measures that come before the Committee. I would like to welcome back Kirsten Bugenig, our Committee Policy Analyst from the Research Division of the Legislative Counsel Bureau. Next our Committee Counsel, Risa Lang, who has served in 11 regular sessions. Our Committee Manager and my personal attaché is Harle Glover. Mrs. Glover has an impressive service of 19 sessions. Taking our minutes today is our Committee Secretary, Janel Davis, who worked with me last session. Our other Committee Secretary is Terry Horgan who also brings many years of service with seven regular sessions. Lastly, our Committee Assistant is Macy Young. I would like each member to introduce him or herself.

Assemblywoman Pierce:
I represent Assembly District 3 in Clark County. This is my sixth time on this Committee and my last term. It is wonderful to be here. We have a lot of important work ahead of us, so it is an exciting time to be serving.

Assemblywoman Spiegel:
I represent Assembly District 20 in Clark County. For those of you who know Clark County, it starts at the Galleria Mall in Henderson, Nevada, and goes up to the intersection of Flamingo Road and Maryland Parkway.

Assemblyman Hogan:
I represent Assembly District 10 in Clark County. I find health and human services to be one of the most important and challenging topics we deal with. I am very encouraged to have active medical support on our team.

Assemblywoman Benitez-Thompson:
I represent Assembly District 27 in Washoe County. I feel very privileged to return to this Committee.

Assemblyman Hickey:
I represent Assembly District 25 in Washoe County. This is my third session and the second time on this Committee. This Committee will be very important, especially with the Medicaid expansion and other issues we will be dealing with.

Assemblyman Duncan:
I represent Assembly District 37 which is in Clark County. It is my first time on this Committee, and I am very excited to be with these members and to tackle the many tough issues we are going to face.

Assemblyman Martin:
I am honored and privileged to be here. I represent Assembly District 9 in Clark County. I am a certified public accountant. I have also been a controller of a medical consulting firm and have had some experiences as a federal government auditor, auditing the Medicare Payment Advisory Commission (MedPAC). I agree that this is one of the most important committees. I look forward to helping our state implement the changes that are forthcoming.

Assemblywoman Fiore:
I represent Assembly District 4 in Clark County. As a Chief Executive Officer of two home health care agencies, I am very excited to be on this Committee to make sure our constituents get what they need.

Assemblyman Sprinkle:
I represent Assembly District 30 in Washoe County. I am excited to be on this Committee. I have spent over 20 years in emergency medicine.

Assemblyman Oscarson:
I represent Assembly District 36, an area of about 26,000 square miles. I am honored to be here to represent the rural communities and all Nevadans. I have approximately 20 years in health care, from nursing to hospital administration. I look forward to the challenges and opportunities we are going to face.

Assemblyman Eisen:
I represent Assembly District 21 in Clark County. I am a native Nevadan, a pediatrician, and a medical educator. It is my first term in the Assembly and on this Committee. We have a lot of challenges ahead of us in this area. I think we are up to the task.

Assemblyman Hambrick:
I represent Assembly District 2 in Clark County. I am also Chairman of the State of Nevada Juvenile Justice Commission. I have a particular interest in this Committee. It is my third time on this Committee, and I look forward to serving.

Assemblyman Brooks:
I represent Assembly District 17 in Clark County. I am proud to be here today. This is the most important committee in all of the Legislature. Mr. Willden, you have done a fantastic job. Let us get all of those homeless people some health care. It is the right thing to do. That is my goal this session.

Chair Dondero Loop:
I am an educator by trade, but education and health care go hand in hand. Our first order of business is the adoption of the Committee's policies (Exhibit C). These policies are consistent with the Assembly Standing Rules, but contain a few additional policies that are useful to make the Committee more efficient. You should familiarize yourself with the Assembly Standing Rules that govern committees, which were adopted on Monday, February 4, 2013. An outline of those specific rules has been included in your handouts for your convenience (Exhibit D). I would like to mention Rule No. 53 which states that the lobbyists, the press, and the members of the public are not allowed at the dais. Are there any questions about the Committee's policies? [There were none.] I will entertain a motion to adopt the policies.

> ASSEMBLYMAN SPRINKLE MOVED TO ADOPT THE ASSEMBLY COMMITTEE ON HEALTH AND HUMAN SERVICES 2013 COMMITTEE POLICIES.
>
> ASSEMBLYMAN BROOKS SECONDED THE MOTION.
>
> THE MOTION WAS ADOPTED UNANIMOUSLY.

Chair Dondero Loop:
I want to emphasize the importance of courtesy in dealing with fellow members of this Committee, staff, and all persons who testify before us. I encourage discussion on the topics by all members and hope we can recognize that while there may be times we disagree on viewpoints, we will continue to be respectful of each other and our staff while in this room. Next, our policy analyst, Kirsten Bugenig, will present the Committee Policy Brief.

Kirsten Bugenig, Committee Policy Analyst:
This is my second legislative session and second time staffing this Committee. I look forward to assisting the Chair and all of you in any way that I can. As nonpartisan staff of the Legislative Counsel Bureau, I can neither oppose nor advocate for any legislation. My role is to assist the Committee in processing the many bills referred to the Committee, while providing policy and research needs to help you make informed decisions about the topics of health and human services.

In front of you is a copy of the Committee Policy Brief (Exhibit E). I want to highlight a few items. Page 2 is where you will find the session deadlines which often dictate the pace of the Committee's workload. There is also an explanation about exempt bills. Exempt bills are unique, and we must pay attention when looking at Committee deadlines. To provide more of a history of

what the Committee has seen before as far as the workload, you will see a chart on page 3 that shows the number of bills referred to this Committee. In the 2011 Legislative Session, we had 70 bills that were referred to this Committee, which resulted in 52 bills that became law. In regard to the jurisdiction of health and human services, it covers a wide range of topics from children, seniors, mental and public health, to food and drugs. Some of those are outlined for you on page 3.

I have included the number of vetoed bills from last session and the prefiled bills we have received so far. Both the Assembly and Senate bills are listed. These measures may come before our Committee when we have the house passage deadline. There is also a listing of the subjects for the bill draft requests (BDRs). [Continued to read from and refer to Exhibit E].

Lastly, I have provided appendices containing a list of contacts and common health care acronyms. There is color coding used for the acronyms; blue is for state and orange is for federal agencies. This list is not all-inclusive. If you find an acronym that would be beneficial to add, please let me know and I am happy to add it. I am here to assist you. Please do not hesitate to ask.

Chair Dondero Loop:
Thank you very much. Every session, the Committee will have a series of presentations from state agencies and other entities whose bills are typically referred to our Committee. These presentations will provide the background needed to better understand the variety of bills that will come before us. The freshman legislators should find many of these presentations especially helpful, and they will serve as a good refresher for the returning legislators. [More housekeeping matters discussed.] We will begin with our presentation by Michael J. Willden.

Michael J. Willden, Director, Department of Health and Human Services:
With me today is Amber Joiner, Deputy Director, Programs, Department of Health and Human Services (DHHS). She will assist me with any questions you may have. There are two presentations: an overview of DHHS and the Affordable Care Act, and Medicaid expansion. I put them both in one document (Exhibit F) which is also posted on our website. It can be found at <www.dhhs.nv.gov>.

I know this is a policy committee and not a money committee, but there is some important financial context I would like to mention. Page 1 shows an organizational chart of DHHS. It is important to understand how health and human services is organized. I want to recognize our deputy directors who are here today in the audience. First, Ellen Crecelius, who is the Deputy Director,

Fiscal Services. Next, is Kareen Masters, Deputy Director, Administrative Services. Lastly is Mary Woods, Public Information Officer.

As you can see on page 1 of the chart, we are organized into six major divisions: the Aging and Disability Services Division, led by Jane Gruner; the Division of Child and Family Services, led by Amber Howell; the Health Division, led by Richard Whitley, the Division of Mental Health and Developmental Services, led by Richard Whitley; the Division of Welfare and Supportive Services, led by Mike McMahon; and the Division of Health Care Financing and Policy, led by Laurie Squartsoff. We have a very new crew this session, but they are powering up rapidly. We also oversee the Office of the State Public Defender.

Under each of the six divisions, you can see the major types of programs that those divisions administer. You will see at least two pieces of legislation on departmental reorganization. More specifically, we are proposing to move Early Intervention Services from the Health Division to the Aging and Disability Services Division. We will also be proposing to move the three regional centers out of Mental Health and Developmental Services to Aging and Disability Services. We are trying to put all the disability programs together so families do not have to go to three different divisions to get services.

Under the Health Care Financing and Policy column, you will see a box called Nevada Check Up. This is a stand-alone health insurance program and the eligibility is done separately from Medicaid. We are in our reorganization phase. In conjunction with the Affordable Care Act, we are proposing that the eligibility functions for Nevada Check Up be integrated under the Welfare and Supportive Services Division.

Page 2 (Exhibit F) is a highlight of the Department's full-time equivalent (FTE) or employees. You can see our staffing levels for about a decade. Over the last four years, we have taken a significant reduction in staff. I want to recognize our staff and the hard work they put in. We have seen tremendous caseload growth. For fiscal year (FY) 2014 and FY 2015, we are proposing to add new staff. We would grow from 2,900 today to a little over 4,500. Most of that staff is related to the Medicaid expansion within the Affordable Care Act. This includes welfare eligibility workers and clerical support workers to deal with the increasing numbers of people who would be Medicaid-eligible. There is also some staff related to the caseload growth, particularly in our development services caseloads in the south.

Page 3 (Exhibit F) is a highlight of where the staff is distributed among the divisions. It is not always intuitive to where people are. For example, Medicaid

is one of the biggest expenditures that we have, but we have very few staff actually working in Health Care Financing and Policy. [Continued to describe chart from Exhibit F.]

I am going to skip to page 5 where you will see two pie charts (Exhibit F). The left pie chart shows the spending that was authorized in the 2011-2013 biennium. You can see that the total authorized spending for the Department was $6.2 billion. The budget request for the 2013-2015 biennium is for $7.4 billion. That is a $1.2 billion increase in the total spending. On page 6, the pie charts show, by division, the General Fund revenues in the legislatively approved budget of the 2011-2013 biennium and the Governor's recommended budget for the 2013-2015 biennium. You can see the difference in the wheel as to where the spending is requested by division. The increase in general fund is about $136 million over the biennium. Pages 7 through 9 review the budget account summary.

It is important to understand the Federal Matching Assistance Percentage (FMAP), especially in the Medicaid program. The FMAP is the percentage of our medical costs that the federal government will pay for. Each state hopes that their FMAP will increase so that fewer state dollars are spent and more federal dollars are received. The chart on page 11 (Exhibit F) shows the good news and the bad news. The three columns on the left show the personal income per capita by year for Nevada and the United States. Nevada's personal per capita income declined while the federal matching percentage increased. Poorer states receive more federal money. The bad news is Nevada has declining personal per capita income. The good news is that the federal government pays for more of our health care costs.

Chair Dondero Loop:
At the bottom of page 11 (Exhibit F), the Children's Health Insurance Program (CHIP) uses an enhanced FMAP by reducing Medicaid shares. Can you clarify that?

Michael Willden:
Yes. I will show how that works on page 12 (Exhibit F). There are three FMAPs that we monitor: the regular FMAP, the enhanced FMAP, and the "new eligibles" FMAP. The regular FMAP applies to the Medicaid population, including those people who are currently eligible for Medicaid, or would meet the eligibility guidelines for Medicaid in the future. In FY 2012, the FMAP was 55 percent, which means the federal government paid for 55 percent of our health care costs. In FY 2014 and FY 2015, our FMAP will be increasing to 62 percent, an 8 percent increase. The enhanced FMAP applies to children eligible in the Nevada Check Up program, also known as the Children's Health

Insurance Program (CHIP). Under the federal rules, states get a higher federal match in the Nevada Check Up program. For the new eligibles FMAP, the Governor made the decision to expand Medicaid to the new population that the Affordable Care Act allows. For the expansion population, the FMAP is 100 percent for the first three years, then it decreases to 90 percent by 2020. To review, there are three FMAPs: regular Medicaid, the enhanced Nevada Check Up program, then the new enrollees.

In the early two weeks of budget hearings, we did not provide enough information about the big picture in Nevada as to what is going on with our health care, our health status, and our child well-being indicators. I want to talk about some of the indicators in Nevada. We update these indicators periodically; the last update was in November 2012. All of these indicators are nationally measured and are collected by a number of organizations. We cite which organizations we report to and collect the data from. There is a data collection lag, but you can see the trend lines on page 12 (Exhibit F).

The first indicator I would like to highlight is population data. Nevada has a population of 2.7 million. People are always curious as to where the population falls. You can see an age distribution chart on page 15 (Exhibit F). Nevada looks like the average in the nation for age distribution. We also collect some school enrollment data because many of our programs are tied to this. On the top of page 16, there is some race and ethnicity data that may be of interest. The United States' percent of minority population over the decade has grown from 32 percent to 37 percent. Nevada's percent has grown more significantly from 36 percent to 47 percent.

People often get confused about the uninsured population and the population living in poverty. Page 18 (Exhibit F) talks about poverty in Nevada and the nation. [Continued to review chart in Exhibit F.] There is always a lot of information in the press about child welfare, child protective services, and child fatalities. There are measureable tools to see how Nevada compares to the nation. Page 20 contains information on child welfare.

Assemblyman Sprinkle:
These are statewide averages in the chart that you are referring to. Child protective services are broken primarily into counties. Do you have these same numbers broken down by county?

Michael Willden:
Yes, we do. I do not have those today, but I can provide them for you. There are three child welfare agencies: Clark County Department of Family Services is the child welfare agency in Clark County, Washoe County Social Services is the

child welfare agency in Washoe County, and the State of Nevada is the child welfare agency in the other 15 counties.

Page 21 (Exhibit F) has information on foster care and adoptions. It contains good information for the Committee to be aware of as legislation is considered. Adoption statistics are one of the things we are proud of. You will see that the ratio of adoptions to children waiting for adoptions in Nevada has increased from 23 percent to 42 percent over the last decade. That is an indication of good work taking place. Page 22 deals with our nursing facility residency rate. We have a firm belief that we should keep the number of nursing home beds at that number. There are certainly people that belong in skilled nursing, but we try to do everything we can through our home- and community-based programs and our Medicaid waivers to try to keep people living independently at home.

Page 23 (Exhibit F) shows our health status indicators. Nevada does not rank very well by most indicators. Page 25 contains a lot of data on obesity and infectious disease. The obesity rate in Nevada and in the nation is increasing. Nevada's obesity rate is increasing at a lower rate than the nation's. Page 26 has health indicators regarding vaccinations and immunizations. Nevada is behind where it should be on childhood immunization vaccinations. We also lag on our flu shots for senior citizens and will continue to work on that.

Page 27 (Exhibit F) depicts some indicators that will be worrisome as we roll out the Affordable Care Act and access to health care. We have made significant improvement on people's ability to visit a dentist. One of the biggest concerns we have is access to primary care. You can see the low-ranking number of the primary care physicians in Nevada. We have 86 primary care physicians per 100,000 compared to 121 per 100,000 in the nation. I know a lot of work is going on between the Department of Employment, Training, and Rehabilitation, the Nevada System of Higher Education, and DHHS to work on access issues.

Pages 29 and 30 (Exhibit F) deal with the rate of Nevadans uninsured. Nevada has the second highest uninsured rate in the nation. In 2011, the indicator shows that 22 percent of people were uninsured. The most recent number I have seen is about 22.4 percent uninsured. Out of 2.7 million Nevadans, approximately 605,000 are uninsured. Of particular concern is children. Sixteen percent of Nevada's children have no insurance source compared to 7 percent of the nation's children. Page 30 gives you some indicators about our mental health system. The fact to take away is that most states in the nation do a poor job funding public mental health and public behavioral health.

It has been widely reported that the State of Nevada bounces from third or fourth, to fifth worst in the nation with its suicide rate. At the top of page 31

(Exhibit F) is the suicide rate among Nevadans aged 65 or older. Nevada has twice the national average in this suicide rate. Page 33 shows the Medicaid spending per capita. I want to make sure you understand that there are two Medicaid spend-rates that people monitor. One is the amount spent per Medicaid recipient. Nevada spends about half per capita what the nation spends on the Medicaid program. That is not necessarily an indicator of cost, but an indicator that we have a low volume of Medicaid recipients.

Assemblywoman Fiore:
When Nevada counts its suicides, are the tourists and out-of-state visitors included?

Michael Willden:
I believe it is where the death certificate is filed. If an individual died or committed suicide in the State of Nevada, it is counted in our statistics.

Chair Dondero Loop:
I believe you are correct and that translates into other areas of our life in Nevada. Many times we have statistics from our tourists.

Assemblyman Eisen:
Mr. Willden, when you said our Medicaid expenditures per enrollee are closer to the national average, but our Medicaid expenditures per capita are substantially lower, is that an implication that Nevada has a relatively low Medicaid enrollee rate when compared to the general population?

Michael Willden:
That is correct. Four years ago, Nevada's per capita Medicaid enrollment ran about 8 percent. The nation's per capita enrollment was about 14 percent. Presently, Medicaid enrollment is increasing in all states and Nevada is around 11 percent per capita. The nation is about 17 percent. As you go through the Medicaid expansion with the Affordable Care Act, depending on each state's choice to expand or not, those comparisons will change again.

Assemblyman Eisen:
What is distinctively different about our Medicaid program that our enrollee rate is lower than the national average even though our economy is not doing as well?

Michael Willden:
Nevada has restrictive eligibility criteria. We do not choose many of the optional categories for enrollment. I will give you two examples. Nevada is one of 15 states that do not choose an option called "medically needy." These are

people with expensive medical bill and incomes that exceed the Medicaid eligibility threshold but are able to spend down their money in order to qualify for Medicaid . We are not a medically needy state. The other example is that Nevada has never covered childless adults unless disabled or elderly. We will start covering childless adults in January of 2014. Those are two more restrictive eligibility options that Nevada has historically chosen.

Assemblyman Oscarson:
Do you have any models based on presumptive eligibility? If that should happen, what would that do to those numbers?

Michael Willden:
Yes. We will talk about presumptive eligibility. There are two presumptive eligibility decisions that states, governors, and legislators need to tackle. States now have an option in the federal rules to do presumptive eligibility. Again, Nevada has chosen to not participate in presumptive eligibility for decades. That policy option has been around for a long time. In the Affordable Care Act, there is a hospital option for presumptive eligibility. We are currently working with the Nevada Hospital Association and the money committees, the Assembly Committee on Ways and Means and the Senate Committee on Finance, to figure out if hospitals are going to choose that option. If hospitals choose that option under the Affordable Care Act, we need to prepare to implement that. We believe that the presumptive eligibility option is not the way to go, but a fast-track eligibility option is. We can talk about this more when we present Assembly Bill 1 to this Committee.

Chair Dondero Loop:
Are there any additional questions? [There were none.] Please continue.

Michael Willden:
There are some food insecurity statistics and child support enforcement statistics on pages 34 and 35 (Exhibit F) that I want you to know about. All of these indicators are updated periodically. I understand that people want to know the big picture and how well Nevada is faring. I would like to briefly mention pages 37 and 38 (Exhibit F). The maps show rates by county for 12 different indicators such as unemployment rates and program participation rates. For example, the Supplemental Nutrition Assistance Program (SNAP) on page 37 shows higher participation in Nye County, followed by Clark, Washoe, Churchill, and Lyon Counties. There is hardly any density in Humboldt, Elko, Pershing, Lander, and Eureka Counties. I think these charts are helpful tools to help us understand key policies and the issues we deal with.

Chair Dondero Loop:
Is there no data on Lander and Eureka Counties? Or is it coincidental that they are in those positions in almost every single map?

Michael Willden:
First, Eureka is a very small and wealthy county. Second, you will see that we do not provide a lot of social services to the mining counties. It is not that those counties do not report; the data is there, but the density is very low.

Pages 40 through 42 (Exhibit F) show a list of the couple hundred programs that DHHS administers. Each program that we administer has a one- to two-page fact sheet that shows the number of participants, the eligibility guidelines, et cetera, which may be found on our website. There are probably hundreds of pages of policy manuals, but this is a good, clean snapshot to help you learn more about the kinds of programs we run.

I will skip to page 66 (Exhibit F). We will save pages 45 through 65 until the end because those pages are all related to the Affordable Care Act. In cooperation with the counties, the Department of Health and Human Services (DHHS) runs the Fund for Hospital Care for Indigent Persons, also known as the Indigent Accident Fund (IAF), and the supplemental fund for medical assistance to indigent persons. The IAF is funded from a 2.5 cent property tax. The counties send it to the state and the Department makes payments to hospitals and other providers for indigent highway accidents and indigent catastrophic claims that have no other pay source.

Because of the economic hard times over the past five years, the money has been paid into the IAF by the counties and the state swept the Fund to the General Fund. You can see a column entitled "Sweep to General Fund" (Exhibit F). If you include FY 2013, we will have swept $110 million out of the IAF to support General Fund needs. That means there is $110 million worth of hospital claims that did not get paid that would have historically and traditionally been paid for from this claim fund. In the *Executive Budget*, the Governor is recommending that we no longer sweep the Fund. We are in a recovery position in the budget. The Fund in FY 2014 and in FY 2015 would have an estimated $21 million each year to start paying hospital and other related claims to catastrophic events. If nothing else is done legislatively or policy related, the IAF will be turned back on and start paying claims in the amount of $21 million a year.

We have been working with the Nevada Association of Counties, the Nevada Hospital Association, and individual hospitals on an opportunity to use the dollars in the IAF in a different way to get matching Medicaid federal dollars and

increase the payments to our hospitals from $21 million worth of claims to $55 or $56 million. We believe new legislation should be considered in order to do revenue maximization. This will administer the Fund in a very different way than in years past. We think this is a significant opportunity and have a general consensus. We hope to bring new legislation forward soon.

Page 70 (Exhibit F) lists eight policy bills that the DHHS recommended to the Governor which he approved to bring forward. On page 71, there is a list of six budget bills coming forward. I never know the path of the bills; they may or may not end up coming to this Committee. Some of them deal with the reorganization plans that we have discussed.

Assemblywoman Spiegel:
I have a question that is tied to the budget BDR you have listed in one of the charts you went through on pages 5 through 6 (Exhibit F). It seems there were a lot of cuts being made for behavioral health services. Are those cuts due to reorganization and included in the dollars to those services elsewhere, or are there large scale cuts in services being made?

Michael Willden:
The short answer is that we are not cutting the total spending in Behavioral Health Services. If you go back to the chart on page 5 (Exhibit F), you will see that Behavioral Health Services spent approximately $631 million. On the Governor's recommended budget chart, you will see that Behavioral Health Services is requesting to spend approximately $334 million. It looks like we made a $300 million reduction. The $300 million goes to Aging and Disability Services, which increased from $108 million to $497 million. The spending moved out of one division into another division.

Pages 72 to the end (Exhibit F) are simply the highlights of the Department's budget. I would end there and go back to the information on the Affordable Care Act.

Chair Dondero Loop:
Are there any questions at this time?

Assemblyman Hickey:
While the Medicaid expansion is mentioned predominantly within your budget and within the Governor's plan, I do not see any BDRs that deal with defining what some of the parameters of that expansion will be. Can you tell me if there are going to be some BDRs or is it just the monies that are being proposed that are going to be allocated to the various existing programs?

Michael Willden:
There is not a BDR contemplated to implement the Affordable Care Act expansion. In our terms, there will be a State Plan amendment. There is a contract between the states and the federal government called the State Plan for Medicaid. Governors choose to make State Plan amendments in cooperation with whatever budget has been approved. The Affordable Care Act will be decided through 35 separate budget decision units that would need to be reviewed and approved by the money committees. If those 35 budget units are approved, there is funding and an approval mechanism for the expansion. We do not believe there is legislation needed.

Chair Dondero Loop:
Are there any additional questions? [There were none.] Please continue.

Michael Willden:
Page 46 (Exhibit F) begins the portion of my presentation entitled the "Uninsured and the Affordable Care Act." There is a list of what I call the "moving parts." It is important to understand all of the moving parts in the Affordable Care Act and relate it to the budgets that are implemented. In the Medicaid program, we see more and more recipients each year. The money committees deal with a caseload growth decision unit, and we projected the regular caseload growth. I want to mention the impact on the state's uninsured population. Earlier, I stated that we have 22.5 percent uninsured rate. The intent of the Affordable Care Act and the Governor's decision to opt-in is to help drive down our uninsured rate.

There are three different funding mechanisms of paying for medical costs. Included in the Affordable Care Act are primary care physician rate increases, estimates regarding the per member, per month, and new populations coming into Medicaid that have not been dealt with. The single biggest population is childless adults, which Medicaid has never covered. We have worked with our actuaries by trying to forecast some per-member, per-month costs, but there are a lot of unknowns about the extent of demand, the behavior, and the medical costs for that group. We will discuss the Affordable Care Act caseload growth, administrative costs, disproportionate share hospital impact, the upper payment limit hospital programs, graduate medical education, mental health savings, and the counties' savings as a result of the Affordable Care Act. More and more people on Medicaid create less of a need for county health care programs.

Page 47 (Exhibit F) shows a chart of Nevada's insured and uninsured populations. Nevada has about 605,000 uninsured persons; that is the 22.5 percent I have been talking about. Page 48 breaks those 605,000 Nevadans into income groups. There are two major implementation projects all

states including Nevada are working on: one is expanding our Medicaid program; Governor Sandoval says we are and the other is running a state-run health insurance exchange or deferring it to the federal government. The Legislature passed Senate Bill No. 440 of the 76th Session which said we are going to run our own health insurance exchange. We have been working on that for the last couple of years. I know that John Hager, Executive Director of the Silver State Health Insurance Exchange (SSHIX), has been on board for over a year. People who are uninsured are going to do one of three things: stay uninsured, qualify and be eligible for Medicaid expansion, or use the SSHIX to purchase health care coverage.

When you look at the chart on page 48 (Exhibit F) there are about 208,000 Nevadans in the 0 to below 100 percent of the federal poverty level (FPL) are uninsured. Those folks are going to be Medicaid-eligible. The question is: How many of them will join the program? In the red portion, on page 48, there are approximately 177,000. The people who are in the 138 percent or below of FPL bracket get Medicaid, but the people above 138 percent of FPL will be going to Mr. Hager in the SSHIX to potentially purchase health insurance. People in the 200 to 300 percent of FPL quadrant, and the 300 to 400 percent of FPL quadrant do not have the opportunity through the Medicaid expansion, but can purchase health insurance through the Exchange with or without their tax credit subsidies. Mr. Hager can talk about that in more detail.

Page 49 (Exhibit F) is a simple chart that demonstrates what the dynamics will look like over the next two years as we try to project what will happen. The top chart is the uninsured that I have talked about. We believe that the uninsured rate of 22.5 percent will go down to 10.5 percent over the next two years. People will either enroll in the Medicaid expansion or the Exchange. As Dr. Eisen and I discussed, we would go from an 8 percent enrollment up to 17 percent of Nevadans enrolled in Medicaid. We are at approximately 313, 000 Nevadans enrolled in Medicaid today. We believe by the end of the biennium, we will be at about 490,000 Nevadans enrolled in Medicaid.

If you look at the Exchange box, on page 49 (Exhibit F) the current estimates are that 5 percent of Nevadans would be purchasing insurance through the Exchange which is about 114,000 Nevadans. Again, that 605,000 number gets reduced by the number of new enrollees in Medicaid. The new enrollees getting insurance through the Exchange would still be somewhere around 300,000 uninsured Nevadans. We would still have a 10 percent uninsured rate.

Page 50 (Exhibit F) talks about the six silos of eligibility in the Affordable Care Act. Under the expansion, the people who would be eligible for Medicaid are people who have income under 138 percent of the federal poverty level. Those

percents are shown in the chart on page 50 in the bottom right corner. In real terms, for a one-person household, 138 percent of the FPL is $15,800 per year. A four-person household would be around $32,500. Families with incomes below those dollar thresholds could be Medicaid eligible. The blue on page 50 is what Nevada Medicaid already covers. Children ages 0 to 5 already have an income-testing threshold; children ages 6 to 18 are currently covered at 100 percent. We need to expand to 138 percent. The CHIP is covered at 200 percent FPL, and pregnant women are covered at 138 percent of FPL. Parents/caretakers of children are covered at 75 percent of FPL, which we need to expand to the 138 percent level. As I have mentioned before, the new group, the childless adults, are going from zero all the way to the top.

Assemblywoman Spiegel:
During the 2009-2010 Interim, the Legislative Committee on Senior Citizens, Veterans and Adults with Special Needs discussed a topic about veterans. It was mentioned that Nevada has one of the lowest rates in the country for veterans applying for veterans' benefits. Has there been any discussion about getting more veterans to apply for veteran health care benefits? I think they would be in this "new enrollee" group that we are looking at. Has there been any analysis or movement on reaching the same goal, but in a different way?

Michael Willden:
I do not have a lot of detail on that matter. I sit on a task force with Caleb Cage, Executive Director of Nevada's Office of Veterans' Services. Mr. Cage heads the Green Zone Initiative, so there is a plan toward working collaboratively with them to get veterans to be eligible for those benefits and Medicaid. I can provide more details if you would like.

Chair Dondero Loop:
Thank you. Please continue.

Michael Willden:
It is important to point out that if you are a childless adult living in the community, not institutionalized, the only way you are Medicaid eligible is to be determined by the Social Security Administration to be eligible for Supplemental Security Income (SSI). It is a very cumbersome, long process. That dynamic changes in January of 2014. Childless adults can be Medicaid-eligible without going through the 18- to 24-month disability determination process. They can have their eligibility determined based on their childless adult status. They may still need to get processed to get SSI eligible in order to have an income source, but their health care status is not dependent on their SSI disability status. This is a huge fundamental change for many of us who work in the system.

Pages 51 and 52 (Exhibit F) show all the math I just mentioned. The takeaways are that currently there are approximately 313,000 Medicaid recipients; we think we will end up somewhere around 490,000 in the future. Seventy-eight thousand of those are the newly eligible population that get 100 percent federal financing. About 68,000 are the individuals who are currently eligible, but have not enrolled in Medicaid.

Page 53 (Exhibit F) is a copy of the law about presumptive eligibility. Earlier I discussed there are two presumptive eligibility options. One is the state-level option, which Nevada is not planning to choose; the second is the hospitals participating in the Medicaid program can choose to do presumptive eligibility. Page 54 is a list of 20 decision units that will be reviewed and outline the mandatory provisions of the Affordable Care Act. In other words, we need to be doing these regardless of the Governor's decision to opt in. Pages 55 and 56 contain a list of the 35 budget decision units that the money committees will need to review to implement the Affordable Care Act.

Assemblyman Hickey:
Will the new, large enrollee group be guided if they go through the SSHIX? Is there going to be synergy between the various agencies people are looking for help in? Hopefully there would be no duplication in getting these persons enrolled.

Michael Willden:
Yes, we are working daily with Mr. Hager and his staff to have a "no wrong door," seamless approach. For example, if you walk into a Medicaid office, our automated systems are going to figure out who is Exchange-eligible or Medicaid-eligible. It boils down to whether or not a person's income is at the 138 percent of FPL or not. If under 138 percent of FPL, you will get enrolled in Medicaid, and if over 138 percent, a decision needs to be made on buying an insurance product and capturing a federal tax credit subsidy. We are working hard to try and make this work. We have two vendors under contract. Deloitte is working with DHHS and Xerox is working with the SSHIX. The state level staff is coordinating with the federal government to build what they call the "federal hub." So, much of the eligibility relies on the states being able to go out to the federal hub to get Internal Revenue System (IRS) data to make income eligibility decisions, U.S. Department of Treasury data for the subsidies, Homeland Security data for citizenship, and Social Security Administration data for various benefits. There is a tremendous amount of automation underway to make all that happen seamlessly. Our goal is for real-time eligibility decisions. I am not sure yet what the definition of real time is. We are talking closer to three to five days in comparison to five to six weeks as it takes now. We think it will be a much quicker process.

Assemblyman Oscarson:
There have to be administrative costs for all these different agencies and hubs. Who is going to pay the cost to administer all of those programs, and how is that going to impact the initial premium cost of the individual that has to go through the Exchange?

Michael Willden:
The administrative costs on the Medicaid expansion are my Department's responsibility to figure out. Within the budget decisions for the money committees, we have estimated what those costs are: the information technology costs, administrative costs, fiscal agent costs, and new staff costs. These numbers are presented on pages 54 and 55 (Exhibit F). They are budgeted at a roughly 50 percent state-federal share. The Office of the Governor has a commitment from Secretary Sebelius of the U.S. Department of Health and Human Services to improve Nevada's funding situation. Some of these budget numbers may change, but in the DHHS budget, we included the administrative costs.

The Exchange received a large federal grant to roll out the automated systems costs, and the initial outreach and enrollment costs. By 2014, the exchanges are required to be self-sufficient. The Board of Directors of the SSHIX is making decisions to implement a per-member, per-month cost that is charged to the insurance carrier. I think it is around $4 per month.

Chair Dondero Loop:
Mr. Hager is in the audience. Did you have something that you wanted to add?

Jon Hager, Executive Director, Silver State Health Insurance Exchange:
I believe that we are working with your staff to schedule a presentation about the Exchange for this Committee. Nevada has received a grant award in the amount of approximately $74 million. It started in 2010 with the implementation and planning phase and is now in the design and implementation phase. The $74 million of funding will get us through December 2014. We will have one year of operations that will be paid for by the federal grant; however, there are a few things that cannot be paid for by the federal grant. One of those is the Navigator program which will be used for outreach and help bring people in the doors that Director Willden was talking about. The other one is to build up operating reserves to make sure that we can pay our bills in the short term.

We will be charging a fee of $4.95 per calendar year in 2014. The fee will be charged to carriers based on the enrollment within the Exchange program. The fee gradually goes up with the long-term fee being in the $8-$9 range in 2017.

We have to wait and see exactly where that will be as the budget estimates become more clear. It is difficult to estimate four years out. Those fees are approximately 1.7 percent of the estimated premium for 2011 and will be lowered in 2014. In the long term, it goes up to about 2.8 percent. The federally facilitated exchanges are charging 3.5 percent of premium. If the State of Nevada were to decide to not operate a state-based exchange, the federal government would come in and run it for us and charge a 3.5 percent premium, which is approximately $3.2 million per year more than what we are charging the carriers. That fee is charged to the carriers based on Exchange enrollment that will go back into the premium because they have to cover their costs. In the long run, it will be charged to consumers; however, if you are between the eligibility thresholds for qualified health plans between 138 percent of FPL and 400 percent of FPL, which is about $92,000 for a family of four, you will be subsidized by the federal government through an advanced premium tax credit.

The fee charged by SSHIX will be covered by the advanced premium tax credit that the federal government provides for people in those ranges. Anybody not in those ranges would be covered. We are very cognizant of costs. There are a lot of fees built into the Affordable Care Act: taxes for the insurers, taxes under medical equipment, and other fees. These will cause upward price pressures on premiums; we are working with the carriers to try and minimize those as much as possible.

Chair Dondero Loop:
Please hold your questions for the Exchange when we have their presentation. Mr. Willden, please continue.

Michael Willden:
Page 58 (Exhibit F) discusses the Disproportionate Share Hospital program (DSH) and Upper Payment Limit (UPL) hospital program for inpatient and outpatient services. The Medicaid program runs a graduate medical education (GME) program and has been trying to get a private hospital UPL program. The Affordable Care Act will create significant changes in these programs. We have a lot of ongoing work to analyze the dynamics of these changes. The DSH is based on uncompensated costs in hospitals. The Affordable Care Act is cutting in half the national pool of dollars available for states over the next eight years. The theory is that more and more people will be insured and there will be fewer uncompensated costs, so the federal government should not be putting money into this program. Moreover, there are more people who will be Medicaid-eligible, and more Medicaid bed days in hospitals. The foundation for UPL programs is based on Medicaid bed days and the difference in the rates paid by Medicaid versus Medicare. That gap creates the UPL opportunity. Going

forward, DSH is going to shrink while UPL volume goes up. The challenge is that the State of Nevada, in all programs that we run, is projected to receive about an $84 million benefit to the Medicaid program in FY 2014 and FY 2015. The real dynamic is how these are going to work and how they are going to affect the hospitals' bottom lines.

The Clark County sued the State of Nevada with regard to these issues. We have settled that for FY 2013, but we still have to lock in what we are doing for FY 2014 and FY 2015. There is more detail in the end pages (Exhibit F) on how the programs work, how the money moves, what the benefits to the hospitals are, and what the benefits to the state are. I will end my presentation with the private hospital UPL program on pages 64 and 65, which is not off the ground yet. We have some statutory issues that need to be cleaned up. We are working on getting a BDR over. You will be hearing from us about the private hospital UPL program.

Chair Dondero Loop:
Thank you. Are there any questions or comments? [There were none.] Is there any public comment? [There was none.]

This meeting is adjourned [at 3:08 p.m.].

RESPECTFULLY SUBMITTED:

_____
Janel Davis
Committee Secretary

APPROVED BY:

_____
Assemblywoman Marilyn Dondero Loop, Chair

DATE: _____

EXHIBITS

Committee Name: Committee on Health and Human Services

Date: February 6, 2013 **Time of Meeting: 1:33 p.m.**

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
	C	Kirsten Bugenig	Committee Policies
	D	Kirsten Bugenig	Standing Rules
	E	Kirsten Bugenig	Committee Brief
	F	Michael J. Willden	Presentation