Summary of Option 5A
Background, the Proposal, Issues and Other Elements
May 5, 2004

This document has been prepared as a summary of "Option 5A" that was presented to the Legislative Committee on Health Care, Subcommittee to Study Health Insurance Expansion Options, Technical Working Group" on April 14, 2004, and further reviewed by the Working Group on May 5, 2004.

The document begins with a brief introduction, follows with a section on background and then summarizes the proposal. Following the proposal summary are discussions of issues surrounding the conversion of the IAF and Supplemental Fund and on implementing the proposal. The summary concludes with a brief presentation of other elements of the proposal as well as a listing of the Issues and Concerns from the Work Group.

Introduction

EP&P Consulting, Inc (EP&P) was retained to assist the State of Nevada in developing a program that would secure federal funds to match money that is currently being spent within the state for health care services. The impetus for this engagement was the observation that the firm had made in previous engagements that a significant amount of federal SCHIP funds were being unused by the State. In designing the program, EP&P was to focus on, among other items, increasing health care services in the state, a design that would assist the state in obtaining approval from the federal government, and a thorough consideration of employer sponsored initiatives.

After organizational meetings, the Technical Working Group was presented at its March 10th meeting with a briefing on both HIFA waivers and the status of the uninsured in Nevada. At that meeting, the Working Group identified several potential groups for which health insurance coverage should be considered. That list of potential coverage groups was expanded by the Subcommittee at its March 12th meeting.

Subsequent to the March 10th meeting, several conference calls were held with members of the Working Group and others in an attempt to define and coordinate data collection activities to assist in the evaluation of various proposals for coverage. Data collection activities were also conducted with the Nevada Department of Human Resources, the Nevada Association of Counties, the Nevada Hospital Association and the Center for Health Information Analysis (CHIA) at UNLV.

In an all day meeting on April 14, 2004 EP&P presented the Technical Working Group with significant amount of cost and caseload, financing, data collection, and program information. At the conclusion of the meeting the firm presented several program options, and recommended that the Subcommittee be presented with "Option 5A" for consideration.

This option would eliminate the existing Indigent Accident Fund (IAF) and Supplemental Fund and convert the revenues into a pool of funds that would be matched by federal funds. The combined federal and Nevada funds would then be used to expand Medicaid coverage to pregnant women up to 185% of the federal poverty level (FPL), provide subsidized health insurance coverage through small employers to employees at less than 200% of FPL, and provide subsidies to employees (at less than 200% of FPL) that cannot afford the group health insurance coverage currently available from their employers.

Background from the April 14th Meeting

During the April 14th meeting several topics were covered. Those topics can be grouped into the following categories:

- Coverage Groups, their benefit packages and service delivery options
- Data available to assess impacts and what that data indicated
- Options to recommend to the Subcommittee

This section will discuss the first two topics and the following section will present Option 5A.

Coverage Groups, Benefit Packages and Service Delivery Options

In all ten different potential coverage groups were identified and or defined. Suggested benefit packages and service delivery options were also presented. The groups included:

1. Small employers not now offering health insurance
2. Employees of firms that offer insurance but who do not participate
3. Pregnant women with income less than 200% of the federal poverty level (FPL) not covered by Medicaid
4. Parents of Title XIX/XXI children
5. Children aging out of foster care
6. Individuals leaving TANF (Transitional TANF)
7. A population that could be covered under the federal Medically Needy definition
8. SSDI recipients that are not yet eligible for Medicare
9. SSI applicants who could have their eligibility determinations accelerated with state determination of eligibility under 42 CFR 435.210
10. Individuals that could be covered under a High Risk Pool program

This discussion provided the foundation for examination of the remaining topics of discussion.

Data Available to Assess Impacts

In order to design a program for the Subcommittee, data had to be collected for three purposes: 1) to determine cost and caseload, 2) to determine the amount of funds

available, and 3) to determine areas where expenditures were currently being made that could be matched by federal funds.

Cost and Caseload

Information was generally available to determine cost and caseload estimates. Where specific data was not available, reasonable assumptions could be made. The one exception where information was not available was for the Medically Needy coverage group. However, assumptions related to the total amount of expenditures related to this group were made. This resulted in a 'menu' of potential groups and their costs that could be included in a recommended program.

Funds Available

In determining the amount of funds available, four potential areas were targeted:

1. The amount of federal SCHIP funds that could reasonably be estimated to remain unused between now and SFY 2009
2. The Indigent Accident Fund (IAF) and the Supplemental Fund established in N.R.S. and administered by the Nevada Association of Counties (NACO)
3. Unmatched state funds administered by DHR that may be available for matching with federal funds
4. The Indigent Funds within each county.

After input from the Technical Working Group, updated estimates of available SCHIP funds were determined. Overall, the updated information (contained as Attachment 1) confirmed previous conclusions that the State will be reverting unused SCHIP funds into the foreseeable future. With their enhanced match rate and the definitions of allotment neutrality applied to these funds under HIFA waivers, these unused funds represent an attractive opportunity for Nevada to extend health coverage in the state. It should be noted that the amount of funds available is determined to some great extent by the amortization of funds that would remain unspent at the end of SFY 2009. These unspent funds were amortized over the 5 year period ending in SFY 2009.

Amounts available in the IAF and the Supplemental Funds were easily identified. They represent a revenue stream that by SFY 2006 will be approximately $16 million and should grow with property valuation growth to $19 million by SFY 2009. In addition, there should be a small cash balance in SFY 2005 that could be amortized over a five year period to extend the amount of funds available from this source.

The Department of Human Resources engaged in an effort to identify a number of potential funding sources that are currently unmatched by federal funds and/or have the potential for use in expanding health care coverage in Nevada. The most significant of these sources included potential excess appropriations in the Welfare Division ($19.7 million), federal fund recovery initiatives in Mental Health and Developmental Services Division ($3 million plus) and in Child and Family Services Division (potentially $2.3

million), and Tobacco Settlement Funds. However, the Division issued a caveat that it could not commit or assure these funding opportunities would be available for the initiative under consideration. As would be reasonably expected, the DHR included the following in their summary of funds available:

> The Department has expressed many times that there are many needs within the Department for extra funding. Dollars available from one source are historically transferred to programs/budgets lacking resources and which usually have significant waiting lists or where caseload growth consumes available funding.
>
> Before any funding can be committed for a HIFA Waiver, there needs to be consultation with the State Budget Office and Governor's Office to determine their priorities and commitment. Also, when DHR completes its budget building process later this summer, available funding may be consumed by other priorities.

As a result of these caveats, the recommended option for expanding health care coverage did not include any of these potential DHR revenue sources. Should the Subcommittee decide that some or all of these revenue sources should be included in an option for expansion, they can readily be incorporated.

With respect to the amount of County Indigent Funds available, this proved to be problematic. Several complications were involved. Among the more notable complications were:

- The lack of a statewide compilation of sources and uses of Indigent Funds in the counties
- The broad spectrum of services (both social services and health care services) provided through the Indigent Funds by the various counties
- The wide variance of eligibility standards among the counties for indigent health care
- The lack of demographic information for the individuals who benefit from the expenditure of these funds

As a result, the possibility of converting any of these funds to matching funds was deemed to be not feasible, and the County Indigent Funds were excluded from further examination.

In summary, the IAF and Supplemental Fund were considered to be potential revenue sources for the expansion of health care coverage. By matching the revenue that these two funds would generate with federal SCHIP and Title XIX (Medicaid) funds, total funds of $45 million could be generated in SFY 2005. This amount could grow to approximately $52 million in SFY 2009.

Current Expenditure Data

When attempting to determine where current health care expenditures were being made that could be analyzed to determine potential for federal match, several sources were pursued. Those sources included:

- NACO and the counties
- CHIA at the UNLV
- Hospitals

NACO was asked to provide information on the nature of the expenditures for the IAF and the Supplemental Fund. The information sought included both the amount of payments to individual hospitals and the demographic information related to the individuals for whom the expenditures were made.

NACO provided the information related to payments to individual hospitals and other providers. That information is presented in the two Tables below.

With respect to the demographic information on the individuals for whom the expenditures were made, no information was available from NACO. Information relating to citizenship, Nevada residency, specific income levels, categorical status (e.g. parental status), or the diagnosis for the patients is not routinely collected and collated, and was therefore not available from the organization. The various counties have engaged in an effort to collect this information, and while partial information is available, the data collection effort is on hold while the usefulness and comprehensiveness of this data is evaluated.

Complete demographic information is necessary in order to perform an analysis of the impact of converting the IAF and Supplemental Fund to matching funds for the potential program. After an evaluation of existing data is performed, final data collection may move forward.

The Tables below indicate which hospitals and provider types were the beneficiaries of the payments from the IAF and Supplemental Fund. The first Table indicates the distribution of the $9.6 million in payments from the IAF to the hospitals initiating the claims, and the provider types that benefited from the expenditures:

Payment Amounts from the IAF by Hospital
SFY 2003

Hospital	Hosp Paid	Physicians Paid	Amb Paid	Services Paid	Total Paid
No. Nevada	44,760	5,882	22,911	1,510	75,063
St. Rose	3,403	288	0	264	3,955
UMC	4,368,144	156,264	44,640	181,093	4,750,140
WMC	3,655,398	192,710	176,771	197,368	4,222,248
Churchill (WMC)	20,095	1,483	0	1,456	23,034
Carson Tahoe (WMC)	131,096	3,569	7,660	12,142	154,467
Humboldt (WMC)	106,487	663	4,807	17,701	129,668
Pershing (WMC)	288,747	7,635	10,117	2,635	309,134
Total	**8,618,140**	**368,494**	**266,906**	**414,169**	**9,667,709**

From the Table, it is clear that the primary facilities benefiting from the IAF payments are UMC and WMC.

The Table below indicates the amount of payments to hospitals from the Supplemental Fund. Here again, UMC and WMC are the primary beneficiaries of the payments made from these funds, though to a lesser extent than from the IAF.

Hospital	Cases	Billed Amt	Tot Ded	Allowed Amt	Amt Paid	Percent
Boulder City	1	32,107	25,000	7,107	1,921	0.03%
Desert Springs	27	1,788,667	830,285	958,382	259,071	4.33%
Lake Mead	51	3,666,575	2,312,993	1,353,582	365,902	6.12%
Mountain View	15	935,985	439,031	496,954	134,337	2.25%
Northeastern	3	135,720	75,000	60,720	16,414	0.27%
Out of State	2	73,683	50,000	23,683	6,402	0.11%
St. Mary's	35	1,860,131	929,445	985,131	266,302	4.45%
St. Rose Dominican	35	2,302,292	942,342	1,359,950	367,623	6.15%
St. Rose Siena	7	879,327	332,296	547,031	147,874	2.47%
Summerlin	3	117,156	75,000	42,156	11,396	0.19%
Sunrise	45	3,102,378	1,649,986	1,452,392	392,612	6.57%
University Med Ctr	385	25,625,917	16,952,895	8,673,021	2,344,500	39.21%
Valley Hospital	38	2,486,704	1,203,509	1,283,195	346,875	5.80%
Washoe Med Ctr	168	9,077,727	4,200,000	4,877,727	1,318,552	22.05%
Total	815	52,084,367	30,017,782	22,121,029	5,979,779	100.00%

The CHIA program at UNLV was contacted in an attempt to improve the information available. The data sought was the payments to hospitals by either the county Indigent Funds or the IAF or Supplemental Fund. Unfortunately, because of the timing of data

collection by CHIA (i.e. discharge information to be reported 45 days after the close of a quarter) and the billing and coding practices of the hospitals, the data provided by CHIA was not helpful for the analysis.

Individual hospitals were then asked through the Nevada Hospital Association for information related to both payments from the indigent sources as well as demographic data on the beneficiaries of these payments. Insufficient information was provided to allow for adequate evaluation, though additional data may be forthcoming[1].

For each coverage group that had been defined and the data collected, a table of advantages and issues was compiled and presented to the Work Group. The table addressed each of the coverage groups that had been outlined and evaluated the advantages and issues from the perspective of various stakeholders including: the state, employers, the counties, providers and beneficiaries. This table is included as Attachment 2.

Option 5A Summary

Several program options were then identified in Options 1 through 5. It was clear from the compilation of various options that a significant number of the identified coverage groups could not be included in the recommendation given the financing limitations.

Option 5A was compiled with the specific intent of fitting within the available financing and focused on the coverage groups of small employer coverage, premium subsidy for employees and pregnant women.

Financing

Option 5A proposes that the State of Nevada use the existing funding that is directed into the Indigent Accident Fund and the Supplemental Fund to match with federal funds. In making this conversion, the statutes would be amended to change the objectives of the funds and to specifically remove any county liability for the current purposes of these funds.

If the amendments were made, the result of this change would be to have no impact on the counties, and remove the revenue source from the hospitals and other providers that provide the services currently covered by these funds.

Based on the estimated amount of funds available from the IAF and Supplemental Fund as well as SCHIP funding available, the total amount of resources available for the program is depicted in the Table below:

[1] However, it should be noted that after the presentation and discussion of Option 5A at the April 14th meeting, both UMC and WMC were invited to make a presentation at the May 5th Technical Working Group meeting, and both did so.

Funding Available for Option 5A

	2005	2006	2007	2008	2009
Indigent Accident Fund (IAF) Revenue	9,445,934	9,823,771	10,216,722	10,625,391	11,050,407
Supplmental Fund Revenue	6,693,632	6,961,377	7,239,832	7,529,425	7,830,602
Est. Amortized IAF Cash Balance	760,000	760,000	760,000	760,000	760,000
Total State Funds (A)	16,899,566	17,545,148	18,216,554	18,914,816	19,641,009

SCHIP Funds	2005	2006	2007	2008	2009
Estimated Loss of Authority	1,980,098	864,320	7,681,336	5,594,352	3,507,368
Allocation of Ending Balance	14,424,480	14,424,480	14,424,480	14,424,480	14,424,480
Total SCHIP Funds Available (B)	16,404,578	15,288,800	22,105,816	20,018,832	17,931,848
Estimated State Funds Needed	7,325,464	6,827,213	9,871,352	8,939,409	8,007,466

	2005	2006	2007	2008	2009
State Funds Available for Standard Match	9,574,102	10,717,935	8,345,202	9,975,407	11,633,543
Additional Federal Monies Available (C)	12,135,880	13,585,772	10,578,159	12,644,564	14,746,373
Total Funds Available	45,440,024	46,419,720	50,900,529	51,578,212	52,319,230
Cummlative Total Funds (A+B+C)	45,440,024	91,859,744	142,760,273	194,338,485	246,657,715

Pregnant Women

It has long been a priority of DHR to extend coverage under the Medicaid program to pregnant women up to 185% of the FPL. Currently Nevada provides the minimum level of coverage that is mandated under federal law, that is, at 133% of the FPL.

Coincidentally, it is also true that the two hospitals that currently receive the greatest amount of funding under the IAF and Supplemental Fund are also the only two hospitals in the state that deliver 'free care' hospital services with respect to births in Nevada (based on state data). Therefore, by extending full Medicaid coverage to this group of pregnant women, the two largest losers from the abolishment of the funds will either have an opportunity to reduce costs or increase revenues.

It is anticipated that approximately 3,050 pregnant women would be covered annually under this provision.

Small Employer Coverage

Based on the Subcommittee's charge and supported by the uninsured data for Nevada as well as the priorities established for HIFA waivers, the option includes the creation of a subsidized health insurance plan for small employers that have not offered health insurance for the preceding 6 months.

Though not yet fully developed, the proposal envisions that the benefits under the coverage would be similar to the "Health Plans for the Small Business Owner" currently offered through the Las Vegas Chamber of Commerce. A small business would have to have two or more, but less than 50 full-time employees.

It is envisioned that as in the Chamber of Commerce plan, the proposed small employer plan would procure services from a health plan to deliver a commercial health care package. Offered for consideration is the thought that the coverage would be offered and administered through the health plans that currently serve Title XIX clients.

It is further envisioned that eligible employees, for health coverage, would include all active employees who work at least 30 hours per week. Subsidies of 50% of the premium would be paid by the state to the insurance carrier (or health plan) for all covered employees that have household income at or below 200% of the Federal Poverty Level. All employees of the employer could participate in the program but the subsidy would not be paid for those employees with incomes greater than 200% of the FPL.

It is anticipated that the average monthly premium for this product per individual would be $250 per month. The subsidy would therefore average $125 per eligible employee (less than 200% FPL) per month. The employer and the employee would be required to each contribute 25% to the cost of coverage.

The Work Group received information that the $250 per month would likely be adequate in southern Nevada, but may be 'light' for products that are offered in rural areas and/or northern Nevada.

Option 5A anticipates the phase in of coverage at 2,000, 5,000, 8,000, 10,000, and 10,000 lives for Years 1 through 5.

The Table below addresses the notion of the demand that one could expect from the small employer market. With the current assumptions ascertained from the documents in the Bibliography (see Attachment 3), there may be a problem in generating sufficient demand for this product. The indicated number, 4,000, is short of the enrollment goal of 10,000. However, the 4,000 does not include spouses, and conversations with knowledgeable parties in Nevada indicate that an enrollment level of 10,000, over the 5 years, should not be a problem. The Technical Working Group briefly discussed this information regarding the 'take up' rate during its May 5 meeting, and further information on this topic from brokers was thought to be helpful.

Estimated 'Take-up' by Small Employers

Estimated number of Small Employers not offering Health Insurance [1]		15,800
Estimated number of employees employed within [1]		78,500
Estimated number of Small Employers influenced to offer Health Insurance [2]	10%	1,580
Estimated number of employees employed within [2]	10%	7,850
Estimated number of employees eligible for subsidy [4]	51%	4,000
Maximum allowable enrollment under proposal		10,000

[1] Data source: Medical Expenditures Panel Survey, 2001

[2] Assumption based upon preliminary review of findings contained in Bibliography (see attachment 2)

[3] Data source: Medical Expenditures Panel Survey, 2001; estimated percentage enrolled in Health Insurance

[4] Data source: Medical Expenditures Panel Survey, 2001; Current Population Survery 2000-2002; estimated number of indiviuals employed at small employers ≤200% FPL

Premium Subsidy for Employees

In reviewing the data related to the uninsured and employer coverage in Nevada, it was observed that there exists a number of employees of firms (both small and large) that provide health insurance coverage that do not take advantage of such coverage. It is thought that a number of low income individuals cannot afford the coverage that is offered to them.

Option 5A therefore includes a proposal that will subsidize the payment of health insurance coverage for this group of employees.

The subsidy would be extended to those employees with household incomes of less than 200% of the FPL. It is envisioned that the state would provide a subsidy to the individual to acquire the current insurance offered by their employer up to $100 per employee per month. It is anticipated that in order to be eligible for the subsidy, the benefit package offered by the employer must include physician services, inpatient and outpatient hospital services, emergency services, and laboratory and x-ray services.

It is assumed that 1,000 lives would be covered under this program in the first year, with 2,500 lives covered thereafter. The Table below supports the notion that sufficient demand should be available to provide for this enrollment.

Estimated 'Take-up' by Employees

Estimated number of Employees offered but not enrolled in Health Insurance [1]		104,000
Estimated number of employees influenced to 'take-up' Health Insurance [2]	20%	20,800
Estimated number of employees eligible for subsidy [3]	53%	11,000
Maximum allowable enrollment under proposal		2,500

[1] Data source: Medical Expenditures Panel Survey, 2001

[2] Assumption based upon preliminary review of findings contained in Bibliography (see attachment 2)

[3] Interpolation from Current Population Survery 2000-2002; estimated number of indiviuals employed at all employers ≤200% FPL

Sources and Uses of Funds

The Sources and Uses of Funds for Option 5A would appear as follows:

	2005	2006	2007	2008	2009
Total Funds Available	45,440,024	46,419,720	50,900,529	51,578,212	52,319,230
Utilization					
Small Business Employees	3,000,000	8,100,000	13,996,800	18,895,200	20,407,200
Premium Subsidy Program	1,200,000	3,000,000	3,000,000	3,000,000	3,000,000
Pregnant Women	24,739,831	26,719,007	28,856,538	31,164,961	33,658,336
Administrative Expenditures [1]	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000
Balance of Funds Available	14,500,193	6,600,714	3,047,191	(3,481,949)	(6,746,306)
Unused Dollars	14,500,193	6,600,714	3,047,191	0	0
Cummulative Unused Dollars	14,500,193	21,100,907	24,148,098	24,148,098	24,148,098

Allotment Neutrality Test

	2005	2006	2007	2008	2009
SCHIP Funds Available	16,404,578	15,288,800	22,105,816	20,018,832	17,931,848
Utilization					
Small Business Employees (50%)	1,500,000	4,050,000	6,998,400	9,447,600	10,203,600
Premium Subsidy Program (50%)	600,000	1,500,000	1,500,000	1,500,000	1,500,000
Pregnant Women (0%)	0	0	0	0	0
Total Utilization	2,100,000	5,550,000	8,498,400	10,947,600	11,703,600
Variance To SCHIP Funds Available	14,304,578	9,738,800	13,607,416	9,071,232	6,228,248

[1] Amount for Administrative Expenditures is a 'placeholder' only.

Issues Related to Converting the IAF and Supplemental Funds

Option 5A would significantly expand the amount of health care dollars that would be generated by the IAF and Supplemental Fund through the leveraging of federal funds. Total annual funds to be expended on health care would grow from approximately $15 million to approximately $45 million per year. However, the services for which the new funds would be spent would be significantly different from the services for which the funds are spent now.

Assuming the enabling statutes are appropriately amended, counties should not feel any impact from the change. Hospitals and other providers on the other hand, may very well experience a change in funding patterns.

This section presents information about some of the issues that are related to the funding change. There is a discussion on the impact to hospitals, primarily the two largest recipients of the IAF and Supplemental Fund. There is also a discussion of the Medically Needy program as a potential alternative to some or all of the elements of Option 5A.

Hospitals

As discussed above, UMC and WMC are the largest beneficiaries of the IAF and Supplemental Fund. They are also the only hospitals providing deliveries under 'free care' in the state. To some extent, the inclusion of the pregnant women category in the proposal will offset some of the hospitals' losses from the abolishment of the two current funds.

In assessing the impact of these connected elements, some background facts are worth noting:

- All of the costs of covering pregnant women will not go to hospitals. A good portion of the costs go to doctors and other providers
- All of the free births, once they receive coverage, will not necessarily continue to use the two facilities that they use now – they will be 'empowered' to use just about any facility that they choose.
- To the extent that they do not provide the services for the free births, the costs of the 2 facilities will decrease
- It is unknown how many of the 'free care' births are for women at or below 185% of the FPL, for undocumented immigrants, or for non residents. To the extent that the mothers associated with the 'free births' do not meet the qualifications for this program, 'free births' will continue and the hospitals will not benefit from the expansion of coverage.
- The potential expansion population is an estimate of all women between 133% and 185% that have children in a year. Some of these women will be uninsured, of which some will receive 'free care' and some of which will be categorized as 'self pay'. There is also a portion of this population that is currently covered by health insurance. The estimate in costing this element assumes that the self pay, free care and currently insured populations will avail themselves of coverage under the Waiver. This may or may not be true.

The chart below shows two possible views of how the waiver population of pregnant women could deploy across facilities. For the purpose of the presentation, the total expenditures for the population are assumed to be split 50% to hospitals and 50% to other providers. The chart also assumes two different patterns of utilization for this population.

The first assumption is that the waiver population will utilize services using the same pattern that emerges when combining current Medicaid, Free Care and Private Pay utilization. The second assumption is that the waiver population will use the same pattern as the combined pattern for Medicaid and Free Care. Hospitals not shown did not report providing any services to the populations described above.

Clearly both the 50% assumption as well as the distribution of utilization will have an impact on the degree to which the two subject hospitals are held harmless.

Potential Distribution of Expenditures for Pregnant Women
133% to 185% FPL
Assuming 50% of State Expenditures Accrue to Hospitals
Differing Utilization Assumptions

	Utilization based upon Medicaid, Free Care & Private Pay Experience		Utilization based upon Medicaid & Free Care Experience	
County / Hospital	**Est. New Util**	**Est. Expend.**	**Est. New Util**	**Est. Expend.**
CLARK COUNTY	2,032	8,241,182	1,966	7,973,506
Lake Mead	223	904,421	124	502,907
Mountain View	47	190,618	27	109,504
St. Rose Dominican	84	340,679	75	304,178
St. Rose Siena	78	316,345	50	202,785
Sunrise	275	1,115,318	238	965,257
University Medical Center	1,325	5,373,803	1,452	5,888,876
RURAL COUNTIES	260	1,054,482	239	969,312
Carson Tahoe	102	413,681	103	417,737
Churchill	51	206,841	41	166,284
Humboldt General	27	109,504	23	93,281
Mt. Grant	1	4,056	1	4,056
Northeastern	66	267,676	60	243,342
William Bee Ririe	13	52,724	11	44,613
WASHOE COUNTY	757	3,070,165	845	3,427,067
St. Mary's	102	413,681	102	413,681
Washoe Medical Center	655	2,656,484	743	3,013,385
Totals	*3,050*	*12,365,829*	*3,050*	*12,369,885*

Note that for expenditures for the Medicaid pregnancies, it is assumed that 50% will be utilized for payments for hospitals.

A comparison between the information presented immediately above and the earlier information on the payments from the IAF and Supplemental Fund indicates that UMC is approaching 'break even' ($6.7 million from IAF and SF combined and potentially $5.4 million from Option 5A births) and that WMC may likely suffer a loss from the exchange of the two current funds for the expansion for pregnant women ($4.9 million from IAF and SF combined and potentially $2.7 million from Option 5A births).

UMC testified on this topic during the May 5th meeting of the Technical Working Group. In their testimony UMC indicated that Option 5A would cause a $20 million loss to the

facility over the next five years. In subsequent questioning by the workgroup, it was determined that the apparent significant differences between the estimates (views) given in the table above and the UMC testimony were likely due to the differences in the assumptions made in performing the estimates. Apparently, UMC assumed that their share of newly paid births would be approximately 7% (based on their share of managed care business) whereas the estimates above were based on an estimated market share of 43%. The workgroup observed that the ultimate truth may lay somewhere between the two estimates. The data depicting births by payment status is included as Attachment 4. It is anticipated that UMC may testify at the Subcommittee meeting on May 7, 2004.

An additional factor to consider is the benefit that the two hospitals would enjoy from the coverage of the small employer population. This is unknown. The extent to which the hospitals will benefit will be determined by the facilities that this newly covered group chooses to use as well as the extent to which this newly covered group uses the two facilities now.

The Medical Needy Population

During the April 14th meeting the Medically Needy program was discussed. At that time a Medically Needy design was discussed that would possibly satisfy likely CMS policy constraints and simultaneously attempt to mimic existing populations currently covered by the IAF and Supplemental Fund.

If a perfect design could be achieved, hospitals would lose nothing from the abolishment of the two funds and additional populations could be covered with the new federal funds. Such a perfect design would be difficult under likely CMS policy constraints.

A program that might maximize CMS constraints and provide a hold harmless capability would encompass:

- A short spend-down period (e.g., one month)
- Require a specified amount of medical/hospital costs
- Limit eligibility to one segment per year (or a certain number of segments per lifetime)
- Allow non-categoricals as well categoricals to be covered
- A limited benefit package

An example was given that would define a medically needy population that covered individuals that have an income of no more than 150% of the Federal Poverty Level (FPL). In addition, there would only be a one-month spend-down period, which should capture those persons who have experienced some type of catastrophic event such as a motor vehicle accident. Finally, the waiver might be constructed such that individuals eligible for the waiver under the medically needy category must incur at least $15,000 (or some other determined amount) in medical expenses.

The advantage of this approach would be the enhanced overlap with the current programs covered by the Funds compared to a more strict, traditional Medicaid medically needy definition. In addition, under a HIFA waiver, the state could cap enrollment and/or expenditures for this population.

Issues Likely To Arise

If the proposed alternative were to be selected as a means of offsetting some of the impact of Option 5A, there are a few issues that will arise, both from the standpoint of the hospitals and also from the standpoint of securing federal approval from CMS.

A major issue will be whether the hospitals believe that the waiver will be a "good deal" for them. The issues will likely be: 1) what areas of hospital costs that are now covered by these funds will be covered by the proposal; and 2) what other areas of the HIFA waiver will provide reimbursements that are now uncompensated.

Given the limited data that is currently available, and the wide variance in current county indigent standards, designing a specific proposal will pose some challenges. Some of the factors that will pose challenges include:

- What income level to establish given the disparity in county eligibility levels
- Establishing the 'spend down' amount, and determining whether this should be based on cost, charges, or the Medicaid fee schedule
- Addressing the practice of prorating payments by the Supplemental Fund
- Determining the demographic characteristics (alien status, Nevada resident status, categorical status, etc) of patients for whom payments are currently being made

Additionally, given that the cases that are paid for by these funds are episodic, there is uncertainty as to the consistency of the demographic characteristics over time. Hospitals will have to see the specifics of this design before they can fully evaluate the impact of a medically needy proposal.

As was noted during the meeting, CMS has never considered a pure medically needy waiver that dictates a specified amount of medical costs. This type of waiver may receive heighten scrutiny because of its innovative approach, but by following some of the basic standards of a medically needy program, such as a spend-down period and a set medically needy income level, CMS may give the proposal a favorable review.

Also, CMS would most likely prefer that those persons eligible for the medically needy program receive a more comprehensive benefit package than what may be currently offered by the two programs. This would be accommodated by structuring a limited benefit package that includes such services as physician services, inpatient and outpatient hospital, and prescription drugs.

Finally, when defining the medically needy population, the state must be mindful of the budget neutrality implications, both for state and federal purposes.

With respect to state budget neutrality, it is conceivable that a program could secure approval under a waiver that has an expenditure cap. This would serve to protect state budget neutrality.

With respect to federal budget neutrality, the greater the overlap of the waiver definition with the Title XIX medically needy definition, the smaller the impact on budget neutrality. However, budget neutrality issues do not arise in cases where Title XXI (SCHIP) funding is used, as is the plan for Nevada. If XXI funds are used to cover the non-categorical population of the waiver, CMS will only require allotment neutrality. However, if SCHIP funds are exhausted and Title XIX funding is needed, budget neutrality will become an issue.

Because a Medically Needy proposal of the nature that would need to be constructed to increase the hold harmless potential for the hospitals is an untested issue, all of the policy implications associated with defining the population have not been fully developed. Additionally, at the present time there is insufficient information available (most notably beneficiary demographic information) that would allow testing of the option in sufficient detail to test the program's veracity to accomplish the purpose for which it would be intended. Because of these issues as well as the 'first impression' nature of the proposal to CMS, this potential program element was characterized as 'high risk' during the Work Group meetings, and was not included in Option 5A.

However, the Work Group expressed serious reservations about Option 5A's omission of such a program element in light of the abolishment of the IAF and Supplemental Funds. Without some provision to protect providers that are currently providing services that are compensated by these funds, there is concern as to the impact of Option 5A on providers. This concern is focused most particularly on the payments that are made on behalf of nonqualified aliens and out of state residents.

Implementation Issues for Option 5A

There are a number of implementation issues that must be addressed if Option 5A is to move forward. Among the more notable issues are:

- An assessment as to whether the general plan for benefits and costs are feasible
- An assessment as to the reasonableness of the anticipated take up rates for the program
- Methods to guard against adverse selection in the small employer program
- The role of brokers and their compensation in the program
- Administrative issues have not been fully vetted or priced.

These issues were broached during the Work Group meetings but additional work will be required on these topics.

Other Elements of the Proposal

During the course of this project, particularly during efforts at data collection, a number of areas of potential reporting reform surfaced. Among the more notable areas are:

- The establishment of financial reporting standards for County Indigent Funds and the requirement that NACO publish an Annual Report of revenue and expenditures from these funds
- Enacting a requirement that the Department of Insurance publish an Annual Report of Health and Accident insurance policies in the state
- Reform the CHIA hospital reporting requirements to:
    - Alter the timelines for reporting such that the payor information can be more reliable
    - Add timelines and methodologies for reporting outpatient services.

Concerns and Issues from the Work Group

After the meeting on May 5, the Work Group raised concerns and issues with respect to Option 5A. Those concerns included, not necessarily in priority order, the following:

1. With regard to the abolishment of the IAF and the Supplemental Fund:
    a. Funding for Option 5A is only targeted at "local" funds and no consideration is given to any state level funds that may be contributed.
    b. Such an abolishment would leave no source of payment for charges (especially for nonqualified aliens and out of state residents) that would otherwise qualify for payment from these funds, and there would be a subsequent increase in uncompensated care to the providers of these services.
    c. There is a wide range of estimates of the potential impact to UMC from Option 5A, but it is recognized that both UMC and WMC may suffer a loss
    d. There is no transition period for the abolishment of these funds that would address charges that are already in the pipeline.
    e. The tradeoff of abolishing these funds will only result in a modest decrease in the number of uninsured (approximately 15,000 lives) from the approximately 350,000 uninsured.
    f. The Subcommittee should keep the possibility of maintaining a medically needy program (or some form of the existing IAF and Supplemental Fund) in the plan to be adopted. It is recognized that designing and getting approval for a medically needy program may be a challenge and that maintaining some form of the existing funds would decrease the amount of federal funds that could be leveraged.

2. With regard to the programs offering subsidies to employers and/or employees:
    a. There is concern that the employee subsidy program, especially if it is extended to large employers, may "reward" employers for not keeping employee contributions affordable.
    b. The Subcommittee should consider only offering one subsidy plan (the employee) versus two (employer and employee). This was thought to be a preferable course because:
        1. A separate state product would not be created to compete with existing commercial products.
        2. It would be difficult to have a single state plan that would be viable throughout the state, especially in the rural areas. HMO type plans are generally not available in the rural areas.
        3. Using existing commercial plans with the employee subsidy will also allow the program to get up and running faster.
        4. Limiting the program to a single approach will save on administrative costs.

Attachment 1
Title XXI Funds
Actual & Projections 1998 - 2009

Actual/Projected SCHIP Federal Funds & Expenditures 1998 - 2009

Utilization of SCHIP Funds Calculation

		Year of Utilization						
	Allotment	1998	1999	2000	2001	2002	2003	2004
1998	$ 30,407,067	$ 30,407,067						
1998 Redist					$ 11,200,763			
1999	$ 30,263,463		$ 30,263,463					
1999 Redist						$ 11,312,497		
2000	$ 30,526,393			$ 30,526,393				
2000 Redist							$ 10,703,421	
2001	$ 31,344,200				$ 31,344,200			
2001 Redist								9,874,000
2002	$ 27,613,689					$ 27,613,689		
2003	$ 30,436,463						$ 30,436,463	
2004	$ 31,164,000							$ 31,164,000
2005	$ 40,068,000							
2006	$ 40,068,000							
2007	$ 40,068,000							
2008	$ 40,068,000							
2009	$ 40,068,000							
Total Available		$ 30,407,067	$ 30,263,463	$ 30,526,393	$ 42,544,963	$ 38,926,186	$ 41,139,884	$ 41,038,000
Carry Forward		$ -	$ 30,407,067	$ 58,154,652	$ 60,789,856	$ 61,870,593	$ 58,957,889	$ 58,050,152
SCHIP Expenditures		$ -	$ 2,515,878	$ 7,842,016	$ 14,460,150	$ 19,467,003	$ 21,831,381	$ 23,928,919
Waiver Expenditures								
Net		$ 30,407,067	$ 58,154,652	$ 80,839,029	$ 88,874,669	$ 81,329,776	$ 78,266,392	$ 75,159,233
Loss of Authority		$ -	$ -	$ 20,049,173	$ 27,004,076	$ 22,371,887	$ 20,216,240	$ 13,558,770
Carry Over		$ 30,407,067	$ 58,154,652	$ 60,789,856	$ 61,870,593	$ 58,957,889	$ 58,050,152	$ 61,600,463

Note: *SCHIP appropriation is not approved for FY 2008 & FY2009.

**Estimate based on national SCHIP appropriations.

Actual amounts a function of each states' uninsured children amounts.

Actual/Projected SCHIP Federal Funds & Expenditures 1998 - 2009

Utilization of SCHIP Funds Calculation

		Year of Utilization					
	Allotment	**2005****	**2006****	**2007****	**2008***	**2009***	
1998	$ 30,407,067						
1998 Redist							
1999	$ 30,263,463						
1999 Redist							
2000	$ 30,526,393						
2000 Redist							
2001	$ 31,344,200						
2001 Redist							
2002	$ 27,613,689						
2003	$ 30,436,463						
2004	$ 31,164,000						
2005	$ 40,068,000	$ 40,068,000					
2006	$ 40,068,000		$ 40,068,000				
2007	$ 40,068,000			$ 40,068,000			
2008	$ 40,068,000				$ 40,068,000		
2009	$ 40,068,000					$ 40,068,000	
Total Available		$ 40,068,000	$ 40,068,000	$ 40,068,000	$ 40,068,000	$ 40,068,000	
Carry Forward		$ 61,600,463	$ 71,232,000	$ 80,136,000	$ 80,136,000	$ 80,136,000	
SCHIP Expenditures		$ 28,456,365	$ 30,299,680	$ 32,386,664	$ 34,473,648	$ 36,560,632	
Waiver Expenditures							
Net		$ 73,212,098	$ 81,000,320	$ 87,817,336	$ 85,730,352	$ 83,643,368	
Loss of Authority		$ 1,980,098	$ 864,320	$ 7,681,336	$ 5,594,352	$ 3,507,368	$ 19,627,474
Carry Over		$ 71,232,000	$ 80,136,000	$ 80,136,000	$ 80,136,000	$ 80,136,000	$ 80,136,000
						Total Federal Funds Available	**$ 99,763,474**
						Total Expenditure Available	144,312,851
						Total Expenditure Available per year	28,862,570

Note: *SCHIP appropriation is not approved for FY 2008 & FY2009.

**Estimate based on national SCHIP appropriations.

Actual amounts a function of each states' uninsured children amounts.

Actual/Projected SCHIP Federal Funds & Expenditures 1998 - 2009

	Expenditure		Allotment Amount											
			1998		1998 Redist		1999		1999 Redist		2000		2000 Redist		2001
			$ 30,407,067		$ 11,200,763		$ 30,263,463		$ 11,312,497		$ 30,526,393		$ 10,703,421		$ 31,344,200
1998	$	-													
1999	$	2,515,878	$ 2,515,878												
2000	$	7,842,016	$ 7,842,016												
2001	$	14,460,150			$ 11,200,763		$ 3,259,387								
2002	$	19,467,003							$ 11,312,497		$ 8,154,506				
2003	$	21,831,381											$ 10,703,421		$ 11,127,960
2004	$	23,928,919													
2005	$	28,456,365													
2006	$	30,299,680													
2007	$	32,386,664													
2008	$	34,473,648													
2009															
Loss of Authority			$ 20,049,173		$ -		$ 27,004,076		$ -		$ 22,371,887		$ -		$ 20,216,240
To Date Loss of Authority			$ 20,049,173		$ 20,049,173		$ 47,053,249		$ 47,053,249		$ 69,425,135		$ 69,425,135		$ 89,641,375

Actual/Projected SCHIP Federal Funds & Expenditures 1998 - 2009

			Allotment Amount						
			2001 Redist	2002	2003	2004	2005**	2006**	2007**
	Expenditure		$ 9,874,000	$ 27,613,689	$ 30,436,463	$ 31,164,000	$ 40,068,000	$ 40,068,000	$ 40,068,000
1998	$	-							
1999	$	2,515,878							
2000	$	7,842,016							
2001	$	14,460,150							
2002	$	19,467,003							
2003	$	21,831,381							
2004	$	23,928,919	$ 9,874,000	$ 14,054,919					
2005	$	28,456,365			$ 28,456,365				
2006	$	30,299,680				$ 30,299,680			
2007	$	32,386,664					$ 32,386,664		
2008	$	34,473,648						$ 34,473,648	
2009									$ 36,560,632
Loss of Authority			$ -	$ 13,558,770	$ 1,980,098	$ 864,320	$ 7,681,336	$ 5,594,352	$ 3,507,368
To Date Loss of Authority			$ 89,641,375	$ 103,200,145	$ 105,180,243	$ 106,044,563	$ 113,725,899	$ 119,320,251	$ 122,827,619

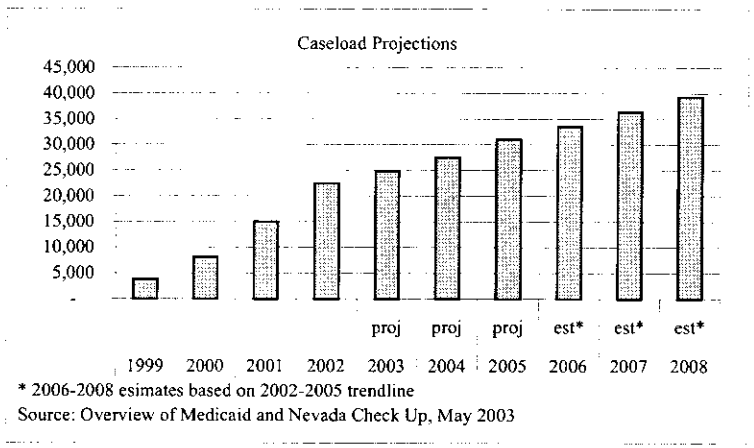
Nevada Check Up Projections

	Caseload		PMPY**	Expenditures	Exp. (net of admin.)		Fed Share %	Fed Share $	CHAP / Asset Test Expansion (Federal)	Adjusted Fed Share $	Actual Funding Lost
1999	3,862		$902	$3,483,524	$3,870,582		65.0%	$2,515,878	$0	$2,515,878	$0
2000	8,079	109%	$1,344	$10,858,176	$12,064,640	212%	65.0%	$7,842,016	$0	$7,842,016	$0
2001	14,985	85%	$1,331	$19,945,035	$22,161,150	84%	65.3%	$14,460,150	$0	$14,460,150	$0
2002	22,414	50%	$1,336	$29,949,236	$29,949,236	35%	65.0%	$19,467,003	$0	$19,467,003	$0
2003 proj	24,844	11%	$1,318	$32,745,434	$32,745,434	9%	66.7%	$21,831,381	$0	$21,831,381	$0
2004 proj	27,532	11%	$1,270	$34,958,246	$34,958,246	7%	68.5%	$23,928,919	$0	$23,928,919	$0
2005 proj	31,023	13%	$1,246	$38,663,559	$38,663,559	11%	69.1%	$26,728,118	$1,728,247	$28,456,365	-$749,999
2006 est*	33,582	8%	$1,226	$41,168,064	$41,168,064	6%	69.1%	$28,459,483	$1,840,197	$30,299,680	-$798,581
2007 est*	36,434	8%	$1,208	$44,003,642	$44,003,642	7%	69.1%	$30,419,718	$1,966,946	$32,386,664	-$853,586
2008 est*	39,285	8%	$1,192	$46,839,220	$46,839,220	6%	69.1%	$32,379,953	$2,093,695	$34,473,648	-$908,590
2009 est*	42,137	7%	$1,179	$49,674,798	$49,674,798	6%	69.1%	$34,340,188	$2,220,444	$36,560,632	-$963,595

Highlighted fields have been updated from the *2003-2005 Executive Budget* , http://budget.state.nv.us/BB_TOC.htm

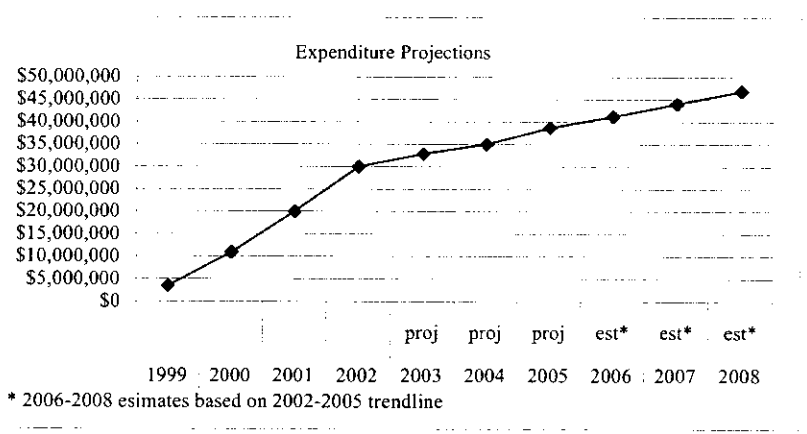
* 2006-2008 esimates for Caseload and Expenditures based on 2002-2005 trendline

** 2002-2008 PMPY calculated (= Exp. / Caseload)



* 2006-2008 esimates based on 2002-2005 trendline

Source: Overview of Medicaid and Nevada Check Up, May 2003



* 2006-2008 esimates based on 2002-2005 trendline

Attachment 2
Coverage Options
Advantages & Issues

Coverage Options for Nevada HIFA: Advantages and Issues

	State		Employers		Counties		Providers		Beneficiaries	
Coverage Category										
	Advantages	Issues/Concerns	Advantages	Issues/Concerns	Advantages	Issues/Concerns	Advantages	Issues/Concerns	Advantages	Issues/Concerns
Small Business Employees	1. Satisfies HIFA requirement for ESI component 2. Allows state to leverage employer dollars 3. Decreases the number of uninsured 4. Can be viewed as more politically palatable than direct coverage 5. Parents in population would be a pass-through for budget neutrality purposes 6. Satisfies HIFA expansion requirement	1. Administrative complexity including systems, subsidy, eligibility and payment of premiums 2. Start-up costs 3. Possible lack of employer participation 4. Role of brokers 5. Childless adults would count against budget neutrality 6. Funding source for state match 7. Guarding against adverse selection 8. Strategies to contain rates -- underwriting requirements 9. What is the appropriate estimate of take up rates? 10. Option would tend to attract higher income individuals	1. More affordable coverage 2. Less time lost from work by workers	1. Administrative complexity (e.g. eligibility determination, enrollment, etc.) 2. Take-up based on benefit package and premiums 3. Equity issue with respect to employers already offering coverage	1. Decreases the number of uninsured 2. Less strain on the safety net	Not enough coverage to change definition of county's responsibility -- therefore dollars cannot be taken from existing funds	1. Decreases the number of uninsured 2. Less strain on the safety net 3. Payment for some services offered that are currently charity/bad debt	Not enough coverage to change definition of county's responsibility -- therefore dollars cannot be taken from existing funds	1. Decreases the number of uninsured 2. Less time off work 3. Better access to services 4. Better health outcomes	1. Take-up based on benefit package and premiums 2. Are premiums and cost-sharing affordable? 3. Must be employed to enroll in program 4. Ability to enroll based on employer

Coverage Options for Nevada HIFA: Advantages and Issues

	State		Employers		Counties		Providers		Beneficiaries	
Coverage Category										
	Advantages	Issues/Concerns	Advantages	Issues/Concerns	Advantages	Issues/Concerns	Advantages	Issues/Concerns	Advantages	Issues/Concerns
Premium Subsidy Program	1. Satisfies HIFA requirement for ESI component 2. Allows state to leverage employer dollars 3. Decreases the number of uninsured 4. Can be viewed as more politically palatable than direct coverage 5. Parents in population would be a pass-through for budget neutrality purposes 6. Satisfies HIFA expansion requirement 7. Existing health care delivery system 8. Reduced possibility for adverse selection	1. Administrative complexity including systems, subsidy, eligibility and payment of premiums 2. Start-up costs 3. Sufficiency of employer health plan 4. Childless adults would count against budget neutrality 5. Funding source for state match 6. What is appropriate estimate of take up rates 7. How to determine subsidy amounts 8. Option would tend to attract higher income individuals	1. More affordable coverage 2. Less time lost from work by workers	N/A	1. Decreases the number of uninsured 2. Less strain on the safety net	Not enough coverage to change definition of county's responsibility -- therefore dollars cannot be taken from existing funds	1. Decreases the number of uninsured 2. Less strain on the safety net 3. Payment for some services offered that are currently charity/bad debt	Not enough coverage to change definition of county's responsibility -- therefore dollars cannot be taken from existing funds	1. Decreases the number of uninsured 2. Less time off work 3. Better access to services 4. Better health outcomes	1. Must have access to employer-based 2. Depending on program design, may have to "carry" the premium until payment is received from state

Coverage Options for Nevada HIFA: Advantages and Issues

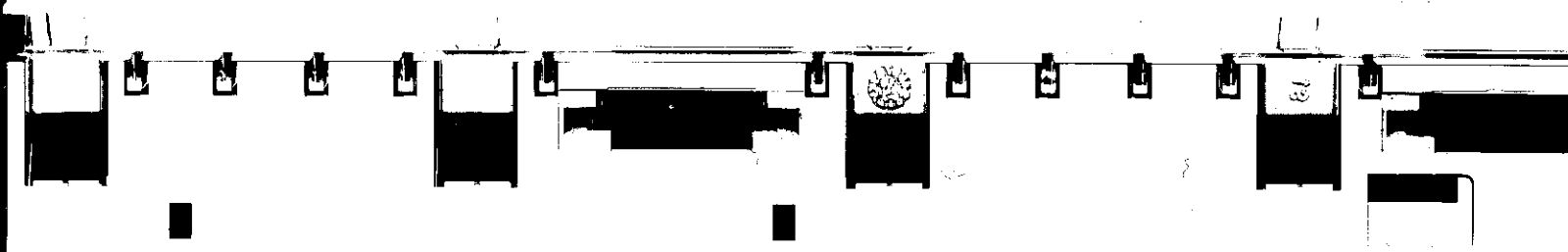
	State		Employers		Counties		Providers		Beneficiaries	
Coverage Category										
	Advantages	Issues/Concerns	Advantages	Issues/Concerns	Advantages	Issues/Concerns	Advantages	Issues/Concerns	Advantages	Issues/Concerns
Pregnant Women	1. Satisfies state policy priority 2. Satisfies HIFA expansion requirement 3. Pass-through for budget neutrality purposes	1. Funding source for state match 2. Likely first priority for SCHIP funding 3. Crowd out issues 4. Expensive population to provide coverage	Less time lost from work	How would this interact with ESI?	Reduces number (if any) of deliveries paid for	Not enough coverage to change definition of county's responsibility -- therefore dollars cannot be taken from existing funds	1. Coverage for more deliveries -- State Hospital Report indicates 1,670 "Free care" and 1,822 "private pay" births provided by the hospitals in SFY 2003 2. Source of offset for revenue lost from federalizing IAF and Supplemental funds	Not enough coverage to change definition of county's responsibility -- therefore dollars cannot be taken from existing funds	Better birth outcomes due to prenatal care	N/A
Parents of XIX/XXI Children	1. Satisfies HIFA expansion requirement 2. Pass-through for budget neutrality purposes 3. Would not have to do eligibility 4. Can control for adverse selection	1. Systems changes 2. Funding source for state match 3. Option would be targeted on lower income individuals 4. Relatively high cost population to cover 5. Crowd out issues	Less time lost from work	How would this interact with ESI?	1. Decreases the number of uninsured 2. Less strain on the safety net	Not enough coverage to change definition of county's responsibility -- therefore dollars cannot be taken from existing funds	1. Decreases the number of uninsured 2. Less strain on the safety net 3. Payment for some services offered that are currently charity/bad debt	Not enough coverage to change definition of county's responsibility -- therefore dollars cannot be taken from existing funds	1. Increase coincident in Nevada Check Up for children 2. Seamless coverage	What will the benefit package look like? (substitute for current coverage)
Children Aging Out of Foster Care	1. Satisfies HIFA expansion requirement 2. Pass-through for budget neutrality purposes	1. Small impact because of the small population 2. Funding source for state match 3. Very high cost population to cover	N/A	N/A	1. Decreases the number of uninsured 2. Less strain on the safety net	Not enough coverage to change definition of county's responsibility -- therefore dollars cannot be taken from existing funds	1. Decreases the number of uninsured 2. Less strain on the safety net	Not enough coverage to change definition of county's responsibility -- therefore dollars cannot be taken from existing funds	Continuous coverage	N/A

Coverage Options for Nevada HIFA: Advantages and Issues

Coverage Category	State		Employers		Counties		Providers		Beneficiaries	
	Advantages	Issues/Concerns	Advantages	Issues/Concerns	Advantages	Issues/Concerns	Advantages	Issues/Concerns	Advantages	Issues/Concerns
Transitional TANF	1. Incentive to work for TANF recipients 2. Increased possibility of ESI availability 3. Satisfies HIFA expansion requirement 4. Pass-through for budget neutrality purposes	1. Funding source for state match 2. Relatively high cost population to cover	Less time lost from work	How would this interact with ESI?	1. Decreases the number of uninsured 2. Less strain on the safety net	Not enough coverage to change definition of county's responsibility -- therefore dollars cannot be taken from existing funds	1. Decreases the number of uninsured 2. Less strain on the safety net	Not enough coverage to change definition of county's responsibility -- therefore dollars cannot be taken from existing funds	1. Incentive to work 2. Continuous coverage	Temporary coverage
Medically Needy	1. Satisfies HIFA expansion requirement 2. Potential to match up with IAF/Supplemental Fund and leverage local dollars	1. Idenfication of eligible individuals 2. CMS approval issues (benefits package, limited definition, spend-down period) 3. Would be a maintenance of effort (MOE) requirement 4. How would costs be controlled so as to not encourage existing county clients to transfer to the state?	Less time lost from work	N/A	1. Decreases the number of uninsured 2. Less strain on the safety net 3. Potential to transfer responsibility for IAF and Supplemental fund to the state 4. Potential to relieve some county indigent fund responsibility to the state	1. To what extent does the medically needy definition capture the currently funded individuals? 2. Will the counties become responsible for the IAF and Supplemental fund clients that do not transfer to the state?	1. Decreases the number of uninsured 2. Less strain on the safety net	1. To what extent does the medically needy definition capture the currently funded individuals? 2. Level of compensation for servcies	Access to a medical home	Limited duration coverage
SSDI	1. Satisfies HIFA expansion requirement 2. Coverage is time-limited 3. Likely to be a population that would a pass-through for budget neutrality purposes	1. Very high cost population to cover 2. What would be the highest income level for coverage?	N/A	N/A	1. Decreases the number of uninsured 2. Less strain on the safety net	1. What is the overlap with current populations? 2. Not enough coverage to change definition of county's responsibility -- therefore dollars cannot be taken from existing funds	1. Decreases the number of uninsured 2. Less strain on the safety net	1. What is the overlap with current populations? 2. Not enough coverage to change definition of county's responsibility -- therefore dollars cannot be taken from existing funds	Coverage for persons with disabilities	Transition to Medicare (less comprehensive coverage)

Coverage Options for Nevada HIFA: Advantages and Issues

	State		Employers		Counties		Providers		Beneficiaries	
Coverage Category										
	Advantages	Issues/Concerns	Advantages	Issues/Concerns	Advantages	Issues/Concerns	Advantages	Issues/Concerns	Advantages	Issues/Concerns
SSI (42 CFR 435.210)	1. Pass-through for budget neutrality purposes 2. One time freeing up of state funding	1. Systems changes 2. Administrative concerns -- SSDI determination 3. Funding source for state match	N/A	N/A	1. Decreases the number of uninsured 2. Less strain on the safety net	Not a population that the counties now cover	1. Decreases the number of uninsured 2. Less strain on the safety net 3. Payments received faster	N/A	1. Coverage for persons with disabilities 2. Continuous coverage, not episodic care	N/A
High Risk Pool	Creation of pool	1. Identification of HIFA eligibles 2. Will benefits outweigh the costs? 3. Creation of the pool (size, funding sources, limited Title XIX eligibles willing to join, creation of administrative entity to run pool) 4. Funding source for state match 5. Very high cost population to cover	N/A	How would this interact with ESI?	1. Decreases the number of uninsured 2. Less strain on the safety net	1. What is the overlap with current populations? 2. Not enough coverage to change definition of county's responsibility -- therefore dollars cannot be taken from existing funds	1. Decreases the number of uninsured 2. Less strain on the safety net 3. Payments received faster	1. What is the overlap with current populations? 2. Not enough coverage to change definition of county's responsibility -- therefore dollars cannot be taken from existing funds	1. Ability to get insurance 2. Continuous coverage, not episodic care	Premiums, co-pays and deductibles would be very expensive



ATTACHMENT 3

BIBILIOGRAPHY

Blumberg, L.J., L.M. Nichols, and J.S. Banthin, "Worker Decisions to Purchase Health Insurance," *International Journal of Health Care Finance and Economics,* Vol. 1, Nos. 3-4, September 2001.

- This paper uses a new Medical Expenditure Panel Survey file which links household and employer survey respondents, supplying data for both employer insurance takers and decliners.
- Like earlier studies with less representative worker samples, we find worker price elasticity of demand to be quite low. This suggests that any premium subsidies must be large to elicit much change in worker take-up behavior.

Chernaw, M., Frick, K., and C.G. McLaughlin, "The Demand for Health Insurance Coverage for Low-Income Workers: Can Reduced Premiums Achieve Full Coverage?" *Health Services Research,* Vol. 32, No. 4 (1997).

- Estimates indicate that a significant number of uninsured, low-income individuals would not purchase insurance even at substantially subsidized rates. Subsidies less than 50% have virtually no effect on participation rates because the employer contribution is often greater than 50%. Above 50%, there are modest increases in participation rates.
- Data taken from Small Business Benefit Survey conducted through telephone surveys of businesses with 2-25 employees working at least 17 hours per week.
- 94.5% of workers who are not required to make any contribution for their health insurance coverage participate in their employer-sponsored plan compared to 80.3% of those who must explicitly contribute
- Assuming employee capture (i.e. the subsidy is given directly to the employee rather than the employer), 29% of uninsured workers would opt for coverage if given a 50% subsidy.
- Premium subsidies are likely to be very expensive relative to the modest reduction in the number of uninsured that will be achieved

Farley, P., and A. Monheit, "Selectivity in the Demand for Health Insurance and Health Care," *Advances in Health Economics and Health Services Research,* Vol. 6 (1985).

Helms, W.D., and A. Gauthier, and D. Campion, "Mending the Flaws in the Small Group Market," *Health Affairs* 11 (2) (1992).

- A demonstration program in Washington State that provided large subsidies directly to low-income individuals had a greater impact than the subsidy programs aimed at employers.

Leibowitz, A., and M. Chernaw, "The Firm's Demand for Health Insurance," *Health Benefits and the Workforce,* U.S. Department of Labor, Pension and Welfare Benefits Administration (1992).

- The study found that premium reductions, even as substantial as 50%, would not greatly increase provision of insurance.

Marquis, S., and S. Long, "Worker Demand for Health Insurance in the Non-Group Market," *Journal of Health Economics* 14 (1): 47-64 (1995).

- Study estimates that a 60% subsidy would cause 24% to 31% of uninsured workers to purchase coverage.

McLaughlin, C.G. and W. Zellers, "The Shortcomings of Voluntarism in the Small-Group Insurance Market," *Health Affairs* 11, no. 2 (summer) (1992).

- This study revealed that over two-thirds of small businesses that do not offer insurance would be influenced to do so by a subsidy.
- The study also found that premium reductions, even as substantial as 50%, would not greatly increase provision of insurance.

Reschovsky J.D. and J. Hadley, "Employer health insurance premium subsidies unlikely to enhance coverage significantly," Issue Brief No. 46, Center for Studying Health System Change, December 2001

- Based on a national study by the Center for Studying Health System Change (HSC), premium subsidies paid directly to small firms are unlikely to significantly reduce the number of uninsured.
- A hypothetical 30 percent premium subsidy targeted to the employers of these workers--slightly more generous than the average in existing small firm subsidy programs across the country--would extend coverage to only about half a million uninsured workers if implemented nationally.
- The impact on the number of uninsured would actually be much smaller, with less than 3 percent of workers in nonoffering firms with fewer than 50 workers actually obtaining insurance as a result of the subsidy.
- Nationally, firms with fewer than 50 people employ nearly 34 million workers, about 16 million of whom-48 percent-are not offered health insurance. Under a 30 percent premium subsidy hypothetically available to all nonoffering firms, 1.5 million workers would gain offers of employer-sponsored coverage, reducing the number of workers who lack coverage offers to 14.6 million

Short, P., and A. Taylor, "Premiums, Benefits, and Employee Choice of Health Insurance Options," *Journal of Health Economics* 8 (3) (1989).

Thomas, K, "Are Subsidies Enough to Encourage the Uninsured to Purchase Health Insurance? An Analysis of Underlying Behavior," *Inquiry* 31 (4) (1994).

Thorpe, K., A. Hendricks, D. Garnick, K. Donelan, and J. Newhouse, "Reducing the Number of Uninsured by Subsidizing Employment-Based Health Insurance," *Journal of the American Medical Association* 267 (7) (1992).

- The study found that premium reductions, even as substantial as 50%, would not greatly increase provision of insurance.
- New York State subsidized the price of health insurance, reducing it by 50%. Eligible employers were responsible for paying the remaining portion of the premium.
- The subsidized health insurance products increased the number of small firms (under 20 employees) offering insurance by a small amount, approximately a 3.5 percentage point increase. When fully implemented and assuming all eligible employers were aware of the program, the subsidy would increase the proportion of firms offering insurance by 16.5 percentage points.
- Increased program visibility and allowing the employee to share in the premium payment may increase the number of employers offering insurance. Even under ideal conditions, however, the results highlight the limitations of voluntary programs to increase the number of employers offering health insurance.

Attachment 4
Nevada Birth Statistics
By Hospital & Payor

Estimated Expenditures for 'Free Care' Births

Data Provided by State of Nevada, Division of Health Care Financing and Policy

	Births by Payor							
County / Hospital	**Medicaid**	**Medicare**	**OthGovt**	**MgdCare**	**Comm**	**PriPay**	**Free**	**Total**
CLARK COUNTY	4,376	33	90	16,050	211	1,405	1,230	23,395
Boulder City	0	0	0	0	0	0	0	0
Desert Springs	0	0	0	1,149	0	0	0	1,149
Lake Mead	354	1	0	617	52	416	0	1,440
Mountain View	78	29	8	2,313	65	85	0	2,578
St. Rose Dominican	213	0	5	519	7	78	0	822
St. Rose Siena	143	0	11	1,921	10	127	0	2,212
Summerlin	0	0	0	1,650	0	0	0	1,650
Sunrise	678	0	16	4,097	38	270	0	5,099
University Medical Center	2,910	3	50	637	39	429	1,230	5,298
Valley Hospital	0	0	0	3,147	0	0	0	3,147
RURAL COUNTIES	679	0	81	555	524	218	0	2,057
Battle Mountain	0	0	0	0	0	0	0	0
Carson Tahoe	295	0	2	502	75	57	0	931
Churchill	116	0	76	49	60	59	0	360
Grover C. Dils	0	0	0	0	0	0	0	0
Humboldt General	65	0	3	0	81	28	0	177
Mt. Grant	2	0	0	0	0	0	0	2
Northeastern	171	0	0	0	297	58	0	526
Nye General	0	0	0	0	0	0	0	0
Pershing	0	0	0	0	0	0	0	0
South Lyon	0	0	0	1	0	0	0	1
William Bee Ririe	30	0	0	3	11	16	0	60
WASHOE COUNTY	1,969	0	96	3,219	231	199	440	6,154
Incline Village	0	0	0	0	0	0	0	0
Northern Nevada	0	0	0	0	0	0	0	0
St. Mary's	291	0	83	1,516	127	59	0	2,076
Washoe Medical Center	1,678	0	13	1,703	104	140	440	4,078
Totals	*7,024*	*33*	*267*	*19,824*	*966*	*1,822*	*1,670*	*31,606*

Expenditure Estimates utilizing identical PMPM as Pregnant Women		
Volume (Free Care Births)	1,670	
PMPM (see Pregnant Women)	676	(includes SOBRA 'kick')
Annual Expenditures	13,547,040	