Modified Verbatim Transcript of the Legislative Committee on Health Care Subcommittee to Study Health Insurance Expansion Options (*Nevada Revised Statutes* 439B.200)

May 7, 2004 – Las Vegas

ANDY HARVEY: My name is Andy Harvey. I am the Webmaster here at the Legislature, so I am in charge of the Internet site and you will see a couple of extra things going on here today other than those used in the committees normally. What we are doing is a demonstration, on the monitor in the back, of captioning. I used to call it closed captioning but I have been corrected since then because it is actually open captioning. What we are trying to do is develop a system for the hearing impaired. What you are seeing is an output of our Internet site. So this is just something, if you were at home right now, you could call up on your Web browser, and what we are doing is trying to put the video of a committee meeting with the caption of the audio content of the meeting.

We have Denise Phipps, from Captions Unlimited in Reno, and I have some brochures I will put out on the table for you if you are interested in this at all. But Denise is basically a court reporter working with a steno machine, and with the technology we have now we can take the output of the stenography machine and get it over the Internet. We have two big challenges with this. The actual text you see here and the video of the meeting you see here will be delayed from the live broadcast for about 15 to 30 seconds. That is typical if you watch a meeting on the Internet, it just takes that much time to get from here to Chicago or somewhere else where another company is that we are using and get all fed through the Internet. And it will depend somewhat on the speed of your computer. But that is what we have going on here today. We have actually done this I think three times now and it has worked very well. We have had great success. We are the first state in the country to do

anything like this, not just legislative, but judicial, or executive branch, or anything. So basically we are feeling we have the technology worked out to do it. My part is kind of done.

Funding is another rather huge issue. In the short-term, what I am kind of recommending is that maybe we can think of a pool of money that we can build and perhaps the Legislature could contribute some to that over a biennium. Deaf and hearing impaired groups could find grants and perhaps some monies to put into that. And then if there is someone who needs the captioning for a particular meeting, we could make it available. Currently what we do is if there is a hearing impaired person, the Legislature will bring in a signer, someone who signs, and sits with the person. I would like to see that extended into being able to make it available over the Internet. So it is just something we are kind of testing at this point. It seems to work very well. There are going to be some issues with cost and whatnot, but I just wanted to kind of explain to you what was going on today.

I would also like to introduce to everybody Nancy Tribble. Nancy is our new Chief Clerk of the Assembly and so you will all be seeing her around here as you come back during the interim and, of course, during session. She has been involved with us on this testing and we appreciate her support as well.

NANCY TRIBBLE: I worked with Denise in the courts for over 20 years. She was a court reporter and this is very exciting for me because it brings back old memories, but also this has a threefold benefit because you can get immediate transcripts of what has been said. It will obviously eliminate -- not eliminate but, you know, having the signing when it is not always available it will be there and captioning for people that are out in the audience looking on the Web site. So I really appreciate Denise coming and doing this demo and having her here today. So with that, I guess you guys can -- whenever your meeting starts, you can go ahead. But thank you.

ANDY HARVEY: Anybody have any questions at all?

NANCY TRIBBLE: Denise would be happy to answer any questions if you have any of her and that is her brochure on what Captions Unlimited does.

ANDY HARVEY: Thanks. If you would have a little patience with us with just the extra person and the extra monitor. But I definitely think that someday everybody will be doing this probably for most meetings. It is always kind of more fun to lead the pack rather than follow the pack. Thanks.

Please stand by. The meeting will begin shortly.

CHAIRWOMAN BUCKLEY: I would like to go ahead and get started and call the Legislative Committee on Health Care Subcommittee to Study Health Insurance Expansion Options. I will ask the secretary to please take the roll. (Roll call.) I am advised Assemblywoman Leslie will be a few minutes late but she will be here. Senator Titus is excused. She was at the last minute unable to attend.

I would like to note that we are doing an experiment today in real time captioning for those with hearing impairments. It basically involves an on-site transcription, court reporting transcription with the words utilized, put on the Web, so that someone could follow along with it. It is a great service and I understand there is a bill pending before Congress on the issue. It is something that state legislators are considering to make their hearings more accessible. So you are all part of an experiment today. So congratulations.

With that, we will go right to the agenda. The first item on the agenda is approval of the minutes of the March 12 meeting. A motion by Assemblyman Hardy, seconded by Senator Rawson. Any discussion on the minutes. All those in favor signify by saying aye. Opposed. Motion carries.

Next, a presentation concerning unauthorized insurers in Nevada. We are fortunate to have Commissioner Molasky-Arman with us. Commissioner, at our last meeting we were concerned about the recent newspaper report on a number of people, especially those employed by small businesses, who spend their hard-earned money only to find out that there really is no insurance offered. We are pleased that you are able to make a presentation on this issue today, and we are also very interested on whether you think there needs to be any bill draft recommendations in this area or whether you think it is merely an enforcement issue. So with that, we look forward to your presentation.

ALICE MOLASKY-ARMAN: Thank you, Madam Chair, and I appreciate your inviting me here today. For the record I am Alice Molasky-Arman, the Commissioner of Insurance. You have asked me to make a presentation principally regarding Employers Mutual, which was highlighted in the recently issued GAO report on unauthorized insurance, and to provide information on health plans. To assist me with this presentation I have with me Van Mouradian, seated next to me on my right, who is the Chief of the Division's Life and Health section. Also with us today are Kay Lockhart, who is the Executive Director of the Nevada Independent Insurance Agents and a member of the Board of Directors of the Nevada

Surplus Lines Association. On my left there is Tim Hall of Interwest Advertising. We do expect our presentation to take approximately one hour for those who are speaking.

As you may be aware, Employers Mutual, LLC, not to be confused with Employers Insurance Company of Nevada, was incorporated in Nevada but it was not licensed or authorized in Nevada or in any state. One of the largest health insurance scams in the nation, it defrauded over 4,000 employers in all 50 states.

I also have with me, because I wanted you to be familiar with the Chief Investigator for the Division of Insurance, and seated on my far right is Ben Gillard. Ben was the principal investigator in Employers Mutual. He was the person responsible for establishing a network among all the states' investigative officers for every single insurance commissioner in the state and he is also the investigator who worked and coordinated the state's role with the Department of Labor. By the time Employers Mutual, LLC was shut down, through the joint efforts of federal and states, it left 30,000 participants and beneficiaries and 25,000 health care providers, an estimated $27 million to $40 million in unpaid claims. In Nevada, Employers Mutual defrauded 41 employers. It has left 1,900 participants, beneficiaries, and medical providers with an initial estimate of $1 million in unpaid claims. Employers Mutual claimed to be a legitimate health plan, exempt from state regulation due to ERISA preemption, but it was, in fact, a MEWA scam.

Health insurance scams proliferate as people struggle to find ways to afford insurance in the face of rising costs or during the strains of a poor economy. The scam artists confuse the public by adopting names similar to legitimate licensed insurers. Their schemes are very elaborate and very sophisticated, marketing their products through the Internet, direct mail, or by selling their product through licensed insurance producers. They enroll as many people as quickly as possible, with little or no consideration for medical histories by claiming to offer coverage with better benefits and at much lower rates than legitimate plans. They lure producers to sell their product by offering large commissions. The scam artists often claim the plans are ERISA, or union plans, and are not subject to state regulation because of ERISA. To give the appearance of legitimacy the plans may even pay a few small claims, leaving the larger claims unpaid. In fact, Employers Mutual even paid $3 million in initial claims in order to keep their scheme alive.

Sometimes scam artists will set up bogus associations. In addition to collecting premiums for fraudulent policies they also collect membership dues. The principals of

Employers Mutual, for example, set up 16 associations in an effort to disguise themselves as an employee organization. There was no criteria to join the associations, nor did the associations meet the definition of an employee organization under ERISA. In reality, these phony associations were used as a marketing tool in order to sell the plans to various types of groups and as an attempt to circumvent regulatory oversight and scrutiny by claiming to be ERISA preempted.

Ambiguity in the federal law contributes to the spread of unlicensed plan. ERISA, which stands for the Employee Retirement Income Security Act, was initially enacted in 1974 by the federal government as a tax law and pension provision. Secondarily, the act also authorized private sector employers in certain circumstances to self-insure their employees health and benefits plan. With some exception, Title One of ERISA preempts state regulation of these self-insured plans. In general, ERISA does not cover plans established or maintained by federal, state, or local governments, or churches for their employees, or plans which are maintained solely to comply with applicable worker's compensation unemployment or disability laws.

ERISA also does not cover plans maintained outside the United States, primarily for the resident benefit of nonresident aliens or unfunded excess benefit plans. The ambiguity of ERISA was intensified in 1983 when the law was amended to clarify the preemption of laws as they related to multiple employer welfare arrangements, or what we call MEWAs. A MEWA is an employee welfare benefit plan or any arrangement other than an employee welfare benefit plan which is established or maintained for the purpose of offering welfare benefits to the employees or beneficiaries of two or more employers.

The definition of MEWA includes both ERISA plans and other arrangements that offer medical, surgical, hospital care or benefits for sickness, accidents, disability, or any of the benefits described in Section Three, subsection one, of ERISA.

As amended, ERISA prohibits state regulation of a self-insured employer or union plans through what was termed the preemption clause. It also prohibits states from deeming an employer or union plan to be an insurer for purposes of regulation through the "deemer clause," but it restores state regulation of MEWAs through what we call or term the "savings clause."

Plans that are both ERISA and MEWA are duly regulated by both the state and federal governments. Simply put, union plans, whether insured or not insured, are not subject

to state regulation but association plans are. This is a very important but it is also an unclear distinction. The unlicensed entity attempts to avoid state regulation by claiming to be an ERISA plan while at the same time they attempt to avoid federal regulation by claiming to be a MEWA. While the regulators are sorting out jurisdiction, the victims of these schemes multiply. The actual organization structure, not the name, MEWA association, AMP, et cetera, is a crucial factor in determining jurisdiction and often requires complex investigation to establish. These investigations are time- and resource-intensive.

There are legitimate ERISA and union plans exempt from state regulation. However, legitimate ERISA or union plans are established by unions for their own members or by an employer for its own employees. Insurance producers do not sell these products. It should be noted that legitimate ERISA plans supersede some state health care initiatives, such as employer insurance mandates and some types of managed care plan standards, if they have a substantial impact on employer-sponsored health plans.

Since neither ERISA plans nor MEWAs are required to register with the federal government before offering such plans, it is incredibly difficult to identify which plans are actually operating in the state. When the state learns of an active scheme operating in its territory, it notifies the NAIC. That is the National Association of Insurance Commissioners. They then issue a nationwide alert to all commissioners. They also maintain and circulate among regulators a list of known or suspected frauds.

The first time our division learns of activity in Nevada, it is, however, usually through a consumer complaint, or when insurance producers, or other persons who are approached to market the plan notify us. Once we learn of the plan, we must first determine whether the benefit arrangement is established or maintained by an employer or an employee organization and, therefore, exempt from state regulation.

If it is, it is then probably an ERISA plan and our investigation has become a futile investment of time and resource. If it is not, then it may well be an insurance plan subject to, but out of compliance with, state regulation, or it could be an outright fraud.

It is at this point that the division investigators can separate a legitimate plan honestly mistaking its regulatory obligations from fraudulent entities. A legitimate plan will work with the division to comply with the law, while a fraudulent entity will avoid our inquiries, stall for time, appeal findings, continue to sell their worthless products, and camouflage assets. Despite the many obstacles erected by the fraudulent entities the Division's

Legal staff moves as quickly as possible to shut down the operations through filing a complaint, issuing a cease and desist order. We issue press releases. We post those on the Web site to alert consumers of the scams. In addition to the issuance of cease and desist orders, Nevada law does allow the Commissioner to take administrative action. We may seize funds and take possession of those funds or assets. We may place the entity into receivership. We may require them to obtain appropriate licensing. We can impose administrative sanctions. We can obtain injunctions, and we can refer the unauthorized activity to the appropriate authority for criminal prosecution.

The administrative process allows the Commissioner to impose administrative fines, but it does not provide for the Commissioner to require restitution. In the case of Employers Mutual, I issued the first of many states' cease and desist orders. I ordered a third party administrator to secure the company records and I seized and took possession of the company's Nevada bank accounts. I also ordered the principals to appear before me at a hearing that was calendared for December 3, 2001, and as I earlier indicated, I designated Ben Gillard, the Nevada chief insurance investigator, to chair the NAIC's Employers Mutual investigative team that was established to coordinate the flow of investigative information between the states. And, as I indicated, Ben also actively assisted the federal Department of Labor investigators in their investigation. I took the additional step of notifying the affected employers in this state, advising them to stop paying premiums and to give them an early opportunity to replace that coverage with legitimate coverage, and, by the way, I am currently being sued for libel and slander by the principals of Employers Mutual for providing an early warning to Nevada policyholders.

Prior to the December hearing, and with the endorsement of all participating states, which numbered 26, my attorneys reached an agreement with principals of Employers Mutual, whereby I would supervise and control all of the company's assets, would hire a third-party administrator for nationwide claims payment, and would supervise the permanent closure of the company.

Before this agreement could be implemented, however, the Department of Labor intervened by initiating an action in the United States Federal District Court in Nevada. In that action, the court issued a temporary restraining order against Employers Mutual and its principals. They appointed Thomas Dillon as national independent fiduciary to oversee the plans and pay the benefits owed. I surrendered just over $750,000 in the assets I had

previously seized to the federal fiduciary. Those dollars represent over half of the total assets that have been recovered to date through both state and federal action.

To further protect the consumers nationwide, as well as in Nevada, I persuaded the United States DOL attorneys to make a request to the United States District Court for an injunction that would preclude all health care providers and collection agencies from seeking payment or taking action against the insureds and beneficiaries of Employers Mutual for claims that have not been paid.

Judge Hagen's order that was issued in February of 2002 did contain that injunction. That prohibited, again, not only the providers but it prohibited any credit rating resulting as a negative against the policyholders, at least until final resolution of the case.

Most recently, the federal court issued a judgment requiring Employers Mutual, its principals, and affiliated companies, to pay $7.3 million in losses. Further state action is pended until the final disposition of the federal litigation. In other words, our case against Employers Mutual still remains an active case before the Division of Insurance.

Quick and effective responses by state and the federal authorities minimized future damages but as yet little has been done to redress financial injury suffered by the victims. The most important lesson I have learned from Employers Mutual is that the problem of unlicensed insurers requires swift and coordinated regulatory reaction, but the solution also demands a coordinated proactive effort to reduce the potential victim pool, and to discourage the schemers. Working with the Nevada Surplus Lines Association and the Nevada Independent Insurance Agents, we developed a media campaign to educate and help consumers avoid becoming victims of unauthorized insurance activity.

Tim Hall of Interwest Advertising will better describe the details of that campaign.

TIM HALL: Thank you, Madam Chair, members of the committee. For the record my name is Tim Hall from Interwest Advertising, based in Reno, Nevada. Let me begin my presentation. In late 2002, the Nevada Division of Insurance, in conjunction with Nevada Surplus Lines Association and Nevada Independent Insurance Agents, identified a growing problem with unauthorized insurers in the state of Nevada. Couple that fact with the fact that Nevada is leading the nation in creation of small businesses under the size of 20 employees, research was fielded in conjunction with Interwest Advertising to determine the best way to address this problem. The research was very clear and very interesting -- very low

awareness for this problem amongst citizens of Nevada. In addition to that, most people made their decisions on who was going to cover their insurance based largely on price. Companies were not verifying if health insurance providers were licensed in the state, and any research that was done on insurance was most often done on the Internet.

The marketing objectives then flowed very clearly out of that. Simply protect Nevadans from the risk of unauthorized insurers and, specifically, we wanted to drive small businesses and the citizens of Nevada to the Web site and the 800 number that we created to check if their insurers were indeed authorized to do business in the state.

The program we put together leveraged four different elements, specifically an aggressive ongoing PR platform, outdoor advertising, print advertising, and direct mail that went to every single small business in the state of Nevada. That is over 69,000 mailers.

I have a very interesting and powerful example of the results of the PR effort. It is about a two and a half minute clip from ABC News. Are you interested in taking the time to look at it?

CHAIRWOMAN BUCKLEY: Sure.

TIM HALL: Okay. It is good.

Video: Consumer groups and government officials are consistently telling people to be careful and yet there are always more vulnerable people out there to be scammed. In the last two years more than 200,000 people have been robbed of more than $150 million in unpaid bills and stolen premiums. ABC's Lisa Stark on the latest travesty.

Terry Orr and her family thought they had health insurance.

They assured me that the bills were going to be paid.

Her husband Pete was a race car driver. He came down with cancer. The bills weren't paid.

Every time he would fall asleep, I would go in the office and try and call the insurance company again to try to get someone to tell me, please, do we have insurance.

Pete Orr died a year ago leaving nearly $300,000 in unpaid medical bills. The Orr's purchased health insurance from a company called TRG, which collected up to 17 million in premiums in 44 states. The Department of Labor now says the firm's owners used the money for personal enrichment, including European family vacations. TRG is just the tip of the iceberg.

I can't remember another time in the history of insurance when so many people have been affected by it or so many millions of dollars in benefits have been lost.

The comment often targets small businesses. Michael Harvey owns an airplane maintenance company. He was desperate for cheaper health care for his employees.

The doctor's list was the same. The insurance card was the same. Everything was the same and the premium was lower, so that's why we opted to go with it.

The health insurance appears legitimate. It is often sold by insurance agents and the companies pay small medical claims to string policyholders along. But there are red flags.

If the coverage is too generous and the price is too low and it is too easy to sign up, even if you have a pre-existing condition, that is a serious warning signal that should tell you to back off.

Harvey, who is now facing $190,000 in employee medical costs is worried about bankruptcy.

I worked too many years for this to have it go down the drain over insurance.

As for Pete Orr, he never got a potentially life-saving bone marrow transplant because of the insurance problems. Now his wife is left wondering what might have been. Lisa Star, ABC News. Washington.

And that is our report on world news tonight. You will have noticed I think that we are…

TIM HALL: So again, that is an example -- national recognition as a result of the efforts of our PR program. The advertising, the first example, is our out-of-home leveraging the proverbial wolves in the wood to bring up some emotion and drive people to the Web site. The print -- we have a little more opportunity to dig a little deeper into the message, we spend a little more time with the consumer. The direct mail, this is the front cover, which is opened to reveal what lurks in the unknown. And then some more information, the direct call to action, again, driving them to the 800 number and the Web site and again some more time to get deeper into the message and the issue at hand. This is what the Web site looks like when people did go to check it. Clearly they are going to the right place, given that it is the same visual and it is easy to see in the green box where they can go to verify if an insurance company is authorized or not. The results are quite phenomenal. In the period of less than six months, we raised awareness from 3 percent, as you will recall, to 18 percent, and over half the respondents indicated that they now verify their insurer is authorized to do business. That

is quite incredible; 9,500 unique Web site visits. That is not traffic, that is unique visitors to the Web site and over 3,000 calls on the 800 number, again, from only April to December of 2003.

We wanted to build on the success of this campaign in 2004, and we wanted to do that by leveraging some more dynamic media vehicles. In addition to the PR we are going to be using TV, radio, and print, and again, this program was designed to lead into Northern Nevada, the Nevada Broadcasters' effort. So we will be doing work with them as well based on this campaign.

I am going to show you the TV first.

TV: Insurance for my business kept going up so much I finally decided to change to a new plan. I wish I had known there were insurance companies in Nevada that weren't legit. But I didn't. Tonight's our last night.

In the past three years Nevada business owners have had to cover $10 million in claims because they purchased unauthorized insurance. Don't be a victim. Check your insurer at nvinsurancealert.com. Nvinsurancealert.com. Don't write a check until you check.

TIM HALL: Next is a radio spot that we did on PBS.

Radio: KUNR received support from nvinsurancealert.com, created to help individuals and employers research insurance companies to avoid unauthorized insurers. In the past three years, Nevada business owners have paid $10 million in uncovered claims due to unauthorized insurance companies. Information about prospective or current providers which are authorized to sell insurance in Nevada is available online at nvinsurancealert.com.

TIM HALL: Finally, this is what the new print looks like, again playing off of the television idea. The first month of results have been again phenomenal, even building on what we have been able to do last year. Over 1,300 unique visits to the Web site. That is in the first month. It is incredible, over 5,000 unique Web sites -- unique visits year-to-date. Since the campaign began we have had a 16 percent increase in visitors to the Web site. That concludes my presentation.

ALICE MOLASKY-ARMAN: Thank you, Tim, for your work with the Nevada Surplus Lines Association, the Nevada Independent Insurance Agents, and with the Division. And, again, I want to thank the associations whose financial support is what enabled this advertising campaign. Nevertheless, to build on the interest and awareness generated by the first phase of the campaign, we did seek and received approval from the Interim Finance

Committee to spend money from our education budget to allow us to contract with the Nevada Broadcasters Association, which will develop the next phase of our campaign. This, again, is being developed with our continuing partnership with both associations. This segment of our outreach efforts is geared to the general insurance buying public through the use of more television and radio announcements. The messages aired on television and radio will warn consumers about the pitfalls of dealing with these unauthorized activities. In addition, the messages will warn and educate insurance producers not to sell unlicensed or unauthorized insurance products and to advise them of the stiff penalties for engaging in unauthorized insurance.

I am convinced that aggressive educational efforts directed at consumers in the industry are the best proactive efforts and protections against insurance frauds. Every state has uniform laws that make it illegal to operate an insurance company without a license. Nevada laws authorized the Commissioner to examine the books and records, review insurance policies, and to investigate persons acting as insurers. MEWAs are allowed in Nevada as long as they become certified by the division and meet other legal requirements. Insurance companies and MEWAs are held to a strict solvency standard established already by law. Protection is also provided to consumers through the guaranty fund if a company were to become insolvent. Of course, in the case of an unauthorized insurer, these protections do not exist. Administrative sanctions do very little to deter those who term themselves entrepreneurs of unauthorized insurance. They simply move their operation from one state to another. We took this another step in 2003 when we proposed to the Legislature a provision that would criminalize the participation of anyone who assisted in an unauthorized insurance scheme. You did pass this legislation and it was signed into law by Governor Guinn to be effective October 1, 2003. Florida also passed similar legislation increasing criminal penalties, depending on the premiums collected by individuals who operate as unauthorized insurers. Their bill, SB1680, is also called or named the Pete Orr bill in honor of the NASCAR driver whose plight you just observed.

TRG was the unauthorized insurer in the Orr case, and yes, TRG was also active in the state of Nevada. For a change, it was incorporated, however, in the state of Indiana. Mr. Harvey, who you saw on the ABC show, was a Nevada consumer. And he, unlike many others, was not afraid to come forward and to state that he had been victimized.

Georgia and Washington have also passed similar laws criminalizing unauthorized activities. Producers will hopefully become more diligent and less willing to sell products because they can now be held personally liable if they engage in unauthorized activities.

The independent insurance agents in the Surplus Lines Association program demonstrate their dedication to improving the image of insurance producers, and fortunately, it is a very, very small percentage of producers who have engaged in the unauthorized conduct. This is not just a problem in Nevada, it is a nationwide problem, and, as you can see, that is how the GAO report resulted. State regulators across the country share concerns about lack of consumer awareness regarding the sale of phony insurance. As reported by the GAO, from 2000 to 2003, there were 144 entities who were not authorized to sell insurance, particularly health insurance, but who were selling health insurance. Those entities covered 15,000 employers, and more than 200,000 policyholders, and left over $252 million in unpaid claims.

CHAIRWOMAN BUCKLEY: Commissioner, if I could interrupt for a minute because I have a couple members who may have to go to another meeting. To cut to the chase, I think we really appreciate your leadership, both in the state and from a national level with your role as Insurance Commissioner, as well as the associations that have partnered with you to try to get the word out in Nevada. Are there any additional measures that you feel that the Legislature could take, and I know you are trying to combat this also from a national level, but any other additional steps that the Nevada Legislature might take in assisting you with these efforts?

ALICE MOLASKY-ARMAN: As far as Nevada laws are concerned, they are very comparable with those of the other states. I do have legal enforcement tools. And, very frankly, what I lack are the resources. With Employers Mutual, for example, we became aware that approximately six months after they were incorporated, and they were incorporated in Nevada, we immediately issued a cease and desist order after they had been incorporated for only six months, but the resources necessary to bring that case even to the point where a complaint and application for an order to show cause could be issued, that took an additional four or five months. Our entire legal staff was devoted to that single case. That is where we do have a problem. I believe our laws are sufficiently stringent. The NAIC is looking at additional measures insofar as criminalizing acts by those associated with unauthorized insurers.

I have the same authority over unauthorized insurers as I do over any insurer, including taking them into receivership. One of the problems there that we looked at in Employers Mutual was the funding for a liquidation. Now, the Legislature has provided $100,000 to the Commissioner in our budget each year for the advancement of monies for receivership, but as you can well imagine, that $100,000 would not nearly have covered the cost of Employers Mutual. Of course, at the time that we were entering into an agreement with the Employers Mutual principals, they promised to transfer to the Commissioner in excess of, I believe, $7 million to $10 million so that the claims could be paid.

I am curious now where that $7 million to $10 million is located because, obviously, neither I nor the federal fiduciary has been able to find it. The NAIC is, and has been asked to propose additional legislation before the Congress. We had a meeting, in fact, of the ERISA working group last week by telephone to develop those measures that we believe that should be before the Congress. One of those, interestingly enough, is going to be seeking federal funding of a national media campaign to coordinate with that established by the National Association of Insurance Commissioners. We are also asking that the federal legislation establish a coalition of investigators, a formalized process of what we did essentially establish with Employers Mutual, but to formalize that process and have it operational on an immediate basis so it does not have to be put together after the fact of unauthorized insurance is observed.

We are also asking --

CHAIRWOMAN BUCKLEY: Commissioner, I think what we will do is ask to be informed of your efforts at the federal level and perhaps to work with staff on what you feel your enforcement needs are so that we can look at that and perhaps make recommendations in concert with you.

So we appreciate very much your testimony. I think raising the awareness and the enforcement of this issue, as well as creating more affordable health insurance for small business is a twofold approach we need to take.

Assemblyman Hardy.

ASSEMBLYMAN HARDY: Thank you, Madam Chair. If I may, I got on the Web site that they talked about and I see about 18 companies in the state of Nevada that are actually allowed to write health insurance. Is that correct? And I do not see a fraud or link

language on that Web site. So the idea is if it is not on the Web site then it is not allowed to write insurance in the state of Nevada. Is that the impression I am getting?

ALICE MOLASKY-ARMAN: We should have a link on our Web site to the site for nvinsurancealert.com, and on that Web site anyone can type in the name of a particular insurer and determine whether that insurer is authorized in the state or not.

ASSEMBLYMAN HARDY: I am looking at nvinsurance.com and I do not see the link, so maybe it is the computer illiteracy in me that does not see that. But I am sure that somebody more affluent in computerese could probably do that. Is that true about the 18 companies? Only if it is on there it is authorized --

ALICE MOLASKY-ARMAN: No, that is not true.

ASSEMBLYMAN HARDY: So there are a whole lot more than 18 companies who are allowed to do insurance.

PEGGY DEHL: Yes, there are. I am not sure where you are looking on the link.

CHAIRWOMAN BUCKLEY: Could you state your name for the record, please.

PEGGY DEHL: This is Peggy Dehl from the Division of Insurance.

ASSEMBLYMAN HARDY: I guess -- I am not going to take up the committee's time any more.

CHAIRWOMAN BUCKLEY: I will ask staff to verify the linkage, where it is, and to go from there.

PEGGY DEHL: And I would be happy to work with you.

CHAIRWOMAN BUCKLEY: Great. Thank you. Any other questions of the committee, for the Commissioner or her staff. I do not see any, Commissioner. We thank you again for all your work in this area.

ALICE MOLASKY-ARMAN: Thank you. I would like to make just one more point, if I may. We seem to be a favored area for unauthorized insurers to incorporate and not simply just those for health insurance but other kinds of scams, including worker's compensation, medical malpractice. We have worked with the Secretary of State's Office. They have a list of what our buzz words are, names that sound like, look like insurance, but still the scam artists continue to incorporate in Nevada, and this despite of being well aware that we do have a strong stance on unauthorized insurance. And I do not know what further

measures might be taken insofar as their incorporation is concerned, but it has become, in a way, an embarrassment to me before the other Commissioners that so many of these scams are -- they are termed our domestics. Of course, they are not our domestic insurance companies but their state of incorporation is Nevada.

CHAIRWOMAN BUCKLEY: Thank you, Commissioner. We will ask staff to contact Secretary of State Heller to see if he has any thoughts on perhaps an early notification system to you or anything that we might do in that area. So we appreciate your time and your presentation and your thoughts.

ALICE MOLASKY-ARMAN: Thank you much.

CHAIRWOMAN BUCKLEY: I am going to take that prerogative of the Chair and skip around on the agenda and go to Item No. 6, presentation of Health Insurance Expansion Proposal. Peter, unless you think I need the county data collection efforts first, I would like to jump right into the heart of things and what can we do to expand health insurance in our state and see where the technical work group is, see what your impressions from all your meetings are, and what we might be able to do here.

PETER BURNS: Thank you, Madam Chairman, members of the committee. My name is Peter Burns. I am a consultant with EP&P Consulting and working for the subcommittee. We have passed out – and I hope that you have a document that is entitled "Summary of Option A, 5-A," and that is largely what I am going to be talking from today. And it has been our experience with the work group that it takes -- these reviews take a little bit of while, but I would like to give you a summary of where the -- what we have been able to do together with the technical working group.

I would like to make three comments before we start. One is that it is very appropriate that this committee is considering this issue today because I think, as you know, Madam Chairman, next week is the "Cover the Uninsured Week" nationally to try to focus attention on the uninsured. The second comment that I would like to make is that the technical working group that you asked us to work with is really an outstanding group of individuals that have put in very long marathon hours listening to me drone on about the intricacies of health insurance and the options that are available, and they have been of great assistance in moving the proposal as far as it is. I guess there are four things. The third thing is that if I could ask the members of the committee to strike through the date May 5, 2004, and write in May 7, 2004, and I use the disclaimer at the bottom of the page draft for discussion as my excuse for

that. And the fourth point would be, I am much more happy testifying in front of your committee today than I suspect Donald Rumsfeld is testifying in front of Armed Services.

With that, I would like to review the document that you have in front of you. We are talking about option 5-A and it is an option that has come together as a result of really two marathon meetings that were held with the technical working group on April 14 and May 5. And I guess at the outset, I take responsibility for whatever anybody does not like about option 5-A and the technical working group can get credit for everything that you do like about option 5-A. What the purpose -- this subcommittee has retained us to assist them in developing a program to secure additional federal funds. And this came out of some earlier work that we had done that indicated that there were some SCHIP funds that are being reverted back to the federal government. Specifically our charge is to see if those federal funds do, in fact, exist and then how those funds could be deployed to increase health care services in the state in a design that would receive federal approval, with a thorough consideration of employer-sponsored initiatives.

We met originally with the technical working group in March and we identified a list of potential coverage groups or populations that could be covered. We met with this subcommittee later that week to which you added additional potential groups. And since that time we have been engaged in data collection and policy discussions.

Finally, in April 14, we had a six-hour marathon meeting with a technical working group that we did not even allow them to have a lunch break, where we considered a lot of information relating to cost and caseload, financing, data collection, and various program information. At the end of that we presented what is called option 5-A. In brief, what option 5-A would be to take the funds that are created by NRS, called the indigent accident fund, or the IAF, and the supplemental fund, and convert them into a pool of funds that we could match with federal funds. Once those would be matched with federal funds, we would use those monies to extend coverage for pregnant women up to 185 percent from the present level of 133 percent, design a health insurance package for small employers that would provide subsidies for employees up to 200 percent of the federal poverty level, and then provide an employee subsidy program for those people that worked for employers that do offer insurance but they do not take it up if the employee is less than 200 percent of the federal poverty level.

The first item that I am going to discuss is background from our April 14 meeting, which was the marathon meeting. We have passed out to the members of the

committee Update, a binder with updated information that we used during that meeting with them and we just commend that to your further study and perusal, if that is your desire, but that will keep you apprised of what we have gone through. As I indicated, we eventually, between the working group and this subcommittee, identified ten different populations or groups to take a look at. They are listed on page 2. I will not go through all of those but we did with the technical working group. We also discussed what benefit packages might be made available to each of those groups, and what service delivery option we might use with each of those groups.

During the period of time between our last subcommittee meeting and today we have also been doing quite a bit of data collection for three purposes. One would be to determine the cost and caseload of all of these ten groups. The second would be to determine how much financing or how many funds would be available for match. And the third would be to try to determine where expenditures that are currently being made would overlap with any proposal that we could design that would receive federal approval. Generally speaking, with respect to cost and caseload, I must commend the support that we got from the DHR in providing us information, and with their assistance and our own work we were highly successful in determining cost and caseload estimates that I believe are reasonable for the ten groups that we identified with the exception of the medically needy, which is a population that we will, in fact, come back to and discuss later. The problem with them is just obtaining enough demographic-related information, their alien status, their Nevada residency, and other issues.

But in your books, I believe there is a section of about ten tabs in there that takes each one of the ten coverage groups, shows you what the population estimates are, shows you what the cost estimates are, and we went through that in some detail with the working group. In terms of funds available, we looked at four sources, primarily. The first was the SCHIP funds, and we did analysis in cooperation with DHR that, in fact, determined that there are going to be monies reverting back from the SCHIP allotments available to the state even in consideration of some of the legislative changes that you made during the last session with respect to the asset test.

Attachment 1 contains a more detailed flow-through of what our expectations are. I would just point out that much of the money that we believe is going to be available is -- results from the fact that Nevada is not, in essence, under SCHIP. A state has three years to

use the money that is made available; the year that it is allotted and then the two subsequent years. Nevada is in a position and appears to be in a position where they will always be spending -- like in the current year they will be spending the money from three years ago, and even at that, they will not spend the entire allotment, so that at the end of our forecast period, if you will, there will be two years of money that have not been touched. So, much of the SCHIP funds comes from taking that balance of two years and amortizing it back over the five-year period that we are budgeting for. And you will see that in a depiction further in the document.

With respect to the second source that we looked at was the indigent accident fund, or the IAF, and the supplemental fund. And those, as you may know, are supported by a property tax levies by the counties, one and a half cents for the IAF and one cent for the supplemental fund. Our estimates indicate that approximately $16 million would be available in SFY 06 and growing to about $19 million because of assessed valuation growth in the state by 2009. Then both the working group and us got the clear message from the committee that the department should engage in an effort to identify what potential revenue sources are unmatched. They did engage in such an effort, and they reported back to the working group that they did identify some funds.

The highlights of that from a high level are that the Welfare Division suspects that it will have excess appropriations of about 19.7 million. There are federal fund recovery initiatives going on in the Mental Health and Developmental Services Division that should generate about 3 million plus. And then the Child and Family Services Division, there is potentially $2.3 million. In addition to that, the DHR observed that there are the tobacco settlement funds which are allocated amongst various programs by statute, legislative direction, and are not matched and could or could not be deployed for some effort that the subcommittee may choose. However, the department was quite specific in pointing out that just because they have identified these means does not mean that these dollars could be necessarily, at least from their actions, committed to this source. They wanted to point out, as is natural in such a large department, that just because you have funds available in some areas you also have shortages in others and sometimes those funds will be moved back and forth to cover those, and that there are programs within the department that have significant waiting lists or caseload growth that is going to have to be addressed during the next budget cycle.

I put two paragraphs in for quotes from the documents conveying -- on the top of page 4 -- the estimates to us. They also suggested that the State Budget Office and the Governor's Office should be consulted to determine whether or not these revenues would be available. As a result of these caveats, when we designed a program we did not include any of the DHR monies that were identified. If the subcommittee wants us to recognize some of those, those can be incorporated into the decision.

We also took a look at county indigent funds and to see if any of those funds might be available for use in this project and there are some complications with that. A lot of it has to do with data issues. Some of it also has to do with just the nature of what those funds are used for. First of all, there is not an easy source to look to to find a sources and uses statement for where county indigent funds are being expended. The second is there is a very, very broad spectrum of services that are covered by the indigent funds in the counties that include both social services and health care services. The obligations of those funds range everywhere from covering inmate health care to providing burial services for paupers, acute care, long-term care, contributions, et cetera. There is also quite a wide variance of eligibility standards amongst the counties as well as a variance in the types of services. We attempted, and in your binders you will find kind of an inventory both of eligibility and benefits covered by the indigent funds in the various 17 counties, or most of them, as well as trying to depict a sources and uses statement for these funds in the 17 counties.

And then finally there is a lack, not through anybody's fault, there is a lack of information available and systems, in terms of being able to retrieve information, that would be useful in analyzing the indigent accidents funds with respect to federalization. Some of the issues that arise are the alien status of the people that are receiving services. Their categorical status, i.e., are they parents or are they receiving SSI or some other thing, as well as other information. The way that these funds operate is not conducive to teasing out from the indigent funds monies that may be removed, if you will, from those funds and deployed somewhere else. So for the purposes of our study, we just determined that indigent funds at the county level were not a feasible source of financing for this.

So in summary, with respect to financing, basically through identifying the IAF and the supplemental and matching them against the SCHIP funds and regular Title XIX, we believe as much as $45 million could be made available by state fiscal year '05 and $52 million

growing, again basically because of assessed valuation growth, to as much as $52 million in 2009.

I am assuming, Madam Chairman, that whenever anybody has a question they will jump in and have at it. Current expenditure data we took a look at and we did a lot of work with both NAICO and the counties, with the center for health information analysis at UNLV and with the hospitals.

With respect to NAICO we were interested in two things, what gets paid to who for the IAF and the supplemental fund, and what are the demographic characteristics of the people that generated all those charges. With respect to what gets paid to who, we have a fairly good idea on that and we will get to that in a very short moment. With respect to demographic information, frankly NAICO does not collect that information. The county certifies the indigency status of the people from the bills whom are moving up to be paid and as long as they have the certification they are good to go. The individual counties have been engaged in a data collection effort which, frankly, we have been put on hold because of the difficulty in collecting information. Some of the nature of the information that we are seeking, that may or may not be available and the systems that are available to collect some of that data, we have asked them to stop. We have some preliminary data in. We will evaluate that and then go back depending upon where the worker group wants to go, where the subcommittee wants to go, and make sure that we will receive benefit back from them expending the effort to do that. Some of these issues have to get decided by the subcommittee on a policy level that additional data does not necessarily make easier.

I worked for a legislature for six years and I worked for various governors for nine years, and I know the dodge, if you will, will be, well, if we just had a little bit more data somehow it will make the decision all that much easier. Well, sometimes it does not and the nature of the decisions are just that you move forward with it. In any event, we did find what I found to be, but I am a numbers nerd, some rather fascinating information about the IAF and the supplemental fund, and we present that on page 6.

The top table on page 6 is expenditures for fiscal year 2003 from the IAF. I would like to point out before we talk about this that the IAF, the indigent accident fund, has been generating more revenues from the property taxes than it has been incurring in terms of expenditures. That resulted in a situation where I believe the cash balance, and it is detailed in your binder there, got to be as much as $8 or $9 million. As a result of that, the Board of

Directors for, it is my understanding this fiscal year, has suspended the property tax levy for the funds so that they can draw down the balance to satisfy their needs. But in any event, for SFY 2003, in the far right hand lower right-hand corner you see the total expenditures were $9.6 million. Those were spread 8.6 million to hospitals, 368,000 to physicians, 266 to ambulances, and 414,000 to miscellaneous services. A couple of points in terms of the operation of this fund that you should understand is, one, as a general rule, the beginning point for payment in these funds is billed charges. For hospitals, it is 100 percent of billed charges for rural hospitals, and 85 percent of billed charges for the urban hospitals.

I also must say that before a payment could be referred to the IAF, counties must pay the first $3,000 and then everything over $3,000 gets referred up. For physicians, there is a fee schedule. Ambulances and services paid -- generally I believe are paid at 100 percent. So obviously you see that the distribution of this is heavily weighted towards hospitals. You will see down on the bottom where it says Churchill, Carson Tahoe, Humboldt, and Pershing and it has WMC in that, that means those were the initial hospitals that received the case and then the case was transferred to those hospitals.

CHAIRWOMAN BUCKLEY: Can I ask a question. On the billed charges, was the uninsured discount given first?

PETER BURNS: Madam Chairman, no. You are talking about the 70 percent that is provided for in NRS?

CHAIRWOMAN BUCKLEY: Right.

PETER BURNS: No.

CHAIRWOMAN BUCKLEY: That is interesting. Wouldn't that be illegal? I would think that would be illegal. These are uninsured people, that is why the county is paying. So you get that uninsured discount, right?

PETER BURNS: Madam chairman, this came up --

CHAIRWOMAN BUCKLEY: Not your role. I can reserve that question.

PETER BURNS: You have counsel sitting at the table but I will say that this did come up, and as I -- and I would refer to counsel but as I recall the operation of the 70 percent -- somebody made a point during these long meetings that we had that, I believe, that the patient has to ask for the discount. It is a policy decision, I think, from the Board in terms of what the compensation levels are. And I think that your counsel has had the opportunity to become intimately familiar during the course of our deliberations with all of the provisions of

the indigent funds in the NRS and may have observations on those that she might want to share with you, but I will --

CHAIRWOMAN BUCKLEY: Any thoughts on this?

LESLIE HAMNER: Thank you, Madam Chair. I believe Peter is correct that it did come up concerning the request for the discount, and that is actually an NAC, the way the regulations are drafted. It is drafted so that the person has to bring it up himself or herself, as well, that 85 percent and the 100 percent of eligible charges is also in NAC. And it is – there is no reference in that section of NAC in chapter 428 to the required 30 percent reduction. So they seem to work independently of each other. It just says 85 percent of all eligible charges.

CHAIRWOMAN BUCKLEY: Don't we have the highest billed charges in the nation? I believe I recall that from last session.

Senator Nolan.

SENATOR NOLAN: Thank you, Madam Chair. Question to staff, once it has been determined that a person is indigent, I do not know if we perform a wallet biopsy first or if that individual volunteers the information that they are not capable of satisfying the charges they are incurring, is there any requirement in NAC that the individual, since they are the ones who are supposed to ask for the discount, are they made aware that a discount is available?

LESLIE HAMNER: Many of those provisions of NAC are drafted is that a major hospital, who is required to reduce or discount the total billed charges, shall provide each patient, who informs the hospital he does not have medical insurance or other coverage to pay for inpatient services, with a written disclosure approved by the director explaining that the person may be entitled. So the duty is first on the patient to inform the hospital. And that is a Department of Human Resources regulation.

CHAIRWOMAN BUCKLEY: I would think the patient informs the hospital immediately as they walk in the door, that is the first question, and then afterwards they then try to submit the documentation to get reimbursement.

SENATOR NOLAN: Madam Chair, if I may, that would seem logical. I just wonder, if in the process of going through a hospital admission of some type usually you are presented with a number of documents to sign, a lot of them are lengthy documents. And some of them are in plainese and some of them are legalese that an indigent person reasonably might not, under the circumstances, read them, they might just sign them. I am just wondering

if they are not actually presented with some type of verbal disclosure that they are eligible for this, that the average person would not ask -- think to ask for a discount that they are eligible for, if they were not told it and if it was presented amongst a stack of documents.

CHAIRWOMAN BUCKLEY: I think that is right. And maybe what we should do is just highlight this area for -- I mean depending on where we finally land, we can come back to this and see where we want to go with it.

Peter, do you want to continue.

PETER BURNS: There will be a point that I will make in the supplemental fund that will offset all of this, to some extent, the concern that you have about the IAF. But we will get there in a moment. The big take-away from the table on the top of page 6 is obviously that UMC and WMC are the largest two beneficiaries of the IAF in terms of how much they get paid for. And so as we talk about option 5-A, I think it is fair to say that we have the attention of both UMC and WMC in terms of what the impact will be on them. And then kind of segue into that, I think that the hospitals would also tell you that as the safety net -- oh, one last thing, for the charges that are listed with the four hospitals on the bottom of WMC, that is the total amount paid, some of which went to WMC that we do not have a breakdown on. So that is the total.

But I think that the safety nets will make a point to you that it may be true that they are getting paid more than charges or more than 70 percent out of this fund but everything does not make it to this fund and when you talk about the supplemental fund, which is what we are going to talk about next, in this millennium, I can say that, since the year 2000, of the bills that have been presented, compensation has been -- because the way this fund works is that the administrators collect all of the bills that are there. These are bills that get passed on to the fund after the county indigent fund has been 90 percent expended and it is only for bills of more than $25,000. They get passed up to the supplemental fund. At the last week of the year, they run a tape as to how much they have been presented in terms of bills, and then they call up the state and say how much is in the account and you divide one into the other and you compensate on a pro rata basis. So compensation in this millennium has ranged from 12 percent to about 21 percent of billed charges.

Tying all of this kind of together in some form or fashion is that, roughly, based on some data that we looked at, cost is approximately in the range of 50 percent -- as a rule of thumb, 50 percent for the hospitals that we are concerned about here in these lists. So while

the hospital -- and I do not want to get in the middle -- we have presented data to the work group and it is in your binder as to how much compensation would be for the hospitals in the supplemental fund if they were paid at cost rather than charges. We did not offset it because at the time that we did that binder we did not have the supplemental fund. But I am sure that the point will be made from the safety net hospitals that, look, we are still losing money. We had a discussion in the work group about, that is fine, but maybe there might be a desire to separate payment for services from subsidy and make two deliberate choices as opposed to kind of letting them all blend together.

We can spend a lot of time on just these two funds and we have a lot of information, so I am going to try to move on. The supplemental fund, again, you see that UMC and Washoe are the primary beneficiaries of these expenditures. These are prorated expenditures against billed charges, and these are only for hospital charges. The 25,000 that goes up to them is measured, as I understand it, in billed charges. And then as I indicated about between 12 and 21 percent of the charges are paid. This account only pays for hospital bills, no other services, as opposed to the indigent accident fund, which, as you can see, does compensate physicians, ambulances, and other ancillary services. We also looked to the CHIA program at UNLV, which is a program, as I understand it, required by statute that requires all the hospitals to file discharge information with CHIA, Center for Health and Information Analysis, to see if they could be helpful. And, in fact, what we found out when you do an analysis by payer source the information is not particularly helpful. The reason for that is that the discharge information has to be submitted with CHIA within 45 days of discharge or the end of the month of discharge or what have you. Generally speaking, the charges that ultimately make their way to the IAF, or to the supplemental fund, are probably at least one year, if not two years, after discharge. It takes that long to vet the charges through both the -- anybody that may have any other liability, checking Medicaid eligibility, checking the indigent eligibility, Medicare, what have you, and then passing it through the system and getting it to these funds, that oftentimes these amounts are compensated two years ago, and in conversations with UMC, I understand that from some of their charges that they were compensated for in the 2002 and 2003 period dated back to 1997, where the health care was actually delivered.

So in terms of -- while CHIA will provide a lot of useful information with respect to diagnosis and all of that, in terms of doing an analysis of who pays for what, lots of

times in order to file this, what is called a UB 92, they put a payer source in there which may or may not come to fruition during their entire revenue cycle. We have also worked with the Nevada Hospital Association to collect data from hospitals based upon -- most of the hospitals employ somebody either through contract or on staff to determine eligibility for people that come in and say that they are not insured, and they keep separate databases. We have gotten some preliminary information from that and, frankly, have not had time to take a look at it.

Once we went through this data and did the cost and caseload with everybody and defined the revenue sources, et cetera, we did, for each one of the ten groups that we had identified an advantages and issues sheet, which is included in Attachment 2 in the packet today, and also in your binder, and we did that from the perspective of the state, the counties, the stakeholders, or the beneficiaries and the providers, I believe. And for each side we talked about what the advantages are and what issues may come up within the context of the program that we are trying to put together and, again, that was reviewed with the work group, and I think serves as a generally helpful guide to try to sort out some of these issues.

In terms of what is option 5-A and getting into a little bit more detail, we had all these ten groups, and when we met with the work group we presented options 1 through 5, kind of mixing and matching and a menu type of approach. And options 1 through 5 basically, these are difficult decisions, because there is not a group necessarily in here that is unworthy of coverage, and this is, you know, how many children are in the water and how much room do you have in the life boat, all those kinds of decisions. But we put through options 1 through 5 with various combinations and permutations of things. They are in your binder and, basically, you could not afford them. The bottom line to take away from that is that the potential groups that you would like to cover are far greater than the amount of revenues that we have defined. So we put together option 5-A with the specific intention of trying to meet available revenues. And, again, our option 5-A --

COMMISSIONER REID: Can I ask a question -- jump in. Those various options you considered when you were talking about the different permutations, were you talking about coverage only or did you consider different financing options?

PETER BURNS: To be honest with you, Madam Chairman, Mr. Reid, we took coverage groups and then with the cost and caseload data that we had done, we costed them out based upon essentially the federalization of the IAF and supplemental and --

COMMISSIONER REID: So the only financing option you considered was IAF and supplemental?

PETER BURNS: Yes.

CHAIRWOMAN BUCKLEY: If I can jump in. You know, I think what we are trying to do is instead of paying for health care at the back end, we are trying to pay for it at the front end, to do a shift to actually help people get insurance. And I guess what my read of the data and the work committee was is that we are doing that from the IAF and the supplemental and the safety net community feels like that is going to hurt the safety net hospitals too much, because regardless of that -- even though some folks might gain insurance so that they would be helped, certain number of people won't, and so they are taking too big of a hit. So to cut to the bottom line, I think that perhaps we should consider some state financing. So let me express this, and I am sure I won't express it very well, but we figure it out, how many people are going to gain insurance, such that we could take some of the IAF and supplemental and don't put all of the risk on the safety net hospitals and the counties and instead come up with some number -- now, everybody has got to share the pain a little bit in this leap to cover on the front end, but say, okay, we are going to assume certain number of people will gain insurance, either from pregnant women now have insurance, and that falls on the safety net hospitals, and the small business piece, but say then "X" amount we really need to look for other revenue from the state. I think that would make the counties feel better because we are not doing this experiment solely with their money. I think it assuages the concern that too much risk is being given to the safety net hospitals, and I would like your reaction to that approach.

PETER BURNS: Madam Chairman, I think that you have probably hit the sweet spot that we will in the course of this presentation go through and discuss some of the impact on the safety nets. And I am sure that you probably have – I am assuming that you have slips from UMC because they made a presentation as I said at the work group on Wednesday. But, yes, you are going to have friction as you move from -- we really are dealing with a dilemma here and the dilemma is you have a safety net system there and the tension between maintaining and expanding a safety net system versus coverage is quite a tension that exists everywhere. And to the extent that you are moving, which is what we are doing, moving dollars from the safety net system into the coverage system and saying, trust me, it will all work out, obviously the people that are in the safety net programs want a little

bit more security. The only way that you are going to be able to make everybody absolutely happy is to perhaps expand this with totally new money, and then you can guarantee that these folks will not get hurt. And then the new money people then say, yes, but to the extent that we are covering some of your expenses here, we ought to take those. And then that gets to be very difficult in terms of teasing out. I have seen states direct their auditor general to go conduct an audit and establish a baseline and, you know, you can do any kind of numbers of things, and so right now what the proposal 5-A is doing is taking this money, putting it in here and saying -- and we will say in a moment that Washoe and WMC will probably suffer some losses probably in different degrees and probably nobody knows how much, I think is the fair answer.

To the extent that we can maintain something here, either in terms of maintaining an existing program that they are relying upon or coming up with a new program that they at least feel good, because this gets the data collection issues, and some of the data that we are asking for, I think that Clark County, Washoe County, UMC, and Washoe will all tell you, yeah, we should have it but we don't. I mean that is just the bottom – that is the truth of it. But if they feel that they stand to break even or do better, obviously I – it is like the point that I make about financing. To the extent that we take IAF and supplemental, change the statutes to say that the counties are no longer responsible for that, they are fine. I do not think that you are going to hear a lot from the counties with respect to their responsibilities, because the plan is to exorcise those responsibilities from them as we move the money.

CHAIRWOMAN BUCKLEY: But I do not know if that is true because even though you take away the legal liability, the counties still have either UMC or Washoe Med coming to them saying, we have all this uncompensated care, we are not going to break even. What do we do. You need to bail us out.

PETER BURNS: Then the county's response is go talk to the Legislature.

CHAIRWOMAN BUCKLEY: I think we need to be realistic. And I think that maybe what we do is we kind of make the counties and the safety net hospitals feel better about that break-even point. And I think the break-even point is going to be, we cannot take all these funds, that we need to have the state supplement it through their unmatched dollars, that way everybody shares the pain, everybody feels like the test just is not on the safety net hospitals. That is the way I think we need to go, and I am really interested in what the other committee

members think, because we have to land by the next meeting, and we could take ten years to study this, but if we are going to take a bite out of the uninsured, we need to do it now.

So, Commissioner Reid and then Assemblyman Hardy.

COMMISSIONER REID: I agree, Madam Chairman, with what you said. You are doing my job for me. I think, with due respect, that theoretically that taking the legal obligation away from the county, that sounds good but in reality I think that is difficult to do because ultimately we are going to provide uncompensated care whatever the state statute says. And I think we need to be cognizant of that.

I think we also need to understand that there may be an opportunity to leverage -- state monies and create new opportunities that do not exist and that should be something we are more interested in than simply shifting money from the county to the state that -- where you cannot take away the responsibility. So I think leverage is what we want to achieve, and we also want to, I think, make the safety net providers feel better about this. You have said that it is difficult to understand exactly who is paying who for what and given that, it is just as difficult on the other hand to say, don't worry be happy, because we are taking the responsibility away from them.

ASSEMBLYMAN HARDY: Thank you, Madam Chair. Recalling the simple saying, follow the money, I can't even find the money. I mean, where is the money that you are talking about, where is it coming from? I recently had a legislative session, it was interesting, so I do not know what we are doing. We came out of the Task Force For the Fund For a Healthy Nevada on children's health with $8 million of requests and $2 million to share. So on the Task Force For the Fund For a Healthy Nevada, for instance, that uses the tobacco money, and looking at that little line item that you talked about using the tobacco monies, Peter, the tobacco settlement funds, is that quote, unquote approved to use the money from the tobacco settlement to multiply those dollars in the Task Force For the Fund For a Healthy Nevada? And if it were, our 2 million become more, and I realize I am talking about 2 million and not 100 million here, but nonetheless. And then I also was looking at your 45 million going up to 52 million in FY 2009. So does that mean that is a yearly thing that we would do, so this committee has talked about a $91 million thing that has become a $45 million that will become a $52 million, but when we were talking about the 91 million, I thought that was spread over a five-year period instead of a one-year period. So I have got all of these numbers

in my head and I am asking a lot of different questions, with just one microphone light on. Thanks.

PETER BURNS: Madam Chairman, if we go through the rest of the presentation I think that some of this will crystallize, and some of those issues will come up. We did not specifically identify under 91 we can address that but like the tobacco tax, we really did not go there in much depth, other than to observe that they are there but through anecdotal sources I have learned that -- well, one of the purposes of the tobacco funds, and I am not targeting any fund, I am just observing that they are there. But one of the purposes of them was, I believe, to buy, to help with pharmacy expenditures for seniors. Would the Legislature may want to reconsider that in light of the recent action of Congress, I do not presume that to be true, but it would be a logical question in terms of maybe we should look at it and to the extent that there is money there, but I think that some of the financing will become a little bit clearer if we go through the rest of the presentation.

And, in fact, if we turn to page 8, you offered me quite the segue, we do have the funds available. And let me just take a moment to walk you through this so that you do have -- and this is again looking at the indigent accident fund and supplemental fund. You see that in, say, 2005, IAF is 9.4 million, supplemental fund is 6.6 million. That represents the one and a half cents and the one cent on the property tax levy. And then if we look at amortizing the indigent accident fund cash balance that we are suspecting will be available at the beginning of 2005, over the time period we would get to the 16.89 million, and I cannot recall, I think it was either four or eight percent of assessed valuation growth over the time period grow to 19.6 million.

In terms of SCHIP funds, the top line, if we look at 2005, 1.980 million, that is money that you are going to -- based upon our estimates and obviously the set of assumptions which are included in Attachment 1 – that is the money that you are going to revert. That is the federal share of the money that you are going to revert each year through 2009. The allocation of the ending balance, the 14.4 million, as I recall the ending balance that we are estimating, which is -- at 2009 you will have just spent 2007 money so you will have 2008 and 2009, which I think we are estimating at about $70 million, and we are retaining, I think, 10 percent of the fund in the fund to not count against the cash balance, so that gets you 14 million. That is $16 million a year over five years, which through revisions and whatever is nominally the $91 million that we started talking about. And I do not have a total on that line

so I cannot do it in my head as I am sitting here testifying. But that is analogous to that plus the ending cash balance that would still be in the fund. So then if we were to match that 16 million with the enhanced match rate say on 2005 you are going to need $7.3 million to draw down all those SCHIP funds which would then -- in the third box -- leave you with 9 million from the 16 million, which you could match with regular Title XIX, so that would make your $45 million a year available. And over the five-year period you are talking approximately a $250 million program for the five years. So that is the sources of funds that we are talking about. I do not know if that addressed all of your questions, Mr. Hardy, but at least it gives you a view of what we are talking about in terms of revenues.

ASSEMBLYMAN HARDY: Thank you. It addressed the issues of the SCHIPs and the indigent accident funds but I was just wondering, I guess for you, Madam Chair, is where do we get the money from the state to participate in that? And that is the question I guess that is the heart of it.

CHAIRWOMAN BUCKLEY: Thank you. Assemblyman Hardy, I have been talking a little bit with Mike Willden and the Department of Human Resources was asked to do a review across the board of all the unmatched state money that is currently being utilized. And he was able to locate some. I think Peter alluded to it, funds from mental health, funds from children's services, funds from the human resources general budget, tobacco dollars are one. With the federal government passing the Medicare bill, prescription drug benefit, that is definitely going to impact Senior Rx, and I think adversely because we have a very good program right now. And the Feds are saying -- I asked Mike Willden, and I do not know if he is here. Mike, come on up. What are the Feds going to do with Senior Rx now that we have a rotten federal prescription drug program, not that I have an opinion. They are going to come down and require some changes. And so that might be some revenue that is available, as well as just saying if we do not require, if we do not take 16 million from the counties, let us say it is more feasible to take 8, I do not know what that number is, but you figure it out, maybe we say it is a priority to have first-party health care, to begin to take steps towards that as to paying it on the back end. We say, okay, we are going to take 2 million of the tobacco dollars just off the top or from a certain area that the Feds will not allow us to do. That might be one area. But Mike, could you elaborate either on the prescription drug issue or generally where we might look from state funding.

MIKE WILLDEN: Madam Chair, for the record Mike Willden, Director of the Department of Human Resources. I will take the Senior Rx issue first, with your permission.

The Medicare legislation that was passed, there are really two phases that we deal with that will impact Senior Rx. The first is what we call the transitional assistance phase, which is what we are in right now, where seniors are having to make the decision to go out and choose which discount card that they might want to enroll in. And along with that discount card, low income seniors have a $600 per year, for two years, actually for 18 months, of transitional assistance benefits available to them. So we are right now trying to figure out how we interface or match up the Senior Rx program so that we take advantage of getting that $1,200, if you will, benefit that the Medicare legislation provides. We are about to release an RFP, or request for proposals, a request for proposal to probably shift the administration of the Senior Rx program from the current form. As you know we have an insured product right now with stop losses and things like that. But we are probably going to shift the program to something that wraps around the federal benefit. And again, we want to take advantage of getting that $1,200 worth of federal benefit.

With regards to discounts that the seniors might receive, my personal opinion, Senior Rx already has better discounts than anything that the federal legislation might offer. So really our challenge is how do we take advantage of the $1,200 in new benefit, and probably only less than half of the seniors that we now serve under Senior Rx -- as you know, we serve seniors up to almost 23,000 a year in income, singles and 28,000 or so couples. So that is significantly above the poverty level and the transitional benefit are for the low income. So we are only probably going to have half or 40 percent of the seniors that we'll get that transitional benefit on.

The other issue on the Senior Rx program that we are worried about right now, is we have really seen the per member per month cost climb dramatically the last year. When we were in the Legislature last, we had a per member per month of about $48, $47, $48 was I think the budgeted amount. We are right now at $64 per member per month, and that is primarily coming from higher utilization from seniors. They are getting more prescriptions per senior. And so I think the program is getting, you know, we have always said it was not very robust in the beginning. Now that we have had two or three years' worth of experience we are seeing way higher utilization.

Bottom line is there possibly could be some money available there, I think was what the Chair was indicating. That is still an unknown until we get the full impact of the Medicare legislation. Then part D, I talked about the transitional system, part D of Medicare takes place in January of 2006. And you know then we get into the full Medicare coverage and we are still trying to attend meetings and analyze what the impact on Senior Rx is.

The second question is what funds are available. We prepared -- and I think Peter may have a copy with him or maybe not -- we prepared a pretty detailed analysis of everywhere that we thought that funds existed within the department that are currently unmatched. In other words, you know we are not using general funds to match federal dollars where we might be able to do it if we did additional work or in some cases additional work is already underway, and then there are just some surplus funds that we identified in here also, general funds that are not currently earmarked for use because of lower caseloads or other issues. But as we have talked before, Madam Chair, and I think I have pointed this out several times in the technical committee, and it is in Peter's EP&P's write-up here, that all those unmatched and uncommitted funds right now, during the budget season, there is always a scramble for those dollars to meet mental health wait lists, children's wait lists, Medicaid caseload growth, and so we will need to make those policy decisions, those priorities over the next weeks, months, as to where those dollars go. But we have identified a fairly long laundry list of places where there are potential funds available, again given whatever priorities we have in the budget.

CHAIRWOMAN BUCKLEY: Thank you, Mike, and I think what I would ask is for you, Mike, perhaps to get in touch with the Governor's Office. And I also called them myself this week to see what the executive branch might be willing to look at, either in terms of the earmarked unmatched configuration. I mean the bottom line is we do not need that much money in the big scheme of things, when you look at the entire state budget and county budget. If we can just do a little shifting, we can get a lot of our federal dollars returned to Nevada, offer a lot of health care insurance. I mean how discouraging. We are sitting here trying to come up with solutions. I think Nevada just went from fifth highest uninsured to fourth in the last couple of days according to the new report. And this, I think, represents the only effort to take a step forward. And I would really appreciate you, Mike, maybe getting with the Governor's staff and seeing what the Governor would be willing to kind of suggest as we go forward with our recommendations.

MIKE WILLDEN: Madam Chairman, if I could respond. As I have indicated to you on the phone a couple times, we have scheduled that meeting. We have tried to keep the Governor's Office up to speed on the HIFA developments over the last couple of months. We have another meeting scheduled with Chief of Staff, Mike Hillerby and Lisa Foster, next Wednesday, to bring them up to speed on the 5-A proposal, the potential need for state dollars to bring them up to date on the TANF caseload situation and on the Medicaid caseload situation so that they can have the benefit of the latest information that we have discussed over the last week or so. So that meeting is scheduled. And I would like to I guess sort of end on the comment that the department is absolutely committed to taking whatever general funds that we have within the department and maximizing federal dollars, not just in this effort, but in all efforts. That has been a commitment for a while. And we are working hard throughout a number of the divisions to maximize federal revenue.

CHAIRWOMAN BUCKLEY: We appreciate that. Assemblywoman Leslie, did you have any questions?

ASSEMBLYWOMAN LESLIE: Thank you, Madam Chair. I apologize for my lateness to the meeting this morning. I did have a chance to talk to Mike kind of off screen and get some of this explained. One concern I had was something that was in the report about the welfare, the extra TANF money that appears to be a result of lower than anticipated caseloads, and I just remember from the budget committee how we zeroed out our reserve funds, so I wanted to be sure that that is on the table, too, that we do not just think those TANF funds is a quick, easy $19 million. And I am satisfied with Mike's proposal and I agree with you that I think the only way to move forward, it costs money. There is no free lunch. And so if there is a way that we can build a partnership and squeeze the budget a little tighter on the county level, the state level, and then get some new money so we can leverage more money, I am all for that. So I think we are on the right track. Thank you.

CHAIRWOMAN BUCKLEY: Thank you.

Peter.

PETER BURNS: Just a few of the dilemmas that you will be facing. To move beyond financing and into the program elements, the first program element that we are talking about is pregnant women. As indicated, it has long been a priority of DHR to expand Medicaid coverage to 185 percent. Currently Nevada is at the federal minimum of 133 percent and if recollection serves me right, you are all one of nine states that are at the federal

minimum. As a coincidence to covering pregnant women, it is also true that the largest beneficiaries of the IAF and supplemental fund, that being UMC and WMC, that those are also the two hospitals in the state that provide, according to state reports, exclusively free births. And the last page, I am kind of jumping ahead a little bit, but the last page of your handout, page 35, is an extract from the state report on hospitalization. And I – we will come back to this or reference it later, but if you look at along the top row, the second to the end on the right, it says free. That is free care. This is births in the state of Nevada. I believe it is for 2003, and you will see that UMC provides 1,230 and Washoe Medical Center provides 440 of them so it is two-thirds and one-third roughly of the free births that occur in the state.

So in terms of having at least some degree of elegance between going after funds that primarily benefit, or to a large extent benefit UMC and WMC, and then providing a program that will at least offer them some opportunity to either reduce costs or increase revenues, pregnant women -- or expanding the coverage of pregnant women is one of those elements. Our estimates are that there would be 3,050 pregnant women that would be covered annually by this program.

The second element of the program would be small employer coverage. Based upon the uninsured data that we did do somewhat of a marathon with you all on, and the subcommittees charged, we looked at some kind of employer-based coverage plan. We have – it is in the conceptional stage now is how I would characterize it. But we looked at the benefits that are being offered through the Las Vegas Chamber of Commerce's health plans for a small business owner, and currently those plans are limited to employers of less than 50 and have a fairly comprehensive benefit. We are envisioning that a program run by the state would be similar to that in terms of its benefit package, and would probably be administered through some kind of commercial entity be it an insurer and/or a health plan. And we offer the thought that currently there are health plans that are participating in Title XIX, in terms of your managed care efforts in Medicaid, and one consideration that might be made is, to the extent that we move forward with this, that you direct that business to those, I do not know – I am assuming it is a reward and not a penalty, but because they are playing it also would minimize -- there are already administrative relationships established between those organizations, data relationships, et cetera. What we are talking about here is a subsidy of the premium that would be required for this coverage. And that would be -- the subsidy would be offered to employees of less than 200 percent of the federal poverty level, while all employees of the

employer could participate. The subsidy would only extend for those employees of less than 200 percent of the FPL. Right now we are anticipating that the monthly premium per person would be approximately $250 and therefore the subsidy could range as much as $125 for the employer and the employee paying the balance, presumably on a 25 percent/25 percent split.

At our meeting, there was some discussion of the 250. And we have gotten some preliminary indications that the $250 per month -- this is without a defined benefit -- I mean we have not set out what the benefits are -- but in terms of conceptually, 250 appears to be adequate for southern Nevada. It is a little bit more problematic for the rural areas and for northern Nevada, the rural areas especially, because there is no HMO or health plan present.

Under this vision or this element of the program, we are anticipating rolling this out more gradually. It would start in year one with 2000 lives, move to 5,000 lives, 8,000 lives. By the fourth year it would hit 10,000 lives and then be topped off at 10,000 lives. There are a lot of reasons for that, one of which is just how much demand will there be in the marketplace, and then the second will be if you start in kind of slow it will allow you to make corrections to the program before it kind of gets beyond you.

In terms of assessing the notion of this kind of take-up rate, we did some – we have done some work based on the information that we gave at the last meeting. If you remember, we went through the last meeting. We talked a lot about the uninsured and what income levels they were and who they were employed by, if they were employed, and how many employers did this and how many employers did that. We put together the chart that appears on page 10, and I would just like to talk about that. At that time we said that for small employers, the MEPS data indicated that there were 15,800 employers in the state, small employers, that did not offer health insurance, that they employed about 78,000 folks. We have done some very, and I want to emphasize and underscore this two or three times, preliminary research in terms of the question of, if you offer a subsidy, how many people that are not now currently offering insurance will offer insurance? This is no small matter. There is a lot of work that was done in the late -- some that even goes back into the mid-'80s -- but in the early '90s on this topic and there seems to be, and we have included some citations in the attachments there. We have only preliminarily reviewed this information but it seems that there is only modest improvement in take-up, according to the academic literature, with a subsidy. So for our estimates, we have assumed 10 percent of employers will make the decision that

will lead to 10 percent of the employees moving into that, into their range of picking up more insurance.

If you take a look at some of the CPS data that we have, which indicates that about 51 percent of small employee -- employees of small businesses were at or below 200 percent, we are talking about a number of employees of about 4,000. If you add their spouses in, you will get to a number larger than that. Since that time we have also been trying to have discussions with folks, and I will not say what each one of them said but we have tried to do some discussion with the Underwriters Association of Nevada, the Nevada Affordable Health Coalition, and some of the health plans or insurers that are in here as well as some brokers. There is a general feeling that 10,000 can be reached, especially 10,000 over five years.

It is just my obligation to you to point out that there is a risk factor that you could get to 10,000 lives, and that you may want to hear from people that are, so to speak, on the front line, your brokers and your underwriters and some of your insurers, about, okay, if we step off this cliff, are you going to be there and where we going to get the lives.

SENATOR NOLAN: Thank you, Madam Chair. Just so I am clear also, the 10,000 lives would include employees, employee spouses, and we have talked about that, and what about additional family members? That is also included in that number?

PETER BURNS: Madam Chairman, Senator, normally an insurance unit would be husband and wife and children, typically in the industry. Children would not be included in that because currently under your current eligibility, children up to 200 percent of the federal poverty level are either covered by Medicaid or Nevada Check Up. If there are aunts and uncles in the household those are typically not part of an insurance unit, so it would be basically spouses.

SENATOR NOLAN: Thank you.

PETER BURNS: The third group that is in option 5-A is the premium subsidy for employees. And again, when we were looking at the uninsured data and the employer data, we saw that there were quite a few employees of firms, which are both large and small, that do not take up coverage. In fact, you see that the numbers generally across the country, and even in Nevada for firms that do offer insurance, somewhere in the 70, high 60s, low 70s, maybe even to the high 70s area, of the employees that are eligible actually pick up coverage. There can be a lot of reasons why they do not pick up coverage. One may be that they get better coverage through their spouse. One may be they are eligible for a public program.

Third may be that they are 21 years old and think they are going to live forever and never get sick. And the fourth may be that they cannot afford it. And it is that fourth group that we are talking about that we would target and what the proposal would be for those people that do have health insurance available. If they are less than 200 percent of the federal poverty level, there would be a subsidy to assist them in procuring the health insurance that their employer currently offers. We targeted that at $100 per employee per month, and we are assuming, in our cost estimates, a thousand lives would come in in the first year and then grow to 2,500 lives and be capped at that. These assumptions, especially with both the employer side and the subsidy side, are pretty fungible. I mean, you can mix and match them. This is just the way that we designed it.

In terms of what the take-up or the demand would be for employees, we, from the MEPS data, estimated 104,000. We estimate, based upon the, again, a quick -- and I have to emphasize that, a quick survey of the academic literature, 20 percent, and doing calculations, 53 percent of them would be eligible under 200 percent, so that would get us a pool of 11,000, and we are talking about 2,500 there.

So if we roll these three programs together with the sources of funds that we have, we get the sources and uses document, our tables that appear on page 11. I will just walk through generally 2005, start with 45 million, small business employees, we start at $3 million a year, and then as we rolled up to the 10,000 enrollment, that would get us to $18 million a year eventually growing to 20. We factored in, I believe it was, memory does not serve, but it was at least eight percent premium growth in here year to year. Then the premium subsidy for employees we actually held flat but the first year would be for the 1,000 and then the 2,500 would be growing out at $3 million a year. Pregnant women is where your largest expenditures are going to be occurring, $24 million growing to $33 million, and then we put a placeholder in. This is not an estimate of cost, but we put a placeholder in for admin costs associated with the program of $2 million a year. So you can see that the program grows such that basically the revenue available -- I should actually put a subtotal in here -- but the revenue available is 45 million and growing, and your balance on an annual basis starts at 14.5 million because we are starting so slow, and then declines actually to the point out by 2008, 2009, you are slightly upside down with the program that is designed, and then we showed cumulative unused dollars there. We did a quick estimate of allotment neutrality making some very high level assumptions, the assumptions being that for the small business employees 50

percent of them would be non-categorical. That would be a group that we would have to prove federal budget neutrality. On the premium subsidy we assumed that 50 percent of them would be non-categorical approved budget subsidy and pregnant women, of course, would be budget -- a pass-through for budget neutrality. And it appears, based on this information, that with the amount of SCHIP funds that we would have available that budget neutrality would not be a particular concern for this type of a proposal, subject obviously, to us getting better breakdowns or making additional assumptions about what the non-categoricals are in the two programs.

Having put this option 5-A out on the table, the issues start and I want to just kind of hit some of the highlights. There will be issues until -- there will always be issues with this.

What option 5-A does, it does expand the amount of dollars that are in the health care system. Basically, we are taking $15 million and growing it to $25 million. However, where those dollars get spent is going to be different from where they are being spent now. Now they are essentially being targeted towards safety net and we are going to expand that into coverage.

Assuming that the counties have their statute changed, at least from their general fund perspective and their indigent responsibility, it will be a pass-through for them, to the extent that they operate public hospitals or in support of public hospitals or provide subsidies to public hospitals those issues may return.

So, in looking at hospitals, UMC and WMC are the primary beneficiaries of IAF. They are also, as we indicated, the only hospitals providing free birth, so to some extent there are two dots there that could be connected. And we took a little bit of a look at that but there are some important factors that you should consider in that. These are the bullet points on page 12. All of the costs of covering pregnant women will not go to hospitals. Some of it goes to physicians and other providers. All of the free births, once they receive coverage, will not necessarily continue to use the two facilities that they are currently using. They will be, in effect, empowered to choose any facility that they would want.

To the extent that the two primary hospitals do not provide services for free birth, obviously, the cost of those births will no longer be a cost faced by the hospitals. It is unknown, because the data just is not collected, of the free births that are provided that you saw on that last page of the attachment, there are a lot of things we do not know. One of the

things we do not know is how many of them are at or below 185 percent of the federal poverty level. Another thing that we do not know has to do with how many of them might be, rather than undocumented immigrants, what is called a non-qualifying aliens. Now there is a way that we can cover non-qualifying aliens under the Medicaid emergency services program.

In order to cover them that way, we would not do the expansion for pregnant women under the waiver, we would have to do it under the state plan. The advantages of doing it, and there is a long technical discussion we can go into, but trust me, that if we do it under a state plan, we get the advantage of covering non-qualified aliens who otherwise would be non-qualified for their delivery costs under the emergency services provision.

The disadvantages of covering them under the state plan is, once we cover them under a state plan, everybody that meets those income qualifications comes in. Under a waiver, we could say we are going to expand coverage but we are going to limit it to 3,050 a year or $24 million a year or something like that. With a waiver you can limit your expenditures. You can modify your benefit package and you can cap your enrollment but you cannot cover non-qualifying aliens. The horns of a dilemma. That dilemma is now presented to Nevada now because you are at the bare minimum, so any non-qualifying aliens that are pregnant are covered because they are covered under your state plan.

Just wanted to point that out. And we don't know --

CHAIRWOMAN BUCKLEY: Can I ask you a couple of questions. On the free births, how come no one is giving birth anywhere else in this state except UMC or Washoe Med?

PETER BURNS: Madam Chairman, I am not a student of this data or of that topic and I cannot – to a certain extent I do not know how accurate -- what the veracity of that data is.

CHAIRWOMAN BUCKLEY: Okay. I am just curious. What do you do when you do not have health insurance and you are about to deliver and you are in Carson Tahoe. I mean, you are in Carson, don't you go to Carson Tahoe or do they make you drive to Washoe Med?

Dr. Hardy.

ASSEMBLYMAN HARDY: I think the reality is these other hospitals just are not reporting the free care that they deliver because there are people who come to the emergency room and they are in labor, and if you transfer them somewhere else and you can

care for them then you go to jail. I mean it happens. So I do not think they are filling out the right form to take credit for their free care. Why would they fill out a form if they are not going to get any money anyway?

CHAIRWOMAN BUCKLEY: I would just be curious, maybe from the department, because -- so anyway that is a question maybe somebody could get that answer to me. And if it is just they do not report it, that is good to know, too.

The second question I have is, on the aliens, now are we getting -- I mean obviously if someone comes to the hospital, say they go to UMC and they are an undocumented immigrant, they are going to have their baby, services are required to be delivered. It is an emergency, I would assume. Are we getting match from the federal government to pay for that care now?

PETER BURNS: It is my understanding that if they otherwise meet the qualifications and complete the application process, yes, they would be eligible for match. And Medicaid -- I see Mr. Willden is moving up. And Medicaid, if going through the proper paperwork channels, Medicaid would pay for them.

CHAIRWOMAN BUCKLEY: Mike, do you have anything to add.

MIKE WILLDEN: Madam Chair, again for the record, Mike Willden. Peter is correct, we do get match on the noncitizens. I had Mr. Duarte collect some data anticipating this question yesterday and in FY 2003, under the emergency services provisions, where the noncitizens -- we cover their pregnancies and other related services, we paid $15.7 million for the noncitizens in total Medicaid dollars and the match would be roughly 50/50 on that. And of that 15.7 million, and that was for 3,947 patients, or noncitizens, and of those the pregnancy-related costs that we paid for, 1,992 deliveries, and those deliveries cost about 2.1 million.

CHAIRWOMAN BUCKLEY: Okay. My next question is, we say we do not know how many free births are for women at or below 185 percent, so we can estimate how many people would be helped if we increased the percentage.

PETER BURNS: Madam Chairman, to be honest with you there is going to be leakage, but for free births I would assume that almost all of those would be -- I admit it is an assumption. I would assume that most of all of those would be at or about 185 percent. Again,

this is some data that perhaps the hospitals will have a better handle on but if they know they are not going to get paid for it once they prove some point, it is a fine point to chase it.

CHAIRWOMAN BUCKLEY: And my last question is, why is this such a priority of the technical working group and others?

PETER BURNS: Madam Chairman, like I said, anything that you do not like is mine and anything that you do like is theirs. I would not necessarily say that -- they would have to speak for themselves in terms of whether they would put that forward as a priority. I am partially guilty for putting this package together because obviously there is a lot of meritorious groups to get there. We saw the connection between the -- based on the data that we have shown you -- the connection between UMC and WMC, free births and IAF and supplemental fund, and when we expand, and we are going to talk about this in a moment, if you expand health care coverage to 12,000 other people, I do not have a clue where they are receiving their services now. I do not have a clue which 12,000 we are going to get. I do not have a clue where they are getting their services now, and I do not have a clue as to where they are going to get their services when they move over. So at least tying the -- and with the added notion that Nevada is at 133, the federal minimum, tied for 41st in the country, knowing anecdotally that it has been somewhat of a priority from DHR, the whole thing kind of came together in my mind that would say, this would be a good idea. But if you don't like it, it ain't the technical committee's fault.

CHAIRWOMAN BUCKLEY: No, no, no. I am just trying to understand. I guess the policy point of view would be that if we have a large number of women giving birth who do not have health care insurance, that that would be a quick way to get match from the federal government by having them insured and at the same time relieve the amount of money that the counties are paying to their safety net hospitals, thereby enabling us to consider the whole package, including the small business piece. I am just trying to keep the policy objectives together in my mind.

PETER BURNS: And you are beginning to see that we cannot provide data that will make these decisions easy. Sometimes you have to squint your eyes and say it feels good or it does not feel good, because it just is not there.

CHAIRWOMAN BUCKLEY: Let me go to Commissioner Reid and then I will go to Chuck Duarte.

COMMISSIONER REID: Thank you, Madam Chairman. My eyes are not squished and I do not know how to feel. I guess the key question for the county for the existing safety net providers will be whether this program will offset hospital losses and, if so, to what extent. And if that is the question, if there is not data to answer the question, we need to know that. And if there is, we need to find it, and that is the obvious question.

PETER BURNS: Madam Chairman, that point follows in two minutes or so.

CHAIRWOMAN BUCKLEY: Mr. Duarte.

CHARLES DUARTE: Thank you, Madam Chair. For the record, Charles Duarte, Administrator for the Division of Health Care Finance and Policy. I wanted to add, the question was, how did expansion coverage to pregnant women get into the overall proposal. It actually got into the initial proposal through questions to the division by EP&P Consulting as to what we felt were policy priorities for the Medicaid program and for two reasons we felt it was important that we expand coverage for pregnant women. One was the fact that we were at the federal minimum and covering only about 3.9 percent of all childbearing age women in Nevada. And number two, that we saw that as a cost to the community hospitals of having to pick up that care. And there really was not any compensation for that. So there were some division priorities that we established and we worked with EP&P and Peter particularly on this. I wanted to make sure you knew how that popped up.

CHAIRWOMAN BUCKLEY: Okay.

PETER BURNS: The last point I think is also important, and begins to tie all this together, and that is the potential expansion population covers our estimate of all women from 133 to 185, and that is through an estimating process. Some of these women will be uninsured, of which some of them receive free care and some of them will be categorized as self-pay on that last page. There is also a portion of this population that is currently covered by insurance so that the estimate that we are providing you in terms of the $24 million covers all of those people because we assume that all three of those subgroups will avail themselves of Medicaid coverage should that be available. My suspicion is you will never get 100 percent of them for various reasons. It may or may not be true. So I mean it is important to understand we had 1,600 free births that we were talking about. We are talking about a population of 3,000. If you go back and look at that last page, you see that there is about 1,600 or 1,800, as I recall, private pay patients. Now, that private pay covers everybody that makes $20 million

a year and has no insurance. To the person who has 134 percent of the federal poverty level and makes some payment, is it charges, is it discount from charges? Is it $10 a month for 24 months? It is a variety of things.

CHAIRWOMAN BUCKLEY: It is not charges, only the counties pay charges.

PETER BURNS: Madam Chairman, it is important for you to make distinctions between the statewide funds and the counties because there are distinctions. Anyway, you have all of this noise going on in terms of performing these estimates, but anticipating the Commissioner's question, and the technical committee asked this as well, what is the impact of doing this? Well, we do not know, is the short answer but we put together two views. The first thing that we did is that we split that $24 million 50/50 between hospital and other providers. We have not done an analysis nor collected data from the hospitals of what do you actually get paid, how much goes to the hospitals versus other providers, et cetera, et cetera.

And then we took that data that is on that last page in your handout and said, okay, how is this population going to scatter through the hospitals. The first column on the page 13 there, estimated expansion, says we are going to add together the current market share of Medicaid free care and private pay and find out what the percentage by hospital is that they get of that total. And then the second set of columns is we are going to look at just Medicaid and free care and determine what the distribution of that market share is. That is how we got these numbers. Then we took the estimate that we had for the first year at 50 percent of the total amount of estimated Medicaid expenditures and split it across that population. And as you see, under these scenarios, University Medical Center, 5.3 under one version, 5.8 under the other one, Washoe Medical Center 2.6, 3.0. Now, if you look at that with a comparison of what they received from the IAF and the supplemental, you would see, based on this, that UMC is approaching breaking even. They were getting 6.7 million from the IAF in supplemental fund and potentially 5.4 million from pregnancies, giving all the assumptions that I have just given above and not netting it, if you will, for however much money they received in self-pay and however much money they would receive in insured people here.

Washoe Medical Center is a little bit more distant. They received 4.9 from the IAF and supplemental fund combined and potentially 2.7 million from the kind of numbers that we are showing you on the table on page 13.

And there is a whole host of assumptions, most of which I have made obvious. But UMC came to the work group the other day and testified in terms of what option 5-A would mean to them. And I am sure that -- well, I am assuming that they are going to testify today. And they indicated that UMC would lose $20 million under option 5-A. There was a little bit of probing by the work group, based on the numbers that we had obviously presented, and then the numbers that they presented, and they indicated that they were anticipating 7 percent market penetration, based largely on their penetration of managed care births under -- on the data that we have previously discussed.

The data that we are using is closer to 43 percent. I suspect that both of our estimates are wrong. I am not sure -- I would hope that we have bracketed at least what the estimates are. But you know there is -- you have those two things out on the table.

CHAIRWOMAN BUCKLEY: Peter, do you know what the percentage is based on Medicaid?

PETER BURNS: No, I do not, but my faithful companion will calculate for say UMC?

CHAIRWOMAN BUCKLEY: Yes.

PETER BURNS: We will have that for you momentarily.

CHAIRWOMAN BUCKLEY: That might be a better marker than managed care.

COMMISSIONER REID: Madam Chair, if I may. I want to make sure I understand -- I understand what UMC said in terms of dollar figure. Your estimate is what, so we can know what the delta is.

PETER BURNS: Basically what appears on page 13, that for want of a -- I would not call it an estimate so much as I would call it a possible view, which is a distinction without a difference, maybe. But 5.4 million would be my initial estimate on what potentially UMC could make, you know, these estimates can be further refined. You could do sub-estimates by how many free births or self-pay births there are. Ours would be 5.7, which, if you look at what is going on between the IAF and supplemental, UMC would look like they would lose $1.3 million a year times five years, you are talking $6, $7 million. UMC is talking, as I understood the conversation, $20 million over the five-year period. I have not reviewed in any -- I have not even seen their estimates so I cannot particularly comment on them. But mine might be too aggressive. Theirs might be a little too tight. It might be

somewhere in between that, somewhere between $6 million and $20 million. Does that narrow it down. I am not sure about that.

The last factor to consider with the hospitals, which is just unknown and potentially unknowable, is that we are going to hopefully cover, under 5-A, 12,000 additional lives. Those people will seek services someplace. Of the total dollars that we are going to spend on them, hopefully more of those dollars are tilted towards prevention than they are hospitalization, but there will be an element of hospitalization in there. How much, if any, will the two primary safety net hospitals benefit, pick your number and take your chances. Depends on where they are getting services now and where they will choose to get their services. So we are not at all representing that this little bit of analysis from UMC and WMC is dispositive. We are just trying to bring a view of how this system may work.

When we had the April 14th meeting, for Medicaid, UMC had 41 percent of the Medicaid births, based on the data that is contained in that table. How is that for qualification?

When we presented to the working group on the 14th, we discussed a medically needy program. I think we talked about it with you possibly. A medically needy program is basically a program that you have set some limits on and then, as a qualified individual incurs hospital bills, charges, that counts against their income until they, quote, spend down to reach a qualifying level. Once they spend down, they become eligible for Medicaid for all their bills moving forward.

If we could achieve a perfect design, we would come up with a medically needy program that would perfectly overlap the IAF and the supplemental fund. Unfortunately, that is probably not true. For example, I doubt that CMS is going to approve a program, one of the qualifications of which is that the injury must have been sustained on a public highway. It is just not going to be there. They have never had to our knowledge -- there have been very few waivers really targeted to the medically needy program, which is a state plan option. To our knowledge, they have never been presented with a concept of – two-part concept of, gee, you must spend down a certain amount, like $25,000 with the supplemental fund and/or that you must have a cap on the income limit from which we begin the measurement because right now, in theory, you could be a millionaire under, given the statewide rules for medically needy, if it was permissible if you ran up $4 million for medical bills you could qualify for medically needy. In terms of what we are trying to mimic, we are trying to mimic the eligibility standards that exist in the counties, and that ranges from very low, $438 I believe, or

is it $483 in the rural counties, to rather high in the urban counties of Washoe and Clark, and you have to spend down a fixed amount of money to qualify for a package of services. That kind of a waiver has never really been presented to CMS. But we think that it may be possible if you shorten the spend-down period, like we are only going to look back one month, that might catch a catastrophic event, like an automobile event, that we would go ahead and require a specific amount of spend down. We have a little bit of a problem here if we are trying to capture both the IAF and the supplemental, but if you just said $15,000 or $25,000 has to be spent down, and then we limited eligibility to one eligibility segment a year, one six-month period or what have you, and we allowed non-categoricals, that is single adults, essentially, to be covered, and we tightened up the benefit package, because as you know with the supplemental package, that only covers hospital, it does not cover physician, CMS probably would not go for that. They would want a broader package. But you might be able to design something that you could put all this together and try to mimic some of the coverage that currently exists with the IAF and the supplemental.

To the extent that we can, that would mean that some of those expenses that are currently being incurred could be federalized and covered under the program. There are some issues both with respect to the hospitals and with respect to CMS. One is can we, in fact, design a program like that, and is there the data available to measure it? And that is some of the things that are kind of ongoing at this point, but to the extent that there are illegal aliens or nonqualified aliens, to what extent they make up the pot of expenditures there we do not want to -- the state plan is not even an option in this because we do not want to go with the state plan, we want to tailor something to us. Those nonqualified aliens would not be eligible for federal match so they are kind of off the table and we have to know how many there are there, and to the extent that --there are various issues. In terms of how to get there, if we set a very high income level, like 100/150 percent, we capture some of the expenses from Washoe and Clark County, but then we bring in a whole lot of expenditures potentially, that do not qualify for indigent care now and the rest of the counties. So on the one hand we expand it to capture existing expenditures, on the other hand we are bringing in new expenditures. Establishing the spend-down amount, currently as we discussed, it is $25,000 of charges. Would you really want to do this program based on charges, costs, Medicaid reimbursement in terms of the fee schedule or what have you?

The supplemental fund currently prorates payments as we discussed, 12 percent to 25 percent roughly. So if we make this all eligible, I do not think CMS is going to approve a program that would allow you to take all the bills, put them in a pot and pay $0.12 on the dollar. I think they are going to want fee schedules.

The bottom line of all of this is that though not impossible, it is going to be a little tricky to find a medically needy population that we can move forward with, and you must understand that this is a -- we can pick up some of the elements that CMS has, this could largely be an issue of first impression, a case of first impression in front of CMS.

And obviously along the process we would want to balance state budget neutrality, federal budget neutrality, and those sorts of things. Again, medically needy may be an option. It is just important to you to understand that there are lots of issues that have to be sorted out, and the more that we attempt to cover what the IAF and the supplemental fund, and if the thought is to leave those there in some form or fashion, I would still suggest that we go with a very restrictive medically needy program because anything that we make is $0.50 on the dollar that we cover. But we characterize this option as higher risk. I would not want this to be the centerpiece -- well, it is up to the subcommittee and the technical working group. In my view this should not be the centerpiece of what you move forward with, but if you made it an element and then you have to start balancing where are the admin costs for this versus what you are getting.

In any event, it is important to note, and we will come back to this as well, that the working group had a high level of concern about moving forward with the abolishment of the IAF and the supplemental fund without leaving something like a medically needy program or an IAF or supplemental fund behind to cover the charges for particularly groups of nonqualified aliens and out-of-state residents, which providers otherwise would have no place to go to seek compensation.

I am getting to the point, Madam Chairman, where we are in a slow decline now into ending this thing. Implementation issues, for option 5-A. Again, I think that there has to be some vetting, and this is to some extent your judgment call in terms of how comfortable you feel. Can the benefits and the costs that we are talking about for the employer coverage, actually, are those feasible? You would want to get some input probably from the broker community, health plans insurers, on the reasonableness on the anticipated take-up rates that we are talking about.

One of the issues that everybody seems to mention would be how do we guard against adverse selections for the small employer groups so that our 10,000 lives are not all made up of 50-year-old men like myself that cannot see and have other problems. We all optimally want 18 and 24-year-old males that do not ride motorcycles. They are very cheap to cover. What is the role of brokers and compensation in this program? And then what would the administrative issues be? One of the things that we had talked about in the work group is you need an administrative infrastructure to support an insurance product run through the employers. If you go with a premium subsidy program as well, you will need an administrative infrastructure for that. At what point does the administrative infrastructure overwhelm the quote good that comes out of this?

Other elements of the proposal, after going through a lot of this, we make three areas of recommendation in terms of improved data reporting. One has to do with county indigent funds in terms of getting a chart of accounts for them so you can get a better idea of what is being spent there. Second would be our recommendation to get an annual report published of health and accident insurance premiums in the state, number of lives covered, et cetera. The third would be to do summary form, including adding out-patient expenditures to the CHIA reporting process.

After we made the presentation -- on April 14th we made the presentation to the working group, they had some time to consider it. A lot of thoughts came to them. We revisited earlier this week. At the end of our meeting they had issues and concerns that they wanted to make sure that the subcommittee was aware of, first with respect to the abolishment of the IAF and the supplemental fund. Their concern --

CHAIRWOMAN BUCKLEY: Peter, I want to cut you off right there because we have a few members that have to leave and I want to see what questions people have.

Questions of the committee?

Okay. I do not see any -- you know what I am kind of inclined to do, but it is up to the members of the committee. We are going to have to land soon, probably at the next meeting in terms of what our recommendations are. What I would like to do is to instruct Peter and the working group to go back and to sharpen the pencils on the issue of what the cost estimates are, are they 7 percent, are they 50 percent. Probably the answer is somewhere in the middle, if the Medicaid number is 41. It is probably a 35 percent number. But to go back in, re-look at it, make a recommendation of at what point there would be too much harm to the

safety net hospitals such that we need to look for state share and come back to us, rather than hearing all of the concerns, which we could for two hours, but I think we already know them and believe in them. So we could skip that part and just have the groups work that out and then come back and report to us.

What do the other committee members think?

Senator Nolan.

SENATOR NOLAN: I think, Madam Chairman, that is probably the most realistic thing to do at this point. In light of some of the deadlines that we have, not only with our next and potentially final meeting, I personally do not mind if we have to meet beyond that, but as well as the time frame to find out information about what we can actually learn and what is all involved in the federal programs that are being presented to us. We may not have a realistic idea of what funds are going to be available, what we are going to have to do in the way of prescription health care costs and those type of things for some time to come. So --

CHAIRWOMAN BUCKLEY: Maybe along with the work of the working group we can get a report back to have Mike Willden and Chuck work with the Governor to get with the working group so we have those state recommendations as well. And it may end up we do it in skeletal form if we have to, but we certainly could cross that next bridge when we get there.

Assemblywoman Leslie.

ASSEMBLYWOMAN LESLIE: Thank you, Madam Chair. I just have one kind of detail I would like the working group to take a look at in the small employer coverage. There was a reference to the benefits being fairly comprehensive, but I did not see any reference to mental health or substance abuse benefits so I would like them to take a look at that. And also, maybe they can answer this now, but it says that a small business would have to have two or more to qualify for that benefit. And I have had quite a bit of correspondence from single employee groups that they really need relief. And so I do not know if there is a prohibition against one employee business, but if there is not, I would like to consider that, too, because that is a group out there that really needs help. Thank you.

CHAIRWOMAN BUCKLEY: I have heard from quite a few one-person groups with this very same issue. They are a one-person employer, self-employed, own business. Are they precluded?

UNIDENTIFIED SPEAKER: Well, they are not a group. I mean, that is an individual.

CHAIRWOMAN BUCKLEY: They are an employer, though.

UNIDENTIFIED SPEAKER: They are an individual.

CHAIRWOMAN BUCKLEY: So the answer is no.

UNIDENTIFIED SPEAKER: Under this proposal, and there are other experts in the room for me, but my understanding of group coverage is you have a group.

CHAIRWOMAN BUCKLEY: I guess we are talking about employer-based coverage as opposed to group coverage.

PETER BURNS: That is fine, but they will be -- just as groups are medically underwritten, single individuals – here is the expert. Save me.

JACK KIM: For the record, Jack Kim from Health Services. I think why you hear the phrase groups of 2 to 50, that is the federal definition of a group coverage. I think that is where this came from. I think the question presented is how do you cover just one person? Employers, they do not qualify as a group, but can you, if the waiver covered that one person. I do not know the answer to that and that is a question you can present to Peter and Gretchen.

CHAIRWOMAN BUCKLEY: Peter, what is the answer.

PETER BURNS: Oh, yes, we can cover individuals. If you want to subsidize an individual policy you can do that. There are examples, state of Oregon being one of them, where they do buy individual coverage.

CHAIRWOMAN BUCKLEY: Okay. Let's include them if that is okay with the committee for at least consideration so we can see if it skews the numbers. Is that okay? Looks like that is okay with everyone.

COMMISSIONER REID: I, Madam Chair, appreciate the spirit of this and the recognition of the counties' concerns, and I guess I agree with your summary of where we go next. I think that there is a difference in views but the numbers are significant whichever view you take. If it is 6 million or 20 million or if it is somewhere in between, that is still a significant number for safety net providers so I think it is good that there be more discussion about that.

I also believe that there has to be a closer examination of the possibility of state funding. I think that it is good that the conversations that seem to be occurring continue and I

think we need to bring, as you suggested, or somebody suggested, the state Budget Office and the Governor's Office into these discussions. And I think we also need to analyze further the medically needy category. I think we know the problems with it but I think we also understand what the benefits would be. So I think that is a summary of the work that needs to be done.

CHAIRWOMAN BUCKLEY: Assemblyman Hardy.

ASSEMBLYMAN HARDY: On our wish list I would like to make sure that we help people get care, we avoid costlier hospitalizations, we leverage money to bring the money back to Nevada. We avoid the inequities of the employers already striving to pay for their employees to get health insurance and we keep the counties and the safety net providers whole. That is my goal.

CHAIRWOMAN BUCKLEY: With low admin costs. That is a good summary. We will copy that for the whole committee. I think we all would sign onto those principles. Thank you very much.

Okay. We will work with you through the technical committee process to try to refine this for our next meeting. Okay?

PETER BURNS: Sure. Do you have any number in -- if I could just probe for one moment. In terms of the money available, if you go to the technical committee, depending on where they stand will depend upon where they sit. Some of them may say, well, the appropriate amount of state money to put into the program is $16 million.

CHAIRWOMAN BUCKLEY: Is how much?

PETER BURNS: Sixteen million dollars, I mean to fund the whole program, unless you give me a specific target like make up the difference that WMC will and Washoe will eventually lose if any consensus could be reached upon what the losses may be and that is --

CHAIRWOMAN BUCKLEY: That is what we are talking about. I mean it is not realistic to go back to the state and to Mike Willden and say, oh, no, you come up with all of it. I think we also recognize that a certain number of people are going to be insured. A certain number of free births now won't happen because people will have insurance. So all of that methodology should be thrown in the mix. And I am sure Mike Alastuey will come up with that methodology and present it to the technical working group.

PETER BURNS: The final point that I would just like to make is that while I have tried to make a fair characterization of everybody's positions you very well may want to hear from them.

CHAIRWOMAN BUCKLEY: Thank you. Okay. We will take public testimony. Mike.

MIKE ALASTUEY: Thank you, Madam Chair, subcommittee members. My name is Mike Alastuey. I have the privilege of chairing the technical working group. I believe the discussion that was put forth by Mr. Burns captured a great many of the concerns and issues raised by the technical working group and I think we have certainly a charge from your subcommittee to go forth, and everybody, including the hospitals, Mr. Burns, and the technical working group sharpen our pencils and attempt to bring these numbers together. I appreciate your direction to Mr. Burns and the technical working group as to the range of potential state dollars that may be required to reconcile the financing picture. Also, we heard Commissioner Reid's characterization of the range of options. That needs to be kept open and I completely agree with that, including and especially the further exploration of the medically needy category.

There are additional technical issues I will not go into today. Some of them relate to the insurance versus -- insurance plan versus employee insurance premium subsidy option. And we want to try to craft the range of options for you insofar as possible to try to consolidate or recommend a balance between the two to minimize the administrative costs. And also, one thing we do want to avoid is a migration of existing insured individuals into this subsidized plan so a design of eligibility criteria has to be crafted very carefully. And we will bring other information to you as we have it. I want to commend Mr. Burns, Steve, and EP&P for their tireless work, and my colleagues on the technical committee for their attention to this issue. They are a great bunch of folks and I am pleased to work with them.

Thank you very much and I will take any questions.

CHAIRWOMAN BUCKLEY: Does not appear to be any. Thank you very much.

Is there anyone else in Las Vegas that would like to provide public testimony?

Anyone else? Okay. So you will be our final witness in Las Vegas and then we will go to Carson City.

JOSEPH COBREY: Thank you, Madam Chair, members of the committee. For the record my name is Joseph Cobrey. I am the President of the Nevada Association of County Human Service Administrators. Much of the data collection we had talked about you seem to have covered in your thing today but I would like to make a couple points on some of the issues that were brought up. Particularly, there was a lot of discussion today on IAF and supplemental and distinguishing between IAF and supplemental being very different from the indigent funds that the counties provide for their clients. I think proceed cautiously with that, particularly with the supplemental fund, because as the counties view their clients as indigents, they see them based on what their income is, and the supplemental fund is used as part of that indigent budget and we really see our budgets linked to IAF and supplemental. If IAF and supplemental were to be removed, it would have an effect on our budgets, because an indigent client in any of the counties in Nevada may also dip into the supplemental funds. So if those funds do disappear, there is going to be an impact on the budget. Many of the counties, particularly in the rural communities, are at their max budget already so they are not able to appropriate any more money so there would be some issues if supplemental funds no longer existed. And, in short, we see concerns as that if this money is removed and not supplanted, residents of our communities that are currently being served are not going to be served because some of those residents will not fit into the categorical Medicaid services that are proposed in this option.

And I think that is all I have to say. The other things we think that you guys covered very well today. Thank you, and if you have any questions or other information, we would be glad to provide that for you.

CHAIRWOMAN BUCKLEY: Thank you. We appreciate it.

Assemblywoman Leslie, is there anyone in Carson City that would like to provide testimony today?

ASSEMBLYWOMAN LESLIE: It does not appear that there is, thank you.

CHAIRWOMAN BUCKLEY: Well, our next meeting is June 25th, 9:00 a.m. here and we will also be videoconferenced. And we are going to try to do a lot of work in between with the working group, with committees, with phone calls to try to keep refining this. And I think if everybody just keeps in mind the principles that Assemblyman Hardy recited, we will be in good shape and we will be making a lot of progress. So with that, we are adjourned.