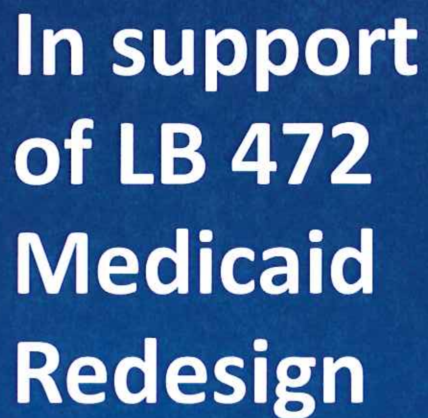

In support of LB 472 Medicaid Redesign

Prepared for the Nebraska Legislature

104th Legislature
First Session
April 2015

NHA Nebraska Hospital Association

The influential voice of Nebraska's hospitals

Laura J. Redoutey, FACHE, President
www.nebraskahospitals.org

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If you have any questions about the contents of this packet, feel free to contact the NHA Advocacy Team at any time.

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The $6B Business Case for Expanding Medicaid

Through the expansion of Medicaid, Nebraska's economy will conservatively avoid more than $1 billion in silent taxes, medical-related bankruptcies, unnecessary state spending, reduced consumer spending power during the next five years. The state will also receive nearly $2.1 billion during that time, drawing in $992,000 in federal expansion funding every day and generating $5 billion in increased economic activity.

Inject $2.1B into Nebraska's economy and spur $5B in economic activity

The state will receive more than $2.1 billion, or $992,000 daily, in federal funding during the first five years, FY 2015-20, of the expanded Medicaid program. These are dollars Nebraska taxpayers are currently sending to Washington, D.C., that could be recaptured to contribute to the state's economy and a healthier, more productive workforce.

The federal infusion of dollars is projected to increase the state's economic activity by more than $5 billion dollars. The $174.8 million in state and local taxes generated by the increased economic activity would be more than enough to offset the $59 million cost to expand Medicaid for an estimated 79,600 low-income, working Nebraskans.

Reduce Nebraska government spending by $73 million

According to the Legislative Fiscal Office, expanding Medicaid would save the state $73 million from FY 2015-20. The state disability program, drug program for HIV and AIDs patients and behavioral health program, all currently supported by the general fund, would be funded by the expanded Medicaid program. The resulting savings is estimated at $69.3 million.

In addition to savings from the state's health care assistance programs, the Department of Corrections would also experience a savings of $3.6 million. Inmates of correctional facilities are not eligible for Medicaid, but Medicaid would cover services provided when inmates are hospitalized outside a correctional facility.

The $73 million in savings would offset the $59 million cost to the state to implement Medicaid expansion, resulting in a <u>$14 million net savings</u> to Nebraska during FY 2015-20.

Save, create and support 47,000 jobs in Nebraska

Medicaid expansion will support 47,000 jobs during FY 2015-20. The 47,000 jobs supported would more than offset the 30,900 jobs lost due to the $2.1 billion in enacted Medicare cuts in Nebraska. Those jobs would also shore up the 13,500 jobs projected to be lost due to an additional $957 million in Medicare cuts under consideration. The resulting net impact would be a net increase of 2,600 jobs in the state.

By not expanding Medicaid, at least 31,000 jobs are projected to be lost in the state by 2024.

Nebraska businesses would avoid up to $16M annually in Affordable Care Act penalties

Nebraska businesses will avoid $11-16 million per year in Affordable Care Act fines if Medicaid is expanded, according to a calculation by Jackson Hewitt Tax Service. According to the report, businesses could face ACA fines of $1.03 billion to $1.55 billion each year in the 25 states that have not yet expanded Medicaid.

Employers will not face penalties for low-income employees that qualify for Medicaid, which provides a protection for all businesses. According to the report, "Any projections of the 'net' costs of Medicaid expansions should also reflect the very real costs of the shared responsibility tax penalties to employers in states that do not expand Medicaid."

Help businesses realize $374.4M in revenue by averting medical-related bankruptcies

In 2013, Nebraska experienced more than 4,800 bankruptcies of which an estimated 2,800 had a significant medical debt component. Of those 4,800 filings, more than 380 would have been avoided for every 10 percent increase in Medicaid coverage. Averting bankruptcies over the next 10 years would prevent an estimated $374.4 million in business losses.

In addition to direct business losses, bankruptcies negatively impact consumer spending. According to the report, expanding Medicaid would increase discretionary spending by an estimated $21.4 million due to averted bankruptcy in the first year alone, steadily increasing to $53.5M in the tenth year. The total tax benefit to Nebraska will result in a gain of $1.2 million in the first year and $3.0 million in the tenth year.

Increased productivity for low-income workers

For low-income workers, a lack of access to health care leads to absenteeism, reduced productivity and vulnerability to employment termination. "Presenteeism," described as a worker who is at work but cannot perform adequately because of illness or injury, costs employers two to three times more than direct medical care. Medicaid expansion would reduce time not on task (in the workplace, but not working); improve quality of work (reduced injury rates, product waste, product defects); increased quantity of work; decrease unresolved unsatisfactory employee interpersonal factors (personality disorders); and reduce unsatisfactory work culture.

Increase low-income worker wages by $407M

The direct economic impact of improving the health of low-income working Nebraskans, those who are most likely to spend their earnings locally, would create an additional $7.4 million in discretionary spending during the first year of Medicaid expansion and an estimated $407 million over 10 years.

An additional $7.4 million in annual discretionary spending is estimated to occur due to better worker health and more days on the job, resulting in a tax gain of $417,000 in the first year alone.

In Summary

Medicaid expansion would support the local economy, protect local creditors by reducing medical-related bankruptcy, increase tax revenue without increasing tax rates, decrease state expenditures, reduce insurance premium subsidization of the uninsured to lower business costs, help businesses by improving worker health and productivity and increase disposable income for low-wage workers.

It would also support Nebraska's hospital infrastructure, which contributes more than $8.7 billion annually to the state's economy with hospitals being the economic anchor and largest employer in many rural communities.

Over the next 10 years, Nebraska can, conservatively, avoid $1 billion in unnecessary state spending AND draw in more than $2 billion in federal Medicaid funding during the next five years if lawmakers approve The Medicaid Redesign Act, LB472. The resulting economic activity, estimated at $5 billion, would generate enough state revenue to offset the costs of expanding Medicaid. Nebraska taxpayers would be wise to not to leave more than $6 billion on the table.

Source: Nebraska Medicaid Expansion: Protecting a Critical Infrastructure, Supporting Main Street, Improving Worker Productivity prepared by Allan Jenkins, Ph.D., Professor of Economics, University of Nebraska at Kearney and Ron Konecny, Ph.D., Professor of Management, University of Nebraska at Kearney

NHA Nebraska Hospital Association

AARP Real Possibilities in Nebraska

Fiscal Impact of LB 472

FY-20 General Fund Fiscal Impact LB 472			
Item	Amount	Information Source	Running Net Cost
General Fund Costs			
State Aid to Individuals	40,486,452	LB 472 Fiscal Note	40,486,452
DHHS Adminstration	4,775,595	LB 472 Fiscal Note	45,262,047
Contracts	32,000	LB 472 Fiscal Note	45,294,047
Federal Funds Leveraged	**446,999,799**	LB 472 Fiscal Note	
General Fund Savings			
State Disability Savings	(9,100,000)	LB 472 Fiscal Note	36,194,047
AIDS Drugs Savings	(900,000)	LB 472 Fiscal Note	35,294,047
Behavioral Health Savings	(8,000,000)	LB 472 Fiscal Note	27,294,047
Corrections Savings	(729,616)	LB 472 Fiscal Note	26,564,431
General Fund Revenue Generated			
Income Tax Generated	(8,820,000)	UNK Economic Impact Study	17,744,431
Sales Tax Generated	(9,500,000)	UNK Economic Impact Study	8,244,431
Corportate Tax Generated	(572,000)	UNK Economic Impact Study	7,672,431
Other Tax Generated	(3,392,000)	UNK Economic Impact Study	**4,280,431**

Other Fiscal Impact		
Local Government Revenue	(16,392,000)	UNK Economic Impact Study
Douglas County Program Savings	(3,819,000)	LB 472 Fiscal Note
Lancaster County Program Savings	(2,500,000)	LB 472 Fiscal Note

Benefits of the Enactment of LB 472 (UNK Economic Impact Study): 79,593 Nebraskans covered by 2020; $98.6 million reduction in uncompensated medical care in 2020; $35.7 million of bankruptcy averted in 2020; $13.5 million in averted business penalties in 2020; $87.6 million in increased discretionary spending for new enrollees in 2020.

Population by Ratio of Income to the Federal Poverty Level in Selected Counties

	Nebraska		Hall		Dawson		Scotts Bluff		Lancaster	
under 150%	407,031	22.6%	15,854	31.4%	7,140	30.0%	10,172	28.4%	67,775	27.1%
150% - 300%	501,626	27.8%	10,170	20.1%	8,196	34.5%	11,962	33.4%	42,021	16.8%
300% - 500%	484,743	26.9%	15,120	29.9%	5,512	23.2%	7,907	22.1%	71,666	28.6%
more than 500%	407,819	22.6%	9,366	18.5%	2,924	12.3%	5,767	16.1%	68,754	27.5%

	Gage		Madison		Dakota		Lincoln		Douglas	
under 150%	4,485	26.6%	8,923	26.2%	5,371	26.1%	7,087	25.6%	126,521	24.4%
150% - 300%	2,075	12.3%	9,865	29.0%	8,152	39.5%	3,790	13.7%	129,637	25.0%
300% - 500%	5,784	34.3%	9,059	26.6%	4,546	22.1%	10,325	37.3%	130,246	25.1%
more than 500%	4,517	26.8%	6,208	18.2%	2,543	12.3%	6,495	23.5%	132,670	25.6%

	Dodge		All Others		Buffalo		Adams		Platte	
under 150%	8,279	23.3%	93,043	23.2%	9,903	22.0%	6,167	20.8%	5,761	18.0%
under 100%	11,357	31.9%	124,079	31.0%	11,937	26.5%	8,995	30.4%	11,601	36.3%
300% - 500%	10,632	29.9%	108,410	27.0%	13,833	30.7%	8,633	29.2%	8,912	27.9%
more than 500%	5,284	14.9%	75,313	18.8%	9,373	20.8%	5,802	19.6%	5,649	17.7%

	Saunders		Washington		Sarpy		Cass	
under 150%	3,462	16.9%	2,730	13.7%	21,378	13.0%	2,980	12.0%
150% - 300%	5,296	25.8%	3,426	17.2%	41,456	25.3%	7,240	29.1%
300% - 500%	6,126	29.9%	6,699	33.7%	53,587	32.7%	7,746	31.1%
more than 500%	5,638	27.5%	7,025	35.3%	47,557	29.0%	6,934	27.8%

Source: U.S. Census Bureau, 2011-2013 3-Year American Community Survey; American Factfinder Table B17002
factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t

Census estimates are only available for counties with population over 20,000. An estimate of the population by ration of income to poverty in all counties under 20,000 population was calculated by substracting the population of the more populous counties from the total population.

Financial Status of Hospitals in Nebraska

Since the adoption of the Affordable Care Act (ACA) in 2010, Nebraska hospitals are and will continue to experience more than $2.1 billion in cuts through 2024 with an additional $957 million in cuts currently under consideration. As a result, more than 20 of the 64 Critical Access Hospitals (CAHs) in the state are facing substantial financial stress.

More than $2.1 billion in cuts from 2010-2024

Medicare payments to Nebraska hospitals have been cut significantly. From 2010-24, Nebraska hospitals will experience a cut in Medicare reimbursement of more than $2.1 billion from legislation and regulations that have already been enacted. These cuts represent 8.3 percent of the total Medicare fee-for-service revenue. On top of the enacted cuts, additional reductions of over $957 million are under consideration.

Cuts Enacted (2010-2024): Legislative	
ACA Marketbasket Cuts	($1,038,107,700)
Sequestration Cuts	(413,427,200)
Medicare DSH Cuts	(146,263,200)
Quality Based Payment Reforms	(39,315,700)
Coding Adjustment Cuts – Leg.	(38,548,600)
Bad Debt Payment Reductions	(5,817,400)
Total Legislative Cuts	**($1,681,479,800)**

Cuts Enacted (2010-2024): Regulatory	
Coding Adjustment Cuts – Reg.	($446,529,600)
Two-Midnight Rule Offset	(16,729,100)
Total Regulatory Cuts	**($463,258,700)**
Total Cuts Enacted	**($2,144,738,500)**

Enacted Cuts as a Percent of Total Medicare FFS Revenue (15-year summary value)	**-8.3%**

Cuts Under Consideration (2015-2024)	
Rural Hospital Cuts (SCH, CAH)	($459,195,600)
Medical Education Payment Cuts	(200,605,500)
Site Neutral Payment Cuts	(171,610,300)
Post Acute Care Payment Cuts	(65,186,600)
Additional Coding Adjustment Cut	(34,232,800)
Bad Debt Payment Elimination	(26,188,700)
Total Cuts Under Consideration	**($957,019,500)**

Community Benefits in Addition to Cuts

The government reimburses hospitals for providing services to those insured by Medicaid and Medicare at a rate less than the cost of providing care. On average, Nebraska hospitals experience negative margins of 13 percent for Medicare and 26 percent for Medicaid to care for these public program beneficiaries. In 2013, Nebraska hospitals lost more than $505 million because of under-compensated care for Medicaid and Medicare patients, while an additional $9 million in expenses above the cost of providing care was incurred by other public programs.

In 2013, Nebraska hospitals also incurred more than $111 million in costs to provide charity care, which is free or discounted care, to individuals who were unable to afford health care because they had inadequate resources and were either uninsured or underinsured. Hospitals also experienced more than $244 million in bad debt from patients who were unable or unwilling to pay their bills and declined to apply for charity care.

Nebraska Hospitals Operating on Unsustainably Low Margins

Even not-for-profit hospitals need a total margin sufficient to cover uncompensated care, acquire new technology and build a capital fund for long-term facility development. The reality is one-third of Nebraska's 64 CAHs are facing substantial financial stress. Using data from the latest financial reports, at least one-fourth of Nebraska CAHs are operating at a negative total margin or an unsustainably low positive total margin.

According to data from the latest report available (2012), the average total margin for Nebraska CAHs is 4.56 percent with an average operating margin of 2.71 percent. According to the American Hospital Association, more than 25 percent of hospitals had a negative operating margin in 2012. At the national level, since January 2010, 48 hospitals have closed in rural areas. Financial losses led to the closure of one Nebraska CAH, Tilden Community Hospital, in 2014.

Hospital Capital Improvements

Hospitals across the state are leveraging low-interest loans and federal incentives to streamline their facilities. Hospitals build and renovate for a variety of reasons, whether it is to upgrade their technological capabilities, improve efficiencies, reduce waste, conserve energy, comply with state and federal rules and regulations, to downsize or to meet growing capacity. A crane on the hospital campus does not mean the hospital is flush with cash. Instead, many projects are budgeted years in advance and the economic and construction climate may have created optimal conditions for current construction.

In Summary

Several Nebraska hospitals, especially CAHs in more remote, rural areas of the state, are struggling financially. For many of these communities, should their local hospital close, the nearest emergency medical facility is more than 50 miles away. Rural hospitals are strategically located to serve the communities in their surrounding areas. A number of medically underserved areas already exist in Nebraska. Failure to expand Medicaid will only contribute to the problem. While a majority of hospitals may have the resources to weather this financial storm, a number of hospitals do not and expanding Medicaid would improve their financial position and ability to survive during this transition period.

Source: Nebraska Medicaid Expansion: Protecting a Critical Infrastructure, Supporting Main Street, Improving Worker Productivity prepared by Allan Jenkins, Ph.D., Professor of Economics, University of Nebraska at Kearney and Ron Konecny, Ph.D., Professor of Management, University of Nebraska at Kearney

HealthLeaders Media

Obama Budget Ax Chops Critical Access Hospitals

***John Commins, for HealthLeaders Media*, February 4, 2015**

While everyone is affected by the proposed cuts, they are particularly painful for smaller hospitals, which have tighter margins and fewer options for dropping services or making up the losses.

The Obama Administration's **2016 budget axe** takes a double whack at critical access hospitals.

First, the proposal eliminates critical access designation for hospitals closer than 10 miles from the nearest hospital, which would create projected savings of $770 million.

Second, critical access hospitals that are fortunate enough to maintain that designation will see their reimbursements cut from 101% to 100% of costs, which is expected to save the federal government about $1.7 billion over the next decade.

>>>National Rural Health Association #SaveRural Campaign

The National Rural Health Association, in Washington, DC, this week for its 26th annual Rural Health Policy Institute, calls the president's proposal "short-sighted."

"Rural hospitals already operate at the narrowest of financial margins—41% already operate at a loss," NRHA lead lobbyist Maggie Elehwany told me by email.

Rural hospitals aren't the only **providers targeted for cuts** in the 2016 budget. Hospitals in general don't fare well under the Obama spending plan. The **American Hospital Association**and **America's Essential Hospitals** earlier this week blasted the budget plan for a broad array of cuts.

While everyone is affected, these cuts are particularly painful for smaller hospitals because they have much smaller margins and fewer places where they can cut services or make up the losses.

"Sequestration, DSH, bad debt, and other types of cuts have already hit rural hospitals hard," Elehwany says. "Forty-seven rural hospitals have closed since 2010, and 283 more are on the verge of closure. If this occurs, 700,000 rural patients will be without access to their closest point of emergency care. We hope that the President will recognize the importance of critical access hospitals and stop calling for cuts to these important facilities."

Sudden Hospital Closure Stuns MA Community; More Coming

Making matters worse, Elehwany says, the 2016 budget again "zeroed out" funding for Area Health Education Centers, which provide recruiting and training for rural medical staff.

"Over 90% of the rural counties in this nation are Health Professional Shortage Areas," Elehwany says. "AHECs do much to improve workforce shortages where the need is the greatest—rural America."

The wisdom of these budget cuts can be questioned, but nobody paying attention should be surprised. **We all saw this coming**. The Obama Administration and the federal government have for several years made it clear that they will closely **examine the critical access hospital sector** to see what savings can be wringed from it.

In August 2013, a report from the Office of the Inspector General for the Department of Health and Human Services recommended that Congress allow the Centers for Medicare & Medicaid Services to **strip critical access designation** from the nearly 1,000 hospitals with "permanent exemption" status under a state "necessary provider" designation.

OIG **refloated the idea** last August in a related report detailing the higher costs that Medicare beneficiaries pay for **outpatient services at critical access hospitals**, when compared with the same services at acute care hospitals.

Critical Access Hospitals Crisis in GA a National Bellwether

Before we rush to the fire escape, let's put some perspective on this. First, Republicans now control the House and Senate, and **GOP lawmakers** in both chambers have declared the Obama budget DOA.

Second, rural health is a true bipartisan issue. A good number of Republicans and Democrats represent rural states. Leaders in both parties understand the importance of properly funding rural healthcare. They understand that rural hospitals are economic engines for their regions, and they understand that access to healthcare is a critical issue for their constituents, the voters.

Nothing is guaranteed when it comes to Congress. (Remember how they **knee-capped ICD-10** last year!) With the new fiscal year, however, I cannot imagine that Republican majorities would agree to the president's call to end non-defense sequestrations and turn around and cut funding for rural hospitals.
Near term, it would be surprising to see critical access hospitals lose their designation or their funding.

That doesn't mean that rural healthcare providers and patient advocates can relax. The president's budget, and recommendations from OIG make it clear that the federal government has critical access hospitals in its crosshairs. This likely will continue after Obama leaves office. The pressure to find savings in a healthcare sector that consumes nearly 20 cents of every dollar spent will continue with Obama's successor, regardless of her or his political affiliation.

Small rural hospitals are free to hope for the best, but they should also prepare for the inevitable.

John Commins is a senior editor with HealthLeaders Media.

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Facing Layoffs And Closures, Rural Hospitals Push For Medicaid Expansion

by Alex Smith for Harvest Public Media

Twenty-two states, including Nebraska, have not expanded Medicaid. Many rural hospitals in those states were hoping for income from more patients covered by the federal health program. (Photo courtesy The Neenan Company/Flickr)

February 18, 2015 - 6:44am

In many rural communities, the local hospital is the largest employer. But unless Medicaid is expanded to include more low-income people, as the Affordable Care Act envisions, officials at some of those hospitals say they may be forced to cut jobs.

If you're in the market for fluorescent light bulbs, you might talk to Chris Smiley. In the past few weeks, she's been trying to sell off what's left of Sac-Osage Hospital.

"Casework, lighting, plumping, sinks, toilets – anything you want," Smiley said.

That's not in her job description. She's actually the CEO of Sac-Osage, a hospital in Osceola, Mo., that closed in September.

"I have become an auctioneer," Smiley said. "And I've learned more about asbestos and construction demolition than I ever wanted to know."

The small, 45-year-old hospital shut down, Smiley explains, because of diminishing payments from Medicare as well as a heavy load of uninsured patients.

Some of Sac-Osage Hospital's last remaining employees: Carolyn Bruce, left, CEO Chris Smiley and Connie Chapman are winding up the hospital's affairs. (Photo by Alex Smith for Harvest Public Media)

It's a scenario more and more hospitals are facing – one that's been especially hard on rural hospitals in states like Missouri, Kansas and Nebraska that have not expanded Medicaid.
Such hospitals are often the biggest employers in rural counties. But unless Medicaid eligibility is expanded to include more low-income people, as the Affordable Care Act envisions, officials at those hospitals say they may be forced to cut jobs – or even, like Sac-Osage, to close down.

Quid Pro Quo

The payment reductions that hospitals face came about in large part because of an agreement they made when the Affordable Care Act was crafted.

"It was a quid-pro-quo deal that the hospitals made," said Timothy McBride, a health economist at Washington University in St. Louis, Mo.

Hospitals expected to see millions of newly insured customers thanks to federal subsidies enabling people to buy health insurance and the expansion of state Medicaid programs. In exchange, they agreed to accept reduced Medicare payments and a huge cut in Disproportionate Share Hospital, or DSH, funding, which the federal government pays to offset the costs of uncompensated care.

Federal law requires hospitals to treat all patients in emergency situations, regardless of ability to pay, and many hospitals provide a full range of services without reimbursement.

McBride says the American Hospital Association offered to forgo more than $100 billion in federal payments.

But in 2012, when the Supreme Court ruled that the Affordable Care Act was constitutional, it also decided that individual states could not be required to expand their Medicaid programs. Many states chose not to do so.

That left many rural hospitals in an untenable situation.

"It's been kind of a double-whammy, if you will. We've taken a cut in reimbursement and not received any additional patients with any type of coverage," said Ronald Ott, CEO of Fitzgibbon Hospital in Marshall, Mo.

Last year, two of Missouri's 74 rural hospitals (including psychiatric, rehabilitation and Veterans hospitals) shut down. Statewide, about 1,800 hospital employees lost their jobs, according to the Missouri Hospital Association.

All told, Missouri hospitals say they expect to lose nearly $3.5 billion by the end of 2019 because of Affordable Care Act cuts. Similarly, hospitals in Kansas and Nebraska anticipate major reductions of well over $1 billion each over the coming decade.

To avoid economic ruin, Missouri hospital leaders say the state needs to expand Medicaid eligibility to include people with incomes below 139 percent of the federal poverty level, as provided by the Affordable Care Act. That would add about 300,000 people to the Medicaid rolls in the state, an increase of nearly 40 percent.

Without expansion, the Missouri Hospital Association says, the state could lose 5,000 jobs in health care and other fields.

Ott shudders to think about what closing Fitzgibbon Hospital would mean for Marshall. The hospital employs 600 people in the largely rural community.

"It would be disaster," he said. "I just can't imagine how difficult it would be for the community."

Holding Fast

But conservatives in Missouri's largely pro-business legislature remain unmoved.

"Now, the hospitals have brought some of this on themselves," said Republican State Sen. Ed Emery from Lamar, Mo., "A lot of it was what we call in the rural areas 'betting on the come': If you'll do this, then we'll promise you this, and those promises were not fulfillable."

Emery is among the majority of Missouri state senators who have held fast against Medicaid expansion because they say it will cost the state too much money and create too much reliance on government.

"Now they want my constituents and taxpayers to bail them out, and I just don't think that's the right thing to do," he said.

The federal government has agreed to pay the entire cost of Medicaid expansion for states through 2016, phasing down eventually to 90 percent.

Studies conducted by the University of Missouri and the Missouri Budget Project show that once the federal funding level drops, expansion would cost hundreds of millions of dollars in state spending. But those costs would be offset or even exceeded by the economic boost provided by the federal funds.

The 2012 University of Missouri study forecast that the state would generate hundreds of millions of dollars in tax revenue and create tens of thousands of jobs in the next few years if it approved expansion.

The principal author of that study, MU professor and health economist Lanis Hicks, says that since the state has missed the first two years of federal expansion funding, the potential tax revenue is somewhat lower now than what her study initially predicted – though she maintains expansion at this point would still save the state money and produce jobs.

Republican Sen. David Pearce doesn't buy it.

This map from the Kaiser Family Foundation shows which states have expanded Medicaid. Twenty-two states, including Nebraska, have not expanded their coverage.

Connie Chapman, who worked at the Sac-Osage Hospital in Osceola, Mo., for 40 years, looks over a nearly empty room in the hospital, which is slated for demolition on May 1. (Photo by Alex Smith for Harvest Public Media)

"The thought that, because you have federal dollars that that creates jobs – at the very end of the day we're all paying for that," Pearce said. "And so if it's something you can't afford, then it's something you can't afford."

Pearce represents the state's 21st district, where Fitzgibbon Hospital is located. He professes to be concerned about jobs there but insists the overall nature of health care is changing due to changing demographics and consolidation.

"As we all know, healthcare is extremely expensive, and so to be able to have a hospital in each county probably is not going to be a model we can sustain in the future," Pearce said.

The End

It's a future that has already come to Osceola.

In a town of around 900 people, Sac-Osage Hospital employed more than 100. Now, a few months after the hospital closed its doors, that workforce has dwindled to five.

The remaining employees include Carolyn Bruce and Connie Chapman, who worked at the hospital for a combined 75 years. In recent weeks, they've been digitally scanning the hospital's decades of paper records and preparing the building for demolition on May 1.

Since the hospital closed, a few clinics have helped fill the health care gap, and most of the employees have been able to find work elsewhere. But the town is now without an emergency room or inpatient services. There's not another full-service hospital for 30 miles in any direction.

And of course the town's largest single employer is no more.

CEO Chris Smiley keeps a stiff upper lip as she talks about the end of the hospital. But after her remaining employees leave for the day, she admits the closure has been difficult.

"This is my last job, so I see it as a failure," Smiley said. "I don't know that I could've done anything different. I don't think I could have saved the hospital. I hope that I have done everything that I could do to minimize the negative impact on my people and on the community."

This story was produced in partnership with Heartland Health Monitor, a reporting collaboration that focuses on health issues and their impact in Missouri and Kansas.

Stateline Midwest

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THE MIDWESTERN OFFICE OF THE COUNCIL OF STATE GOVERNMENTS

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- States in Midwest adopt 'second chance' laws
- Ohio temporarily halts executions

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For states, more Medicaid options

Policymakers are using unprecedented federal flexibility to not only expand the program's reach, but change how it works

by Kate Tormey (ktormey@csg.org)

After a nearly two-year negotiation, Indiana — once considered unlikely to expand Medicaid — is currently enrolling Hoosiers in a first-of-its-kind program.

The state is the latest to receive unprecedented flexibility in shaping its Medicaid expansion, and the third Midwestern state to do so in just over a year.

Indiana now becomes the 28th state in the nation to expand Medicaid under the Affordable Care Act. The 2010 law called for states to expand Medicaid eligibility to all adults earning less than 138 percent of the federal poverty level.

But the Supreme Court later ruled that states could not be required to expand eligibility to this new population, many of whom (namely non-disabled, childless adults) had never before been eligible for benefits.

State policymakers were left with a question: To expand or not to expand?

For some policymakers in non-expansion states, the benefits of extending eligibility for Medicaid were tempting: an unprecedented federal matching rate (100 percent through next year and gradually decreasing to 90 percent in 2020) and the opportunity to decrease the rate of uninsured.

And as extra incentive, the federal government has been granting unprecedented leeway to states in shaping Medicaid expansions. Some of the provisions recently approved have never been seen in the 50-year history of the program, which is financed jointly by the federal government and states.

"Expanding Medicaid is a good thing for a state from a health perspective — it's good for the individuals who get coverage, it's good for businesses whose employees get coverage, and the burden of uncompensated care goes down, so hospitals and doctors get paid for the work they do," says Vern Smith, managing principal of Health Management Associates and former director of Michigan's Medicaid program.

Expansion, he adds, can improve the state's overall bottom line as well. Individuals who are now receiving care through state and local health programs, especially mental health services, can be shifted to Medicaid coverage — at a historically high federal matching rate.

Still, the political climate in some states can make expanding the program an uphill battle.

"The politics are very difficult on this," Smith says. "There are very good reasons why a number of states have chosen not to [expand]. Even though it can be tremendously good for citizens, it is a very difficult step politically."

But in 2013, a new strategy emerged: Expand Medicaid using a Section 1115 waiver, which permits states to temporarily stray from Medicaid rules in order to experiment with a new way of providing coverage to a state's low-income population.

"This allows a state to capture federal dollars and reap the benefits, but without doing it as a straight Medicaid expansion," Smith says.

"Now we have, for example, a Healthy Michigan plan or a Healthy Indiana Plan 2.0, which incorporates conservative principles — personal responsibility, cost sharing and features similar to health savings accounts — so that it is a state-specific approach to coverage."

Arkansas was the first state to receive approval to expand Medicaid using policies not traditionally permitted in the program. Its waiver was quite different than anything that had ever been tried at such a large scale in Medicaid.

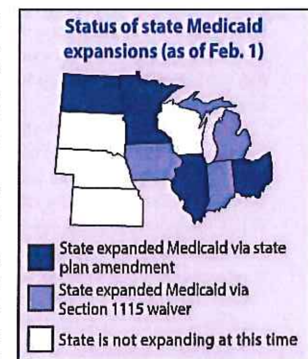
Instead of the traditional fee-for-service program, Arkansas is using Medicaid dollars to purchase private health insurance plans for beneficiaries. This so-called "private option" directs beneficiaries to choose from certain plans in the state's online insurance marketplace.

After this unprecedented waiver was granted, policymakers in other states, including several in the Midwest, took notice.

States began shaping Medicaid proposals that included

- enrollment in private health plans;
- new cost-sharing measures, such as modest premiums and co-pays for low-income enrollees;

Status of state Medicaid expansions (as of Feb. 1)



State expanded Medicaid via state plan amendment
State expanded Medicaid via Section 1115 waiver
State is not expanding at this time

▶ PLEASE TURN TO PAGE 6

Medicaid-reform options for states: Expansion waivers in the Midwest

State	Increased cost-sharing	Premium assistance	Sunset/"circuit breaker" clause	Health incentives	Health savings account
Iowa	✓	✓	✓	✓	
Indiana	✓		✓	✓	✓
Michigan	✓	✓	✓	✓	✓

Source: Health Management Associates, CSG Midwest research

▶ CONTINUED FROM PAGE 1

Waivers test new cost-sharing levels, savings accounts, bonuses for healthy behavior

- incentives for healthy behaviors; and
- the use of health savings accounts for enrollees to pay for care.

Healthy Indiana Plan 2.0 expands coverage, 'consumer-driven' approach

In late January, policymakers in Indiana announced that the state's Medicaid-expansion waiver had been approved by the federal government.

The state's expansion will be modeled after a program that has been operating under an existing Medicaid waiver for the past seven years. The Healthy Indiana Plan has been using a "consumer-driven" model to provide coverage to 60,000 Hoosiers. Enrollees have a high-deductible health plan and are required to contribute monthly to personal savings accounts, which they can use to pay for care until the deductible is met.

"The idea is for participants to have some skin in the game by making a monetary contribution to their coverage," says Rep. Ed Clere, chair of the House Public Health Committee. "Individuals can see what the cost of their care is because every time they go to the doctor, they can see the amount coming out of their account."

"HIP 2.0" extends coverage to Indiana residents earning up to 138 percent of the federal poverty level, meaning 350,000 people are now eligible to enroll. All non-disabled adults currently enrolled in HIP will be shifted to the new plan.

"We are very pleased we're able to expand coverage based on a proven model," Clere says. "We're moving forward with something that already has a track record of success and bipartisan support. The original HIP bill was widely supported by legislators on both sides of the aisle."

Like the original program, HIP 2.0 will require contributions to a health account (up to 2 percent of family income). Rates will range from $1 to $27 per month for an individual, and the state will contribute the remainder up to the plan's annual deductible.

By keeping up with their monthly contributions, participants will be enrolled in the "HIP Plus" plan. But if they fail to pay their monthly contributions, enrollees below the poverty line will be moved to a more basic plan, which has fewer benefits and requires co-payments for services.

Medicaid does not typically allow disenrollment for failure to pay, because this population has such low income — or none at all. However, a controversial rule will allow those above the poverty line to be locked out of the HIP 2.0 program for six months if they don't pay premiums.

According to Families USA, an organization that advocates for access to affordable health care, this is the first waiver to include lockouts for non-payment.

"Imposing premiums on Medicaid beneficiaries limits both initial enrollment and enrollees' ability to retain coverage," states a letter to the federal government from Families USA.

"The premiums proposed in Indiana would be a significant financial burden relative to income, inevitably resulting in program drop-out and depressed enrollment."

Some consumer advocates point out, too, that the unique and complex program will require a massive education effort to teach enrollees how to use their benefits.

Influencing health behaviors

The HIP 2.0 plan, along with the other Midwestern states' programs, also aims to encourage certain behaviors. While there are financial incentives for getting an annual checkup, there are penalties for using the emergency room for non-urgent issues ($8 the first time and $25 each time thereafter). But both of these behaviors can be dependent on getting a timely appointment with a provider.

Clere adds that an important element of the program is that, like its predecessor, HIP 2.0 will pay providers at Medicare rates (these rates are considerably higher than those paid under Medicaid).

"Medicaid typically pays low rates, so there are not enough providers and it's tough to get an appointment, which is what drives people to the emergency room," Clere says. "If your child has a fever and when you call the doctor they can't see you for a month, you're not going to wait."

Clere is hopeful, too, that the program will have a variety of long-term benefits.

For example, Indiana has typically not fared well on measures of overall health. In the "America's Health Rankings" report published by United Health Foundation last year, Indiana placed 41st among the states.

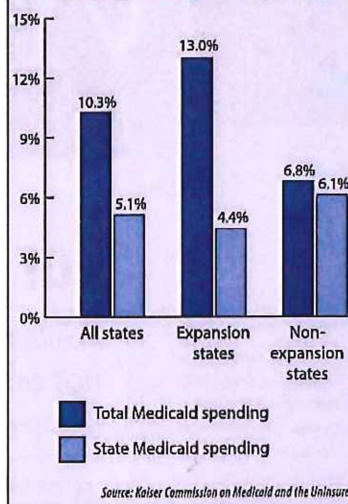
"This expansion of coverage should help us improve our ranking as a state, which will have benefits for both individual Hoosiers who will be in better health and for the state as a whole," he says. "This should improve our quality of life and our attractiveness from a business standpoint, because it doesn't do us any good to be 41st in anything."

While Clere supports the HIP 2.0 expansion, he's also introduced legislation that would address personal responsibility in other ways — including through participation in a financial literacy program. Clere believes that helping enrollees get on the path to financial stability can help them not only keep their health coverage, but foster overall success.

Though the federal government denied Indiana's request to require unemployed enrollees to take part in career counseling, everyone signing up for the Medicaid expansion will be referred to job training and job search programs.

For now, the federal government is paying for the cost of covering all newly eligible enrollees. But in 2017, the states' share will begin increasing, which has given some expansion critics pause. Indiana will cover its share through a combination of cigarette-tax revenue and an assessment on hospitals.

Projected growth in total and state Medicaid spending, fiscal year 2014



Source: Kaiser Commission on Medicaid and the Uninsured

Bipartisan compromise led to approval of Iowa Medicaid waiver

While Indiana's recent Medicaid waiver was the result of negotiations with the federal government, Iowa's experience began with the need for compromise among state legislators themselves. Partisan control in that state is divided between a Republican governor, a Democrat-led Senate and a Republican-led House.

Senate President Pam Jochum served as co-

Waivers allow states to experiment with new ways of delivering care

Medicaid was launched in 1965 as a way for states to offer a "safety net" for the poor. Along the way, the federal government has developed guidelines designed to ensure that certain vulnerable populations receive health care (for example, children, pregnant women and the disabled).

But states also have some flexibility to experiment with new ways of delivering care.

"States are great innovators; there are very smart policymakers in each state who have ideas that might not have occurred anywhere else," says Vern Smith, a managing principal with Health Management Associates and a former Medicaid director. "If you have the chance to try something at the state level, history shows that other states look at that and leapfrog to come up with something even more innovative."

Section 1115 waivers have been used by states for decades to temporarily suspend certain Medicaid rules in order to experiment with new cost-saving measures or methods of providing care. These waivers generally need to be cost-neutral for the federal government and maintain coverage for mandatory populations.

Most states expanded their Medicaid programs under the Affordable Care Act by submitting state plan amendments, which don't seek suspension of Medicaid rules. But five states — Arkansas, Iowa, Indiana, Michigan and Pennsylvania — designed state-specific expansions by submitting Section 1115 waivers.

Medicaid experts anticipate that these expansion models could lay the groundwork for new options that will be available in 2017 under the Affordable Care Act. Using Section 1332 waivers, states can seek approval to suspend certain elements of the health care law — as long as coverage levels stay the same and there is no additional cost to the federal government. States could take their federal Medicaid funding and use it in completely new ways, from designing a "single-payer" system (as Vermont is exploring) to eliminating the individual mandate or offering new types of plans in the state exchange.

chair of the conference committee that produced the compromise, which has since enrolled 120,000 people over the past year.

Jochum originally advocated for a straight Medicaid expansion — but she soon realized a compromise would need to be reached with policymakers who were calling for a more limited program (or no expansion at all).

"Our goal is to be the healthiest state in the nation, and we can't do that if people don't have health coverage," she says. So she went to work explaining why she thought a Medicaid expansion would be a good move for Iowa — for example, citing statistics that hospitals in the state were incurring about $1 billion in uncompensated care each year.

"Those of us who are fortunate enough to have health insurance are paying for the uninsured — and in the most costly way, because people were showing up in the emergency room," Jochum says.

In December 2013, the federal government approved a waiver for Iowa that includes two components.

The Iowa Wellness Plan is being offered to adults earning up to 100 percent of the poverty level; it will be much like Medicaid, with benefits similar to those offered to state employees. Monthly $5 premiums will be charged for enrollees with incomes of between 50 percent and 100 percent of the poverty level, but coverage cannot be canceled for non-payment.

Under the Marketplace Choice Plan (for adults earning between 101 percent and 133 percent of the poverty level), new Medicaid enrollees will be offered private health plans through the state's health insurance exchange. The state will pay premiums directly to the health plans, and enrollees will be asked to contribute a $10 monthly premium.

Beginning this year, Iowans enrolled in both of these new programs can have their premiums waived by participating in certain healthy behaviors — for example, getting an annual checkup or completing a health-risk assessment. All beneficiaries in Iowa's new plans will be charged a fee ($8) for visits to the emergency room that are deemed non-urgent.

"We are on target to getting everyone insured," Jochum says.

Adults who are newly eligible for Medicaid (with incomes below 138 percent of the federal poverty level)

State	Number of newly eligible residents	As a % of total population
Illinois	522,000	4.1%
Indiana	374,000	5.8%
Iowa	106,000	3.5%
Kansas	141,000	4.9%
Michigan	564,000	5.7%
Minnesota	130,000	2.4%
Nebraska	78,000	4.3%
North Dakota	24,000	3.6%
Ohio	578,000	5.0%
South Dakota	40,000	4.9%
Wisconsin	181,000	3.2%
U.S. total	*15,060,000*	*4.9%*

Source: United States Census (2010 data)

In Michigan, number of new enrollees tops expectations

Most states in the Midwest have now expanded Medicaid, but getting these bills passed through a legislature and signed by a governor has often proved difficult. That was certainly true in Michigan, where the expansion became law in 2013 after months of negotiations between lawmakers and Republican Gov. Rick Snyder.

Snyder argued that the bill would not only result in net budget savings, but would also help the state have a healthier, more productive workforce.

Critics, however, expressed concern over whether the savings would be enough to offset the future costs to the state when the federal match drops, in 2017 and beyond. (Michigan, along with many other states nationwide, has implemented what is often called a "circuit breaker" provision: the state will bow out of the expansion if projected savings don't meet goals or if federal matching funds are no longer available.)

The state initially estimated that it would receive a maximum of 470,000 applications under the Medicaid expansion. But by early February — just nine months into program enrollment — more than 533,000 residents had enrolled, Smith says.

In some ways, the program is similar to the one being implemented in Iowa (in fact, the two waivers were both approved in December 2013).

Under the Healthy Michigan plan, newly eligible adults are enrolled in private health plans that contract with the state.

Enrollees are subject to co-payments ranging from $1 to $3 for most services and prescriptions. Preventive services, prenatal care and family planning are completely covered.

Beneficiaries earning more than the federal poverty level pay monthly premiums amounting to about 2 percent of income, and they can receive reductions in co-pays if they follow certain healthy behaviors.

Total out-of-pocket costs are capped at 5 percent of household income.

The recent Medicaid changes and expansions in Michigan, Iowa and Indiana are emblematic of what is occurring across the country.

"It will be interesting to see how legislative discussions go this spring, because the environment has changed significantly," Smith says.

"It's a completely different discussion now. ... There is an opportunity for every state to tailor an expansion of coverage that is consistent with conservative principles."

As a former Medicaid director, Smith has some advice for states considering their options: "Put on your thinking caps. There may be a way to expand Medicaid that has not yet been proposed. I don't think we've seen the end of the innovative ideas."

Premium and cost-sharing requirements for selected services for adults receiving coverage through Medicaid expansion

State	Monthly premiums required?	Income at which cost-sharing begins	Non-preventive physician visit	Non-emergency use of emergency room	Generic drug co-pay
Illinois	No	0%	$3.90	$3.90	$2.00
Indiana	Yes	0%	Varies*	$8 ($25 after first time)	Varies*
Iowa	Yes (>50% FPL)	>50%	$0	$8	$0
Kansas	State is not expanding Medicaid at this time				
Michigan	Yes (>100% FPL)	0%	$0	$0	$1.00
Minnesota	No	0%	$3	$4	$1.00
Nebraska	State is not expanding Medicaid at this time				
North Dakota	No	0%	$2	$3	$0
Ohio	No	0%	$0	$0	$0
South Dakota	State is not expanding Medicaid at this time				
Wisconsin	State is not expanding Medicaid at this time				

* Indiana's expansion program does not utilize flat co-pays; it deducts provider costs from health savings accounts until a deductible is met.

Source: Kaiser Family Foundation, CSG Midwest research

Timeline: Medicaid expansion in Midwest under Affordable Care Act

March 2011

Minnesota takes part in an "early" Medicaid expansion, through an executive order signed by Gov. Mark Dayton. Adults with incomes up to 75 percent of the federal poverty level are shifted from a state-funded health program to Medicaid, allowing the state to draw federal matching funds for these 84,000 enrollees.

June 2012

The U.S. Supreme Court rules that states cannot be required to expand Medicaid under the Affordable Care Act. States can opt out of the expansion, which would cover all Americans earning up to 138 percent of the federal poverty level. The expansion would, for the first time, offer Medicaid to childless adults.

January 2014

Expanded Medicaid coverage begins in **Illinois**, **Minnesota**, **North Dakota** and **Ohio** — all of which expanded traditional Medicaid through a state plan amendment. Residents earning up to 138 percent of the federal poverty level (about $16,000 for an individual and $32,000 for a family of four) are eligible for Medicaid.

Expanded enrollment also begins in **Iowa**, which received approval of a Section 1115 waiver to cover the newly eligible population. The Iowa Health and Wellness Plan uses a combination of Medicaid managed care and subsidies for enrollees to purchase health plans in the state exchange. The federal government approves charging premiums for enrollees below the poverty level (however, beneficiaries cannot lose coverage if they don't pay).

April 2014

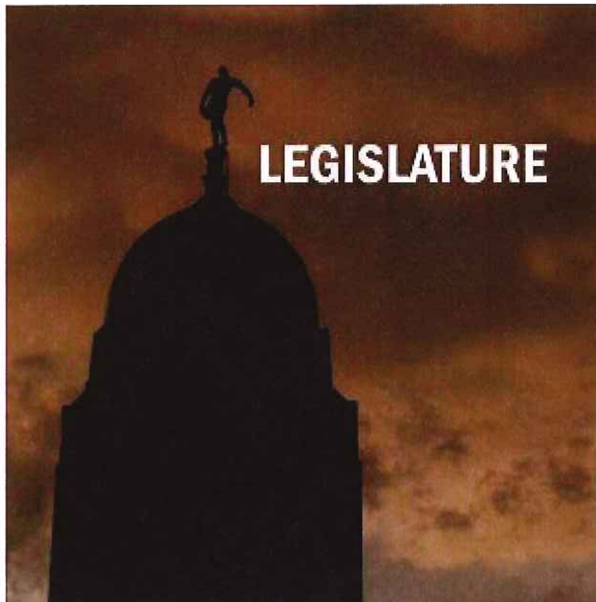
Enrollment begins in the Healthy **Michigan** plan, achieved through a Section 1115 waiver. Participants are asked to contribute co-pays, and some pay premiums amounting to 2 percent of income. Through engaging in healthy behaviors, participants can receive discounts on their out-of-pocket costs. The plan is estimated to cover about 500,000 adults.

January 2015

Indiana announces that it has received federal approval to expand Medicaid using the existing Healthy Indiana Plan. HIP 2.0 will continue offering a high-deductible health plan paired with a health savings account, funded jointly by the state and enrollees. For the first time, the federal government approves a lockout period for some low-income beneficiaries who do not pay monthly premiums.

JournalStar.com

Study: Medicaid expansion could save $1B over five years



APRIL 01, 2015 11:00 PM • BY JOANNE YOUNG | LINCOLN JOURNAL STAR

Two University of Nebraska at Kearney professors are hoping Nebraska state senators will look at Medicaid expansion somewhat differently this session.

"If Medicaid expansion does not occur, there will be a tremendous negative impact on the state," said Ron Konecny, co-author of a Medicaid expansion study released Wednesday.

The Medicaid Redesign Act (LB472), introduced this session by Lincoln Sen. Kathy Campbell, is not an economic development bill, Konecny said, it's an economic salvation bill.

Konecny, a professor of management, and Allan Jenkins, an economics professor, both at UNK, recently completed a study that shows the state's economy would conservatively avoid more than $1 billion in silent taxes, medical-related bankruptcies and unnecessary state spending in the next five years with expanded Medicaid.

With expansion, the state would receive nearly $2.1 billion during that time, drawing $992,000 daily in federal expansion funding and generating $5 billion in increased economic activity, the study showed.

It would save, create and support 47,000 jobs between 2015 and 2020.

"It preserves the hospitals. It preserves jobs. It preserves communities," Konecny said.

Health care is not welfare, Jenkins said. Medicaid expansion is about protecting the health care infrastructure.

Rural hospitals all over the country are closing because of bad debt and charity care, he said.

Individual families have limited resources if anything bad happens, Jenkins said. The Federal Reserve says half of American families cannot come up with $400 for emergencies without borrowing or selling something.

Expansion would generate $174.8 million in state and local taxes, which would be more than enough to offset the $81 million cost to the state to expand Medicaid to 79,600 low-income, working Nebraskans, the study said.

Konecny, who formerly did revenue forecasting for the state, said his track record on economic projections is "extremely good."

Overall, he said, Medicaid expansion would provide a modest gain in revenues for the state, a great gain for local communities, and for businesses and individuals, there are huge gains.

Of the top 10 states in reducing bankruptcies, he said, seven were states that expanded Medicaid. Eight of the 10 states with the best growth in employment are expansion states.

Much of the early discussion of expansion was focused on the costs to the state -- which are always more obvious -- with little discussion of the benefits, which are harder to estimate, Jenkins said.

The act would expand Medicaid to Nebraska adults who fall into a health insurance coverage gap between current Medicaid requirements and insurance exchange coverage.

The Legislature's Health and Human Services Committee advanced Campbell's bill to the full Legislature for debate this session.

Campbell said it is important to have the discussion, particularly with the 18 new members. Opponents could very likely filibuster the bill again, as they have in the past, each time successfully. Thirty-three votes to break the filibuster will be difficult to get, Campbell said.

Last year, opponents of Medicaid expansion said there were other ways to make health care access better and the cost lower. They said the expansion would saddle taxpayers with a massive bill for a government-run program ill-suited to meet the needs of the poorest Nebraskans.

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March 2015

UNK professors see economic gain if Medicaid is expanded in Nebraska

By Martha Stoddard / World-Herald Bureau | Posted: Friday, April 3, 2015 12:15 am

LINCOLN — Expanding Medicaid coverage to more low-income Nebraskans makes economic sense, says a pair of business professors at the University of Nebraska at Kearney.

Allan Jenkins, an economist, and Ron Konecny, a management professor, reached that conclusion after studying the potential costs and benefits of expanding the Medicaid program as allowed under the Affordable Care Act.

Their study, made public this week, found that the expansion would bring more than $2.1 billion in federal funds into the state over five years, which would translate into more than $5 billion worth of new economic activity.

The increased activity would generate $174.8 million in state and local tax revenue — more than enough to offset the $81 million net cost to the state of implementing the expansion, the two said.

The Nebraska Hospital Association and AARP, which commissioned the study, publicized it in advance of legislative debate on the latest proposal to expand Medicaid, a federal-state program that provides health care for the poor.

Lawmakers are to begin debate Wednesday on Legislative Bill 472, introduced by State Sen. Kathy Campbell of Lincoln. It marks the third attempt to expand Medicaid. Both previous attempts stalled in the face of filibusters.

Writing in his weekly column, Gov. Pete Ricketts called on senators to oppose this bill as well.

He said the expansion would take $158 million of state tax dollars over six years that could otherwise be used to reduce property taxes, help pay for education or build better roads.

The governor's cost figure came from a study done by Milliman Inc., a consultant hired by the state. Jenkins and Konecny's figure came from the Legislative Fiscal Office.

Ricketts said Nebraska could be at risk for still more spending if the federal government did not live up to its financing commitment: Under the Affordable Care Act, federal funds would pay 100 percent of the cost of Medicaid expansion through 2016. After that, the federal share would fall to 90 percent by 2022 and stay at that level.

LB 472 would use a combination of Medicaid and private health insurance subsidies to extend health coverage to people with incomes of up to 133 percent of the federal poverty level.

Under Nebraska law, adults without minor children cannot qualify for Medicaid no matter how low their income. Parents and disabled adults can qualify only if their incomes are well below the federal poverty level.

This year the federal poverty level is $24,250 for a family of four. For such a family, 133 percent of that would be $32,253.

Jenkins and Konecny concluded that Medicaid expansion, in addition to boosting economic activity, would save the state's economy more than $1 billion.

The savings would occur because fewer people would file medically related bankruptcies, hospitals would have less bad debt and charity care, hospitals would receive income to offset Medicare cuts, and businesses would not have to pay penalties for failing to offer affordable health insurance to workers.

Contact the writer: 402-473-9583, martha.stoddard@owh.com

Nebraska Eyes Medicaid 'Redesign' Bill to Close Coverage Gap

KOLN - Lincoln, NE

JournalStar.com

Local View: Failure to pass Medicaid Redesign Act would be irresponsible

APRIL 04, 2015 11:57 PM • BY LAURA J. REDOUTEY

The Medicaid Redesign Act (LB472) would prevent more than $1 billion in unnecessary and wasteful spending and draw in more than $2.1 billion in federal funding, spurring more than $5 billion in economic activity over the next five years.

Those are but a few of the highlights contained within an economic impact study that examines the cost of not expanding Medicaid in Nebraska and provides a detailed cost-benefit analysis of how the Medicaid Redesign Act would positively affect the state's economy. The study, released Wednesday by the Nebraska Hospital Association (NHA) and AARP Nebraska, was prepared by two University of Nebraska at Kearney professors who have conducted numerous economic impact studies for Nebraska municipalities and prepared an economic impact study focusing on Medicaid expansion in South Dakota.

The results indicate the state's continued rejection of Medicaid expansion would conservatively cost Nebraska more than $1 billion. Included in this cost is $73 million in general funds for state health care assistance programs between 2015 and 2020, programs that could be supported by Medicaid expansion. The state would realize $69.3 million in savings within the state disability program, HIV/AIDS drug program and behavioral health program. Another $3.6 million in savings would come from the Department of Correctional Services, because correctional facility inmates who receive treatment outside of the facility would be covered under Medicaid expansion.

Nebraska businesses are projected to pay $11 million to $16 million annually to pay Affordable Care Act (ACA) related taxes and penalties, costs that would be avoided if lawmakers approve LB472. Another $142.7 million in medical-related bankruptcies would also be averted during the next five years should Nebraska expand its Medicaid program. These are but a few of the wasteful expenditures that would be avoided through passage of LB472.

Should lawmakers enact the Medicaid Redesign Act, their decision would not only help nearly 80,000 low-income, working Nebraskans obtain health care coverage, but also recapture more than $2.1 billion in federal funding between 2015 and 2020, tax dollars Nebraskans are sending to Washington, D.C., that could be used to improve the state's health and economy.

As mandated by the ACA, Nebraska's redesign of Medicaid would be federally funded at 100 percent from 2015 through 2016, 95 percent in 2017 and 90 percent in 2020 and beyond. If federal funds should unexpectedly fall below 90 percent, the Medicaid Redesign Act requires coverage to be terminated immediately, a circuit-breaker protection that will prevent unexpected costs to the state.

The results of the study indicate the $2.1 billion in federal funding would spur $5 billion in economic activity. The resulting economic activity would generate enough state revenue to offset the $81 million, five-year cost to the state to expand Medicaid. The state and local tax revenue generated by expanding Medicaid, combined with the $73 million in state savings, would result in a revenue swing for the state.

The federal infusion of funds would also support more than 10,000 jobs that will be lost due to Medicare cuts in the ACA and subsequent congressional actions by 2020. Medicaid expansion would also provide funding to avoid nearly 31,000 jobs projected to be lost due to future cuts in Medicare through 2024. Before the U.S. Supreme Court ruled that mandatory expansion could not be required under the ACA, the Medicaid expansion dollars were initially intended to offset the Medicare reimbursement cuts. Those cuts, which began in 2010, are estimated to cost Nebraska's hospitals $2.1 billion through 2024. Our state's hospitals are experiencing those cuts with no offsetting revenue, financial losses that would be reduced by Medicaid expansion.

The Medicaid Redesign Act would strengthen local economies, protect local creditors by reducing medical-related bankruptcies, increase tax revenue without increasing tax rates, decrease state expenditures, reduce cost shifting that inflates costs for everyone who purchases insurance, help businesses by improving worker health and productivity and increase disposable income for low-wage workers.

The study is available at www.nebraskahospitals.org/advocacy/medicaid_redesign.html.

The NHA contends it would be irresponsible for Nebraska's lawmakers to deny adoption of the Medicaid Redesign Act, costing Nebraska more than $1 billion and leaving more than $2.1 in federal funds on the table, dollars that are currently boosting economies in those states that have chosen to expand. The NHA and its 89 member hospitals proudly support the Medicaid Redesign Act. It is the right thing to do.