Study of Health Insurance Expansion Options

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LEGISLATIVE COMMITTEE ON HEALTH CARE'S
SUBCOMMITTEE TO STUDY HEALTH INSURANCE EXPANSION OPTIONS

BULLETIN NO. 05-24

JANUARY 2005

TABLE OF CONTENTS

SUMMARY OF RECOMMENDATIONS

LEGISLATIVE COMMITTEE ON HEALTH CARE
SUBCOMMITTEE TO STUDY HEALTH INSURANCE EXPANSION OPTIONS

(*Nevada Revised Statutes* 439B.200)

This summary presents the recommendations approved by the Legislative Committee on Health Care's Subcommittee to Study Health Insurance Expansion Options at its July 14, 2004, meeting. The Subcommittee submits the following proposal for consideration by the 73rd Session of the Nevada Legislature:

- **Draft legislation to facilitate a Health Insurance Flexibility and Accountability initiative waiver to expand insurance coverage under the State's Medicaid program**. The waiver is to include the following coverage groups:

  1. Pregnant women between 133 percent of the federal poverty level (FPL) and 185 percent of the FPL;

  2. Employees of businesses with 2 to 50 employees, who would receive a premium subsidy in an amount of $100 per person per month for themselves and their spouses if their household incomes are less than 200 percent of the FPL; and

  3. Individuals with incomes and resources above the Medicaid "medically needy" standards.

  Further, it was agreed by the Subcommittee that there be joint house sponsorship for the bill. **(BDR 38--736)**

REPORT TO THE 73ND SESSION OF THE NEVADA LEGISLATURE
BY THE SUBCOMMITTEE TO STUDY
HEALTH INSURANCE EXPANSION OPTIONS

I. INTRODUCTION

This report summarizes the work and findings of the Legislative Committee on Health Care's Subcommittee to Study Health Insurance Expansion Options. The Subcommittee was created to address the issue of the growing number of Nevadans who do not have health insurance.

In 2003, the Legislative Committee on Health Care retained EP&P Consulting, Inc. (EP&P) to examine the possibilities for maximizing federal funds available to Nevada for health care. That engagement resulted from observations made by EP&P while working on the *Report on Indigent Care Costs and Disproportionate Share* for the Committee the previous year. At its October 29, 2003, meeting the Legislative Committee on Health Care was provided a report from EP&P that identified potential sources of funding for a Health Insurance Flexibility and Accountability (HIFA) initiative waiver and identified possible coverage groups that might be granted Medicaid eligibility through a Medicaid expansion.

At its December 3, 2003, meeting, the Committee agreed to pursue a HIFA waiver to expand health insurance coverage to certain groups of people who could not afford coverage but who were not eligible for Medicaid or other public programs. On January 7, 2004, the Task Force for the Fund for a Healthy Nevada granted to the Committee $172,800 to proceed with the development of the parameters for a HIFA waiver. On January 21, 2004, the Committee appointed a Subcommittee to Study Health Insurance Expansion Options. The following persons were appointed to the Subcommittee by Assemblywoman Ellen Koivisto, Chairwoman of the Committee:

Assemblywoman Barbara E. Buckley, Chairwoman
Senator Dennis Nolan
Senator Raymond Rawson
Senator Dina Titus
Assemblyman Joe Hardy
Assemblywoman Ellen Koivisto
Commissioner Rory Reid, Clark County Commission

A Technical Working Group (TWG) consisting of representatives with expertise from a broad array of fields including health care, insurance, law, local and state government, and organized labor was appointed by Chairwoman Buckley to provide technical assistance to the Subcommittee in conducting its study and to work with the Subcommittee's consultant. Members of the TWG included:

Mike Alastuey VRJ Consulting, Chairman
Robert S. Hadfield, Nevada Association of Counties
Jack Kim, Sierra Health Services
Ruth A. Mills, Nevada Health Care Reform Project
Jon Sasser, Washoe Legal Services
Pilar Weiss, Culinary Workers Union
Bill Welch, Nevada Hospital Association
Michael Willden, Nevada Department of Human Resources

Professional consulting services were provided by EP&P Consulting, Inc.

Legislative Counsel Bureau (LCB) staff services for the study were provided by Vance A. Hughey, Chief Principal Research Analyst, Research Division; Leslie K. Hamner, Principal Deputy Legislative Counsel, Legal Division; and Maryann Elorreaga, Senior Research Secretary, Research Division.

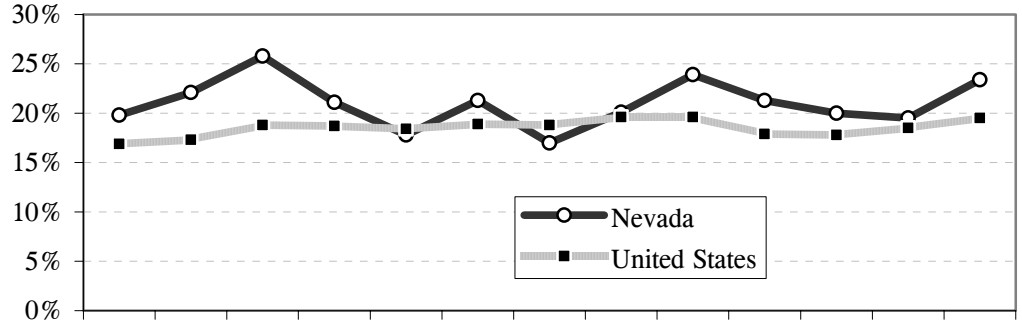
II. THE NATURE OF THE UNINSURED POPULATION IN NEVADA

Based on data from the U.S. Census Bureau—the most widely used source of statistics on the uninsured[1]—an estimated 15.6 percent of the U.S. population, or 45.0 million people, were without health insurance coverage in 2003, up from 15.2 percent and 43.6 million people in 2002. The Census Bureau reported in August 2004 that the percentage of people with health insurance coverage dropped from 84.8 percent to 84.4 percent, mirroring a drop in the percentage of people covered by employment-based health insurance (61.3 percent in 2002 to 60.4 percent in 2003). This decline in employment-based health insurance coverage has been attributed to (1) rising unemployment during the weak economy in 2001 and 2002, and (2) increasing costs of health care.

Additionally, the percentage of people covered by government health insurance programs rose in 2003, from 25.7 percent to 26.6 percent, largely as the result of increases in Medicaid and Medicare coverage. Medicaid coverage rose 0.7 percentage points to 12.4 percent, and Medicare coverage increased 0.2 percentage points to 13.7 percent, in 2003.

The Census Bureau also provides a state-by-state breakdown of uninsurance rates. A comparison across states, using 3-year average uninsured rates for 2001-2003, shows that Texas and New Mexico had the highest and second highest proportions of uninsured, while Nevada had the sixth highest proportion of uninsured. When considering the adult population under age 65, Nevada's uninsured rate consistently has exceeded the national average in recent years (see Figure 1 below).

Figure 1—Percent of Adult Population
(Age 18-64 Years) Without Health Insurance



Source: Current Population Survey, U.S. Bureau of the Census

[1] The U.S. Census Bureau considers people "insured" if they were covered by any type of health insurance for part or all of the previous year, and they are considered "uninsured" if they were not covered by any type of health insurance at any time in that year.

As depicted in Table 1 (below), most of the non-elderly population in Nevada who have health insurance obtain coverage through employer-sponsored health plans. Approximately two-thirds of the population of the state obtains health insurance coverage through an employer-sponsored insurance program.

Table 1—Distribution of Health Insurance in Nevada

Comparison of Current Population Survey (CPS) and Kaiser Family Foundation Estimates for 2002 (Non-elderly ages 0-64 years)

	CPS*		Kaiser**	
Source of Insurance	**Population**	**Estimated Percentage**	**Population**	**Estimated Percentage**
Employer Sponsored	1,253,800	66.9%	1,299,000	68.8%
Private	77,900	4.2%	75,800	4.0%
Public	124,600	6.7%	133,200	7.1%
Uninsured	416,700	22.2%	379,100	20.1%
Total	1,873,000	100.0%	1,887,100	100.0%

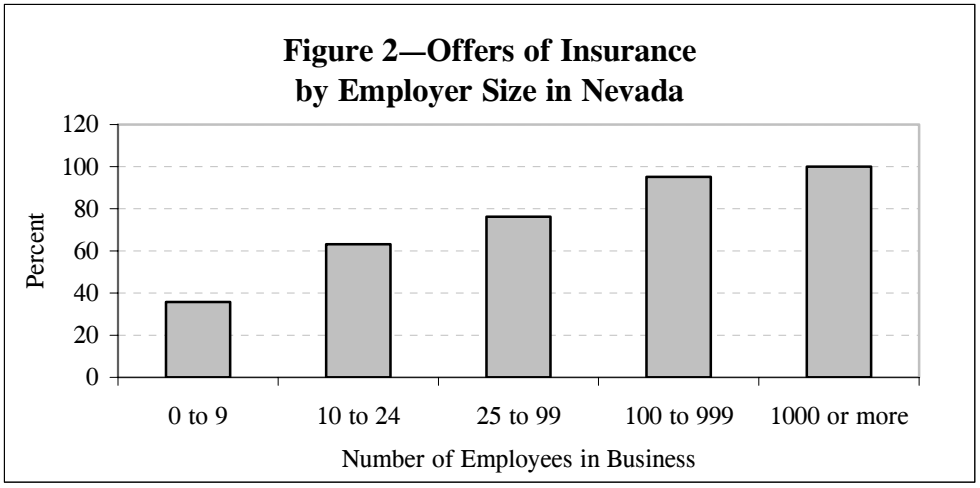
** Data Source: 2003 March Supplement to the Current Population Survey*

*** Data are an average of 2001 and 2002.*

Some Nevadans obtain coverage through private insurance, but the percentage is very small (approximately 4 percent of the total population) due to the high cost of individual health insurance policies. Medicare and Medicaid make up most of the balance of insured individuals in Nevada and are included in the "public" source of insurance in Table 1. The rest of the population is uninsured, and a sizable number of them are employed but are either not offered or not eligible for employer-sponsored health insurance.

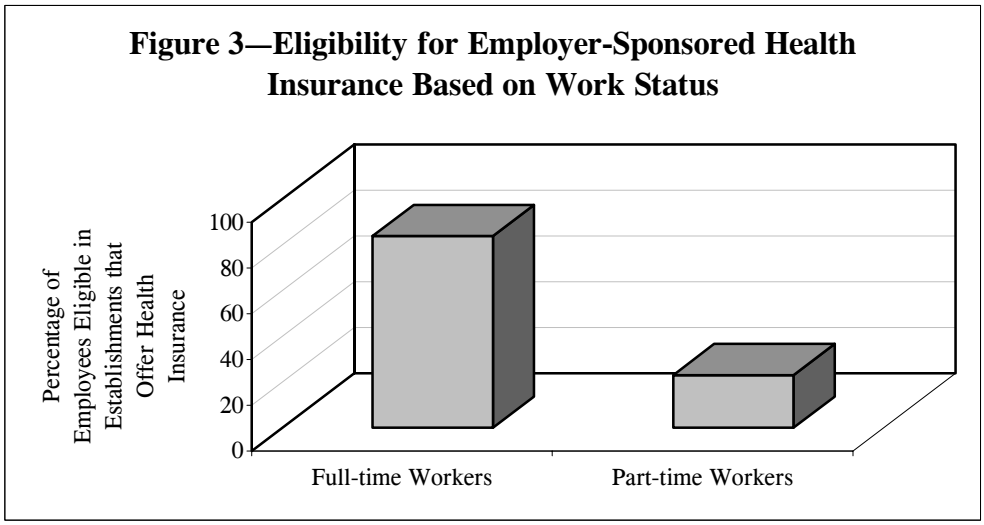
Many employees whose employers do not provide health insurance coverage do not qualify for government-subsidized insurance programs such as Medicaid, Medicare, or the State Children's Health Insurance Program (SCHIP) and they cannot afford individual private health insurance coverage. Most of these people are low wage earners but are either not offered group health insurance by their employers or cannot afford their share of the insurance premiums. These people constitute a segment of the Nevada population that is referred to as "the working uninsured."

Part of the reason these workers are not offered employer-sponsored health insurance is because they are employed by small companies that typically cannot afford to provide insurance for their workers. As indicated in Figure 2 (below), small employers are much less likely to offer insurance coverage to their workers.



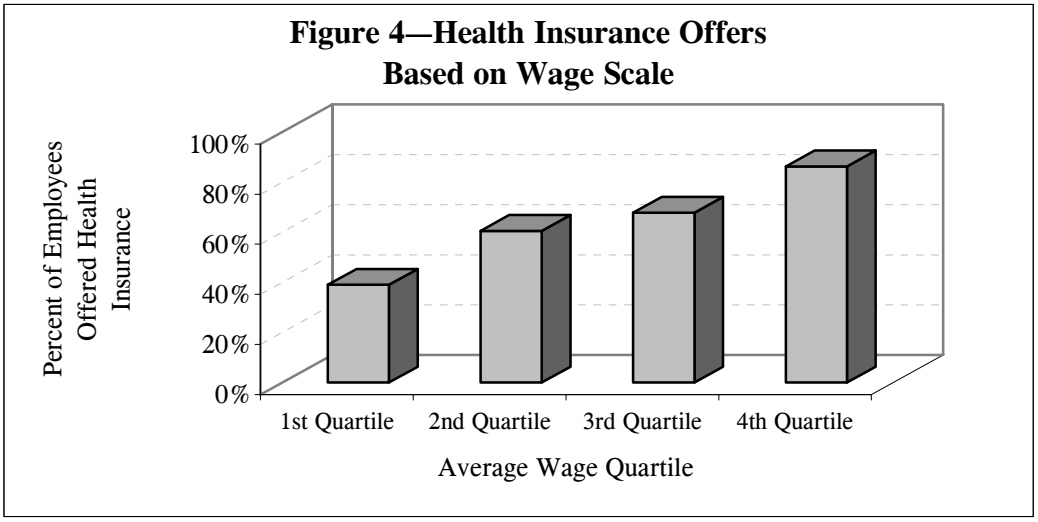
Source: Agency for Healthcare Research and Quality. *2001 Medical Expenditure Panel Survey*.

Some workers whose employers offer insurance do not qualify for coverage either because they are part-time or temporary workers. Only 23 percent of part-time workers who are offered employer sponsored health insurance are eligible for such coverage (see Figure 3).



Source: Agency for Healthcare Research and Quality. *2001 Medical Expenditure Panel Survey*.

Additionally, data from the Agency for Healthcare Research and Quality indicate that low wage workers are much less likely to be offered employer-sponsored health insurance than are high wage workers. Persons in the lowest wage quartile are about half as likely to be offered employer-sponsored health insurance as those in the highest wage groups (see Figure 4).



Source: Agency for Healthcare Research and Quality. *2001 Medical Expenditure Panel Survey*.

Cost of health insurance coverage is a significant problem for the working uninsured. Premiums for employer-sponsored health insurance rose at about five times the rate of inflation (2.3 percent) and workers' earnings (2.2 percent) for an average increase of 11.2 percent in 2004. This increase was less than the 13.9 percent increase reported for 2003, but was still the fourth consecutive year of double-digit growth, according to the 2004 Annual Employer Health Benefits Survey released by the Kaiser Family Foundation and Health Research and Educational Trust. In 2004, premiums reached an average of $9,950 annually for family coverage ($829 per month) and $3,695 ($308 per month) for single coverage, according to the new survey. Family premiums for preferred provider organizations, which cover most workers, rose to $10,217 annually ($851 per month) in 2004, up significantly from $9,317 annually ($776 per month) in 2003. Since 2001, premiums for family coverage have risen 59 percent.

III. HEALTH INSURANCE FLEXIBILITY AND ACCOUNTABILITY (HIFA) INITIATIVE WAIVER

The Centers for Medicare and Medicaid Services (CMS),[2] U.S. Department of Health and Human Services, introduced the HIFA demonstration initiative in August 2001. The HIFA initiative is a new approach to Section 1115 research and demonstration waivers for Medicaid and SCHIP.[3] The HIFA program's goal is to expand Medicaid coverage to populations with incomes above current income eligibility levels without requiring additional funding from the federal government.

A. HIFA Requirements

A HIFA waiver must be budget-neutral for the federal government, which means it cannot require federal funding beyond current Medicaid expenditure levels. Because of this restriction, states must show how they intend to cover newly eligible individuals in the Medicaid program. In order to facilitate eligibility expansions, HIFA guidelines give states flexibility in structuring their Medicaid benefit packages and financing mechanisms. Specifically, under HIFA, states are allowed to cap enrollment, reduce benefits, increase cost-sharing for "optional" Medicaid beneficiaries and to redirect federal SCHIP or Disproportionate Share Hospital (DSH) funds to pay for services for additional populations.

HIFA SUMMARY

A HIFA demonstration proposal must:

* Include an expansion of coverage;
* Include a public/private coordination component;
* Include a goal for reducing the rate of uninsurance and a methodology for monitoring attainment of the goal;
* Include a maintenance of effort provision (if a state-funded program is being federalized); and
* Be budget-neutral for the federal government.

A HIFA demonstration proposal must not:

* Reduce mandatory services to Medicaid eligible persons; or
* Provide coverage to individuals with incomes above 200 percent of the federal poverty level (with certain exceptions).

Three separate eligibility groups in the Medicaid and SCHIP programs are identified for the purposes of the HIFA demonstration: mandatory, optional, and expansion populations.

> Mandatory populations—This category consists of groups of people whose coverage is required by the state's Medicaid plan, as specified in Title XIX[4], Section 1902(a)(10) of the Social Security Act and at 42 CFR Part 435,

[2] The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program, and works in partnership with states to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards.

[3] Section 1115 of the Social Security Act provides the Secretary of Health and Human Services with broad authority to authorize experimental, pilot, or demonstration project(s) that, in the judgment of the Secretary, are likely to assist in promoting the objectives of the Medicaid statute.

[4] Title XIX of the Social Security Act, also known as Medicaid, was established in 1965 as a joint federal–state program. Medicaid provides medical assistance to certain families and individuals with low incomes and persons with disabilities.

Subpart B. Examples of people in this eligibility group include a child under age 6 whose family income is at or below 133 percent of the federal poverty level (FPL)or a pregnant woman with family income up to 133 percent of the FPL.

Optional populations—This category refers to eligibility groups that can be covered under a Medicaid or SCHIP State Plan, i.e., those that do not require a Section 1115 demonstration to receive coverage and who have incomes above the mandatory population poverty levels. Groups are considered optional if they can be included in the State Plan, regardless of whether they are included. The Medicaid optional groups are described at 42 CFR Part 435, Subpart C. Examples include children covered in Medicaid above the mandatory levels and children covered under SCHIP. For purposes of the HIFA demonstrations, Section 1902(r)(2) and Section 1931 of the Social Security Act expansions constitute optional populations.

Expansion populations—This category refers to individuals who cannot be covered in an eligibility group under Title XIX or Title XXI[5] of the Social Security Act and who can only be covered under Medicaid or SCHIP through the Section 1115 waiver authority. Examples include childless non-disabled adults under Medicaid.

The HIFA demonstration initiative places strong emphasis on coverage through private health insurance and allows states more flexibility with benefit packages and cost sharing requirements with premium assistance programs than the standard rules for Medicaid and SCHIP. Under the HIFA initiative, states are encouraged to submit proposals that that include premium assistance programs for individuals whose employers offer insurance or for individuals able to pay a portion of a private individual health insurance policy.

The HIFA guidance very clearly outlines that Medicaid and SCHIP expenditures are not intended to replace employer contributions to their employees' health coverage or an individual's contribution to an individual policy. Therefore, the HIFA law requires states to present a plan for preventing substitution of private coverage with public coverage but does not provide exact guidance for this plan, as was the case with SCHIP.

FLEXIBILITY UNDER HIFA

Under a HIFA demonstration proposal, a state may:

* Reduce benefits and/or increase cost sharing;
* Provide only a primary care benefit to certain populations;
* Impose enrollment caps;
* Federalize a state-funded program (as long as the maintenance of effort requirement is met);
* Use unspent SCHIP funds to finance increased coverage; and
* Divert disproportionate share hospital (DSH) funds to finance coverage expansion.

As noted above, a HIFA demonstration must be "budget neutral," which means that the costs to the federal government over the life of the demonstration may be no more than would have been spent in the absence of the

[5] The Balanced Budget Act of 1997 created Title XXI of the Social Security Act; also called the State Children's Health Insurance Program (SCHIP).

demonstration. States need to save money with HIFA reforms (or as a result of HIFA reforms) or use unspent federal SCHIP money to finance any insurance coverage expansions. States may find these savings by:

- Creating less expensive benefit packages for their optional and expansion populations that more closely resemble the private market;

- Implementing a premium assistance program, which potentially could generate revenue from the employer share of the premium (although the research is not conclusive on this);

- Experiencing potential savings on emergency indigent care funding to hospitals (disproportionate share payments) and other providers of emergency services, since more people will have access to primary care through the health insurance expansion; or

- Spending down the state's SCHIP allotment, if the state has unspent federal dollars because of lower costs or lower enrollment for the program.

While not a stated purpose of HIFA, it is possible to use a HIFA waiver to maximize federal reimbursement by matching funds for previously state-only funded health coverage programs. However, the waiver must include a "maintenance of effort" provision under which state expenditures under the demonstration must continue to meet or exceed previous state expenditures.

B. HIFA Waivers in Other States

To date, a number of states have implemented HIFA waivers including Arizona, California, Colorado, Idaho, Illinois, Maine, Michigan, New Jersey, New Mexico, and Oregon. Following is a brief description of each of these programs:

Arizona—Under a demonstration waiver approved in 2001, the state uses Title XXI funds to expand coverage to two populations: (1) adults over age 18 without dependent children and with adjusted net family incomes at or below 100 percent of the FPL; and (2) individuals with adjusted net family incomes above 100 percent of the FPL and at or below 200 percent of the FPL who are parents of children enrolled in the Arizona Medicaid or SCHIP programs, but who themselves are not eligible for either program.

California—A waiver approved in 2002 allows the State to use Title XXI funds to expand coverage to parents and legal guardians of SCHIP children with incomes up to 200 percent of the FPL.

Colorado—A waiver approved in 2002 provides coverage for pregnant women with incomes between 135 percent and 195 percent of the FPL.

Idaho—Approved in November 2004, the Idaho Access Card program is a premium assistance program administered in partnership with Idaho insurance carriers. An eligible child qualifies for up to $100 per month in premium assistance or up to $300 per month for families with three or more children. Children from families whose income is between 150 percent and 185 percent of the FPL may be eligible. Parents are responsible for premium payments, co-payments, and deductibles.

Illinois—A waiver approved in 2002 provides coverage for parents of Medicaid and SCHIP children with incomes up to 54 percent of the FPL (expanding eventually to 185 percent of the FPL).

Maine—A waiver approved in 2002 expands health insurance coverage to childless adults with incomes at or below 100 percent of the FPL (expanding to 125 percent of the FPL after one year) by redirecting a portion of its DSH allocation to cover this population.

Michigan—A waiver approved in 2004 expands health insurance coverage to childless adults with incomes at or below 35 percent of the FPL by utilizing unspent SCHIP funds.

New Jersey—A waiver approved in 2003 expands coverage to uninsured custodial parents and caretaker relatives of children eligible for Title XIX or Title XXI who are not Medicaid eligible, and have family incomes up to and including 133 percent of the FPL. This expansion of coverage will be funded through Title XXI with cost savings generated by standardizing the service package for both demonstration groups of parents in its current SCHIP Section 1115 demonstration. In the HIFA demonstration, parents with incomes at or below 133 percent of the FPL will receive the most widely used Health Maintenance Organization package with the largest commercial non-Medicaid enrollment marketed in New Jersey, as is currently the case with parents with incomes up to and including 200 percent of the FPL. Parent coverage will be funded with Title XIX funds in the event that the Title XXI allotment is insufficient to fund such coverage, after first covering children.

New Mexico—A waiver approved in 2002 covers uninsured parents of Medicaid and SCHIP children, as well as childless adults, in a partnership with employers in the State, using unspent SCHIP funds to pay for the coverage expansion. Those eligible for coverage will include uninsured parents of Medicaid and SCHIP children, who are themselves ineligible for Medicaid under the State's current rules, with incomes up to 200 percent of the FPL. Adults without dependent children, who are otherwise ineligible for Medicaid, also will be eligible with incomes up to 200 percent of FPL.

Oregon—A waiver approved in 2002 provides for coverage of the current mandatory, optional, and expansion Medicaid populations included in the original Oregon Health Plan and provides for an expansion of coverage of targeted low-income children, parents of children eligible for Medicaid and SCHIP, pregnant women, and childless adults.

IV. OVERVIEW OF SUBCOMMITTEE PROCEEDINGS

The Subcommittee received extensive testimony regarding the nature of the uninsured problem in Nevada, alternative approaches to providing expanded insurance coverage using certain state and local funds to leverage additional federal funds, and recommended solutions. Between February and July 2004, the Subcommittee held four meetings. Additionally, the Technical Working Group met six times between March and June 2004. All of the meetings were held in Las Vegas with simultaneous videoconferencing between meeting rooms at the Grant Sawyer State Office Building in Las Vegas and the Legislative Building in Carson City.

For more detailed information, please consult the minutes and exhibits from the meetings, which are available from the LCB's Research Library. The minutes (without exhibits) and a copy of this report are electronically available on the Legislature's Internet Web Site at www.leg.state.nv.us.

A. Meeting on February 13, 2004

The first meeting of the Legislative Committee on Health Care Subcommittee to Study Health Insurance Expansion Options was held on Friday, February 13, 2004. Following is an overview of the topics discussed.

- Mr. Hughey gave a presentation entitled "Characteristics of the Uninsured in Nevada," which addressed such issues as: (1) who is uninsured; (2) how Nevadans get health insurance; (3) how people access employer-sponsored health insurance; (4) the challenge of the working uninsured; and (5) factors affecting health insurance offers.

- Gretchen Engquist, Ph.D., Corporate Director, and Peter Burns, Corporate Manager, EP&P Consulting, Inc., gave a presentation entitled "HIFA New Coverage Opportunities for States." They explained HIFA highlights and gave an overview of approved HIFA proposals. They also discussed waiver product and coverage options, employer-sponsored insurance, financing issues and options, and opportunities for Nevada.

B. Meeting on March 12, 2004

At the second meeting, Mr. Burns discussed insurance coverage gaps in Nevada and compared Nevada's statistics with national uninsured rates. He also explained efforts at state and local levels of government in Nevada to find money that can be used to match federal funds under a HIFA waiver. Dr. Engquist reviewed financing proposals that use employer dollars in Arkansas and Maine.

James Wadhams, Wadhams and Akridge, provided an update on the small employer insurance market in Nevada, which was followed by testimony from Randy Robison, National Federation

of Independent Businesses, concerning the cost and availability of health care to small businesses.

Dr. Engquist discussed several possible coverage groups that may be included in a Nevada HIFA waiver. She explained that she will add to her list of possible groups 18-21 year olds, but that federal immigration law prevents undocumented aliens from being included as a coverage group in a HIFA waiver. Mr. Burns discussed various benefit plans being used in other states.

C. Meeting on May 7, 2004

At the third meeting, Alice Molasky-Arman, Commissioner of Insurance, gave a presentation concerning "Unauthorized Insurers in Nevada." She noted that this issue stemmed from activities of Employers Mutual, an unauthorized insurer that defrauded 41 Nevada employers and left approximately $1 million in unpaid claims owed to 1900 participants and health care providers. She explained Nevada's participation in a federal effort to identify and shut down companies that operate unauthorized insurance companies that were defrauding the public. The Commissioner also described Nevada's public awareness media campaign designed to educate insurance consumers about health insurance scams. The Commissioner noted that the Division of Insurance has legal tools to address the problem of insurance fraud but does not have the resources to prosecute insurance fraud cases.

Peter Burns discussed a proposed health insurance expansion option that includes an employer-based insurance component, a premium subsidy program, and an expansion of coverage for pregnant women up to 185 percent of the federal poverty level. He described the proposal in terms of the groups to be covered, cost and caseload estimates, and available financing possibilities. Chairwoman Buckley instructed the consultant and the Technical Working Group to review the cost estimates and make a recommendation that would identify the point at which the safety net hospitals might suffer excessive financial hardship that would justify using State money. In addition, she suggested that the DHR work with the Office of the Governor to try to obtain State recommendations as well. Assemblywoman Leslie suggested that the consultant consider mental health and substance abuse benefits as part of a benefits package. Finally, Assemblywoman Buckley asked the consultant to also consider providing a coverage option for individuals and to consider a medically needy coverage group.

D. Meeting on July 14, 2004

Mr. Burns discussed a proposal for a HIFA waiver consisting of three elements. These elements are:

- Expand Medicaid coverage to pregnant women up to 185 percent of the federal poverty level;

- ❖ Subsidize the cost of an insurance product for low income employees of small employers; and

- ❖ Provide a "medically needy" program to provide health insurance coverage for certain individuals who are not covered by other programs.

The waiver programs would be financed equally by current county funding sources for the Indigent Accident Fund (IAF) and the Supplemental Fund (SF), and the State of Nevada. One cent of the current 2.5 cents that funds the IAF and the SF would be used in addition to State funds. A mechanism would be established whereby unused funds would be redirected back to the sources of the funds.

Public testimony was offered in support of the proposed HIFA waiver after which the Subcommittee voted unanimously to proceed with a bill draft request. Further, the Subcommittee agreed that the bill should have joint house sponsorship.

V. DISCUSSION OF PROPOSED HEALTH INSURANCE EXPANSION OPTION

Attached as Appendix A is a document prepared by EP&P Consulting, Inc. that summarizes the proposal developed under the direction of the Subcommittee. Referred to as "Option 7D," this proposal outlines a program for extending coverage to certain targeted groups of people using a HIFA waiver.[6]

A. Coverage Groups

The groups that are recommended to be extended coverage under this proposal include:

- **Pregnant Women**—Currently, Nevada's Medicaid program provides the minimum level of coverage that is mandated under federal law (133 percent of the FPL). The *Current Population Survey*[7] (CPS) estimates that in 2003 approximately 3,050 pregnant women between 134 percent and 185 percent of the FPL were uninsured in Nevada. This proposal would extend coverage under the Medicaid program to pregnant women up to 185 percent of the FPL. In order to provide funding for other elements of the health insurance expansion proposal, the Subcommittee proposed that expenditures for this program element be limited to $20 million during the first year. Under this funding limitation, it is estimated that coverage could be extended to approximately 2,500 of the 3,050 pregnant women each year. The expenditure cap is proposed to increase to $29 million over the five year waiver period to accommodate the effects of inflation.

- **Employees of Small Employers**—The Subcommittee identified a small employer (2-50 employees) insurance program under Medicaid as the most cost effective method of expanding coverage to uninsured Nevadans. This coverage element would provide a premium subsidy in an amount of $100 per person per month to employees and their spouses with household incomes of less than 200 percent of the FPL. The cost of the coverage would be shared by the employee, the employer, the State, and the federal government. To ensure that employers do not reduce their levels of contribution, the program would require each employer to cover at least 50 percent of the premium cost and that there be a six-month period during which the employee was not covered by any form of insurance. This proposal calls for enrollment to be phased in over several years, beginning with 2,000 covered lives during the first year of the program and increasing to 8,000 covered lives by the fourth year of the program. A full benefit package would be required, including physician services, inpatient and outpatient hospital services, emergency services, and laboratory and X-ray services.

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[6] The Technical Working Group considered many different proposals before agreeing in principal to commend to the Subcommittee the provisions contained in Option 7D.

[7] The Current Population Survey is a monthly survey of about 50,000 households conducted by the Bureau of the Census for the Bureau of Labor Statistics. The CPS is the primary source of information on the labor force characteristics of the U.S. population.

- **Medically Needy**—States may choose to cover individuals who do not meet the financial standards for Medicaid benefits but fit into one of the categorical groups and have income and resources within special "medically needy" limits established by the state. Individuals with incomes and resources above the "medically needy" standards may qualify by "spending down"—i.e., incurring medical bills that reduce their income and/or resources to the necessary levels. The details of this coverage group still need to be developed (key elements are listed on page 5 of the Appendix A), but the Subcommittee hoped that this program element would cover as many of the situations as possible that the current county-level IAF and the SF now cover and become a federally matched funding source for many of the cases that are currently being compensated through unmatched IAF and SF monies. The number of covered lives that might benefit from this program element is unknown at this time.

B. Financing

As noted in Appendix A, the underlying principle of "Option 7D" is one of shared risk where existing State funds would be used along with local funding from the IAF and the SF. By design, only part of the IAF and SF resources would be used to extend insurance coverage, leaving a substantial portion of those resources to serve as an important and viable funding source for safety net and rural health care providers. The 1 percent property tax levy that currently supports the SF would be redirected to support the HIFA waiver. The remaining 1.5 percent property tax levy that currently supports the IAF would be used to support the current functions of both the IAF and the SF. The Subcommittee felt that a revision to the charges paid by the IAF or the adoption of a Medicaid or other fee schedule as a basis for payment to providers would generate enough savings such that the 1.5 percent levy would fully support the IAF and have resources available to continue to support a new combined IAF/SF.

In addition to redirecting the IAF and SF resources to the waiver program, the Subcommittee, by adopting Option 7D, approved a recommendation that the State contribute approximately $7 million of State General Fund revenue in order to minimize the amount of funding that would be directed away from safety net providers such as the University Medical Center in Las Vegas, and Washoe Medical Center in Reno. Additionally, the Subcommittee was informed that the Governor already was considering funding an expansion of coverage for pregnant women in the 2005-2007 *Executive Budget*. By expanding this coverage via a HIFA waiver, the Subcommittee believes that the State will spend less money than if it were to fund the pregnant women expansion on its own, resulting in a savings for the State.

Finally, funding to support the proposed expansion of health care coverage would include Title XIX and Title XXI funds. Together with the IAF/SF revenues, federal matching funds, and State General Fund revenues, total funding to support the proposed waiver is estimated to be $37.8 million in the first year of the waiver and increasing to $48.9 million in the fifth year.

C. Approval of the Proposal

The members of the Subcommittee expressed their approval of this proposal by a unanimous vote in support of a bill draft request to proceed with a HIFA waiver. Further, it was agreed that there be joint house sponsorship for the bill.

VI. CONCLUDING REMARKS

The Subcommittee wishes to thank the many individuals who participated in meetings of the Subcommittee and who offered expert testimony and valuable suggestions, including persons representing Nevada's Department of Human Resources, health care providers, hospitals, insurers, local governments, small businesses, the Las Vegas Chamber of Commerce, the Nevada Network Against Domestic Violence, the Nevada Public Health Foundation, and the Nevada Women's Lobby, among others.

Appreciation also goes to Peter Burns, Corporate Manager, EP&P Consulting, Inc. (EP&P), and his staff, who provided consulting services to the Subcommittee. Finally, special appreciation goes to the members of the Technical Working Group who volunteered their time and energies to work with EP&P and the Subcommittee to formulate the proposed health insurance expansion option.

VII. APPENDICES

APPENDIX A

Nevada Revised Statutes 439B.200

NRS 439B.200 Creation; appointment of and restrictions on members; officers; terms of members; vacancies; annual reports.

1. There is hereby established a Legislative Committee on Health Care consisting of three members of the Senate and three members of the Assembly, appointed by the Legislative Commission. The members must be appointed with appropriate regard for their experience with and knowledge of matters relating to health care.

2. No member of the Committee may:

(a) Have a financial interest in a health facility in this state;

(b) Be a member of a board of directors or trustees of a health facility in this state;

(c) Hold a position with a health facility in this state in which the Legislator exercises control over any policies established for the health facility; or

(d) Receive a salary or other compensation from a health facility in this state.

3. The provisions of subsection 2 do not:

(a) Prohibit a member of the Committee from selling goods which are not unique to the provision of health care to a health facility if the member primarily sells such goods to persons who are not involved in the provision of health care.

(b) Prohibit a member of the Legislature from serving as a member of the Committee if:

(1) The financial interest, membership on the board of directors or trustees, position held with the health facility or salary or other compensation received would not materially affect the independence of judgment of a reasonable person; and

(2) Serving on the Committee would not materially affect any financial interest he has in a health facility in a manner greater than that accruing to any other person who has a similar interest.

4. The Legislative Commission shall select the Chairman and Vice Chairman of the Committee from among the members of the Committee. Each such officer shall hold office for a term of 2 years commencing on July 1 of each odd-numbered year. The chairmanship of the Committee must alternate each biennium between the houses of the Legislature.

5. Any member of the Committee who does not return to the Legislature continues to serve until the next session of the Legislature convenes.

6. Vacancies on the Committee must be filled in the same manner as original appointments.

7. The Committee shall report annually to the Legislative Commission concerning its activities and any recommendations.

(Added to NRS by 1987, 863; A 1989, 1841; 1991, 2333; 1993, 2590)

APPENDIX B

Summary of Option 7D
(Prepared by EP&P Consulting, Inc.)

Summary of Option 7D
Background, the Proposal, Issues and Other Elements
July 14, 2004

This document has been prepared as a summary of "Option 7D" that has been created by the Technical Working Group (TWG) of the Legislative Committee on Health Care, Subcommittee to Study Health Insurance Expansion Options.

The document begins with a brief introduction, and then summarizes the proposal.

Introduction

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

EP&P has been working with the Technical Working Group since March. In April EP&P presented the Technical Working Group with a program construct that became known as "Option 5A". This design would have eliminated the existing Indigent Accident Fund (IAF) and Supplemental Fund and converted the revenues supporting these programs into a pool of funds that would be matched by federal funds. The combined federal and Nevada funds would then be used to:

- Expand Medicaid coverage to pregnant women up to 185% of the federal poverty level (FPL),
- Subsidize the cost of an insurance product for low income employees of small employers, and
- Provide premium assistance to low income employees that cannot afford the group health insurance coverage currently available from their employers.

During meetings held by the Technical Working Group and the Subcommittee to Study Health Insurance Expansion Options in May, Option 5A was presented and discussed. The outcome of the meetings was direction to EP&P to further refine Option 5A. These refinements were to include the addition of financing from the State of Nevada and additional coverage groups.

At the Technical Working Group meeting on June 16th, EPP presented Options 6, 7 and 8. The coverage groups included in all the options were limited to two variations:

- The 'A' package that included premium assistance to low income employees, expansion of coverage for pregnant women, and continuation of a limited IAF or Supplemental Fund.
- The 'B' package that included the same elements as the 'A' package with the addition of a medically needy program.

The options differed in how they provided the non-federal financing for the waiver:

- Option 6 utilized the current funding for the IAF and Supplemental Funds as the non-federal funding source.
- Option 7 utilized an equal proportion of state and local funds, with the local funds coming from the existing IAF and Supplemental Funds.
- Option 8 had the Nevada General Fund providing all the non-federal funds required to finance the expansion of the pregnant women coverage group with the balance of the non-federal funding for the waiver being supplied by the IAF and Supplemental funds.

The Technical Working Group focused on the Option 7 alternatives. The preliminary recommendation from the TWG included the 'B' package of coverage groups with a series of reforms to the operations and the funding system of the existing IAF and Supplemental fund. The preliminary TWG recommendation was labeled Option 7D.

The following section examines Option 7D in more detail.

Option 7D Summary

The underlying principal of Option 7D is one of shared risk. The Technical Working Group felt that Option 7D balanced the risk of moving forward with the waiver proposal among the provider community, the counties and the State.

The primary means of the risk sharing is the financing. The utilization of state funds and the current funding for IAF/Supplemental Fund in equal proportions spreads the funding obligation of the waiver. With the inclusion of both sources of funding, the IAF/Supplemental Fund will remain an important and viable funding source for safety net and rural health care providers.

In previous iterations of the waiver proposal, it was felt that the safety net providers were in jeopardy of losing an important funding source for their uninsured patients, while only being left with the possibility of recouping this revenue loss with the addition of the expanded pregnant women coverage. It was perceived that such a trade off was too risky to this important component of the state's safety net system. By maintaining the viability of the IAF and Supplemental Fund – although at a reduced funding level -- the risk to the safety net health care providers is substantially reduced.

As mentioned, Option 7D includes the coverage groups of pregnant women, premium assistance to low income employees, a medically needy program, and continuation of a

limited IAF or Supplemental Fund. The following discussion briefly describes each of these coverage elements and background on the thinking of the TWG on that element's inclusion.

Pregnant Women

It has long been a priority of DHR to extend coverage under the Medicaid program to pregnant women up to 185% of the FPL. Nevada currently provides the minimum level of coverage that is mandated under federal law, that is, at 133% of the FPL. As such, the state is tied for last among the states in the coverage level provided through Medicaid to pregnant women.

For the year end June 20, 2003 the Current Population Study estimates that approximately 3,050 pregnant women between 134% and 185% of FPL were uninsured. For the same time period, state reported data reflected that University Medical Center and Washoe Medical Center reported 1,670 cases in which no compensation was received, "free care". The care for these cases was provided through tax dollars unmatched by Federal monies. If the State were to change the guidelines for Medicaid enrollment, the State would receive matching funds from the federal government to assist in the coverage of this population.

By including the pregnant women expansion, the waiver program would also be directing matched Medicaid funds to the two major safety net hospitals in the state as well as other hospitals which provide delivery services which are now uncompensated. These two hospitals are also the two largest recipients of payments from the IAF and Supplemental Fund. Therefore, by extending full Medicaid coverage to this group of pregnant women, the providers that would see the largest impact from the changes to the IAF/Supplemental funds will have the opportunity to mitigate the fiscal impact of the proposed changes to the two funds. This mitigation opportunity will be in the form of either reduced costs (by 'free care' deliveries that are now paid for being diverted to other hospitals) or increased revenues (by the receipt of payment for these services).

In order to provide funding for other elements of the proposal, the Technical Working Group recommended an annual cap of $20 million for this program element. It is estimated that approximately 2,500 pregnant women would be covered from the potential population of 3,050 under this provision. The expenditure cap grows to $29 million over the five year waiver period to accommodate inflation.

Small Employer Insurance Program

A small employer insurance program under Medicaid has been identified as the most cost effective method of expanding coverage in Nevada. This is largely due to the fact that the cost of coverage will be shared by as many as four different parties: the employee, the employer, the state and the federal government. In addition, the requirements for a HIFA waiver from the federal Centers for Medicare and Medicaid Services (CMS)

mandates that an employer sponsored insurance element be included in all HIFA waivers. Therefore Option 7D contains such a small employer insurance program.

This coverage element would provide assistance to employees and their spouses with household incomes of less than 200% of the FPL. It initially would be targeted to those employees that work at firms with 2-50 employees. The state, in conjunction with the federal government, would provide assistance in an amount of up to $100 per person per month in order for the employee to acquire the insurance offered by their employer. The direct assistance to the employee will provide flexibility and portability to the employee in the event of a job change. A full benefit package must be offered by the employer including physician services, inpatient and outpatient hospital services, emergency services, and laboratory and x-ray services in order for the package to be eligible for the program. This assurance would be evidenced by a Department of Insurance certification. The product would have to meet all Nevada coverage requirements.

To ensure that employers do not reduce the level of contribution, the TWG recommends that the employer cover at least 50% of the premium cost, and that there be a "bare" period to be eligible for the program. The bare period would be a period of 6 months in which the employee was not covered by any form of insurance.

The uninsured and employer coverage data for Nevada reveals that there are an estimated 21,000 employees that are eligible for, but do not take advantage of, the employer sponsored insurance. Additionally, there are over 15,000 small employers, with 78,000 employees, that currently do not offer any health insurance.

Because there is no example of a very large and successful employee based premium assistance program operating in any state, the forecast for enrollment in this program is very modest. The proposal calls for enrollment in this program element to be phased in with 2,000 lives covered in the first year, 4,000 lives the second year, 6,000 lives in the third year and 8,000 lives covered thereafter. This phase in would allow for the program administration to develop, for refinements in the programs structure to be incorporated and to allow for the marketing of the program to grow gradually.

The estimates of potential demand for this program element (see Attachment 1) indicate that as many as 4,700 employees of small firms would participate, and together with their spouses, the 8,000 targeted lives could be achieved. If the program element is under subscribed, the state would have the option of expanding the program to larger employers.

The Medical Needy Population

In considering a HIFA waiver, the Technical Working Group had a strong desire to adopt a Medicaid eligible program that would cover as many of the situations as possible that the current IAF and Supplemental Fund now cover. This desire stemmed from the realization that:

- The funds currently used for these programs could be leveraged through Medicaid
- The recognition that a major source of funding for the waiver program would (or should) come from these funding sources, and
- The major safety net providers rely on these funds for their coverage of the uninsured

Although the final design of a Medicaid medically needy program has not been developed, the TWG is including a medically needy program in its recommendation. The specific design should be one that would satisfy CMS policy constraints and simultaneously attempt to mimic existing populations currently covered by the IAF and Supplemental Fund.

The outline of the medically needy program being recommended includes:

- An upper limit on the income levels of potential participants – for example, 150% of the FPL
- A short spend-down period (e.g., one month)
- A requirement for specified amount of medical/hospital costs – probably between $3,000 and $25,000 – the levels utilized by the two funds the proposal would seek to replace
- A requirement that the spend-down take the income of the participant to no more than 24% of the FPL
- A limit on eligibility to one segment per year (or a certain number of segments per lifetime)
- An allowance for non-categoricals as well categoricals to be covered
- A limited benefit package
- An overall cap of $9 million per year in total funding. This amount could grow if the types of claims being paid under the program element were the same types of claims that were being paid by the IAF and Supplemental Fund.

This type of medically needy program would differ from the traditional Medicaid medically needy program, and would likely be a case of first impression for CMS. If approved, it is hoped that this program would become the funding source for many of the cases that are currently being compensated through the IAF and Supplemental Fund.

The advantages to Nevada of this proposal include the addition of federal funds to an existing, non matched program; additional opportunities for safety net providers to mitigate potential negative effects from a reduction of funding to the IAF and Supplemental Fund; the possibility to further reduce non-matched expenditures; less stress on county indigent fund budgets; and a limited exposure to the program with a waiver cap on expenditures.

IAF/Supplemental Funds

The Technical Working Group received testimony in its early meetings concerning the proposed abolishment of the IAF and Supplemental Fund. The testimony revealed a

great deal of discomfort with the notion that the funds would be eliminated. Even with the addition of the pregnant women expansion and the medically needy program, the TWG was concerned about the impact that the elimination of the funds would have on safety net and rural health care providers.

This concern stemmed from the fact that certain populations cannot be covered under Medicaid programs in Nevada. Examples of these groups would be non-residents of Nevada and certain categories of non U. S. citizens. Additionally, some of the safety net providers that currently receive funding to cover their uninsured clients may not receive any funding under the new program elements, e.g. ambulance companies.

The Technical Working Group wanted to preserve some form of the current IAF and Supplemental Fund. With the inclusion of State monies, the scale back of the pregnant women provision, and the inclusion of reforms to the operation of the two funds, the TWG could include a continuation of the IAF and Supplemental funds in its overall proposal. The operational reforms of the two funds are discussed in the *Financing* section below.

Financing

As indicated earlier in this paper, Option 7D proposes that the funding for the proposal be equally provided by the current funding sources for the IAF and Supplemental Fund and the state.

There are currently two property tax levies that support the IAF and Supplemental Fund. The IAF is supported by a 1.5 cent levy and the Supplemental Fund is supported by a 1.0 cent levy.

The Technical Working Group recommended that the 1.0 cent levy be redirected to support the HIFA waiver. This would leave the 1.5 cent levy to support the current functions of the two funds. The TWG further recommends that the operation of the IAF be modified such that the remaining levy amount could largely support the operation of the two current funds.

During their deliberations the TWG became aware of two aspects of the IAF that led them to conclude that the existing levy for the IAF could largely support the functions of the two existing funds. These features were the reimbursement levels and the revenues versus expenditures equation of the Fund.

Currently, the IAF receives claims twice per year and pays rural hospital and medical transport providers 100% of approved charges; urban hospitals 85% of approved charges; and other providers based upon a predefined fee schedule. The reimbursement at such a high percentage of charges differs markedly from the compensation levels paid by Medicaid and most insurers, and from hospital costs. A rough average of cost to charge ratio in Nevada would probably be closer to 50% (or less) than it is to 85% or 100%. Therefore, the Technical Working Group recommends that the percentage of charges paid

by the IAF be reduced, or that the Medicaid or other fee schedule be adopted as a basis for payment to providers. This reform will generate savings to the IAF program while still allowing the fund to cover the claims it currently covers.

In addition to the savings generated by the introduction of a fee schedule, the TWG became aware that the IAF has not spent the entire amount of revenues it collects through its levy for some number of years. As a result, a cash balance has been accumulating. This cash balance has grown so significantly that during SFY04 no levy for the fund was made, and a significant cash balance still remains at the end of the fiscal year.

With the excess revenue and the savings associated with a new fee schedule, the Technical Working Group felt that a portion of the current revenue would fully support the IAF and have resources available to continue to support the Supplemental Fund.

It is likely however that the percentage of compensation in the Supplemental Fund will decline. Currently, claims for the Supplemental Fund are collected throughout the year and at year-end, the claims are settled on a prorated percent of charge reimbursement. That is, the total amount of charges for eligible claims are summed up and compared to revenues available. The claims are paid based on the percentage that revenues are of eligible charges. In the last few years this percentage has ranged between 12% and 21%. Since it is not anticipated that an amount of excess revenues will be available from the IAF that equals the amount of revenue currently generated for the Supplemental Fund, it is likely that future compensation percentages for Supplemental Fund claims will decline under the recommendation.

To partially offset this decline the TWG anticipates that some of the charges that currently are directed to the IAF and Supplemental Fund will be directed to the new medically needy program. If this does in fact occur, both of the funds will have less fiscal pressure and the percentage decline in Supplemental Fund reimbursements will not be as great.

As a final hedge against adversely effecting the safety net providers by taking funds from the IAF and Supplemental Fund levies, the Technical Working Group is proposing that the funding mechanism for the waiver program have an element of flexibility. This flexibility is discussed below under "Funding Flows."

The TWG also recommends that these reforms of the IAF and Supplemental Funds not alter the current county responsibilities (and limitations) that are contained in the statutes.

In addition to redirecting the IAF and Supplemental Fund monies to the waiver program, Option 7D includes a recommendation that the state contribute an equal amount of funding to the program. This recommendation was made for two reasons: to minimize the amount of funding that is directed away from the safety net providers, and because in funding the proposed waiver program, the state would spend less money overall than if it were to fund the pregnant women expansion on its own. This "savings" argument is

based on reports that the TWG has received that the Governor is considering the funding of the pregnant women expansion in his upcoming budget.

Based upon the estimated amount of funds available from the IAF and Supplemental Fund, an equal match from the state, as well as the SCHIP and regular Medicaid match funds, the total amount of resources available for the waiver program is depicted in the Table below:

Funding Available for Option 7D

Non-Federal Funds	2005	2006	2007	2008	2009
Supplemental Fund Revenue	6,970,011	7,248,811	7,538,763	7,840,314	9,288,692
State of Nevada General Fund Revenue	6,970,011	7,248,811	7,538,763	7,840,314	9,288,692
Total Non-Federal Funds (A)	13,940,022	14,497,622	15,077,526	15,680,628	18,577,384

SCHIP Funds	2005	2006	2007	2008	2009
Estimated Loss of Authority	1,980,098	864,320	7,681,336	5,594,352	3,507,368
Allocation of Ending Balance	12,821,760	12,821,760	12,821,760	12,821,760	12,821,760
Total SCHIP Funds Available (B)	14,801,858	13,686,080	20,503,096	18,416,112	16,329,128
Estimated Non-Federal Funds Needed (C)	6,609,769	6,120,114	9,168,534	8,235,280	7,302,027
Total Matched SCHIP Funds (D)	21,411,627	19,806,194	29,671,630	26,651,392	23,631,155

Title XIX Funds	2005	2006	2007	2008	2009
State Funds Available for Standard Match (A-C)	7,330,253	8,377,508	5,908,992	7,445,348	11,275,357
Additional Federal Monies Available (D)	9,024,062	10,336,375	7,212,422	9,156,709	14,003,657
Standard Match Funds (E)	16,354,315	18,713,883	13,121,414	16,602,057	25,279,014
Total Funds Available (D+E)	37,765,942	38,520,077	42,793,044	43,253,449	48,910,169

In addition to these funds, the balance of funds currently used for the IAF and Supplemental Fund would continue to provide funds to the now combined IAF/Supplemental Fund.

Sources and Uses of Funds

The Sources and Uses of Funds for the waiver program (that is, the federally matched portion of Option 7D and not including the continuation of the combined IAF/Supplemental Fund) would appear as follows:

Sources and Uses Statement
Nevada HIFA Waiver Proposal

	2005	2006	2007	2008	2009
Total Funds Available [1]	37,765,942	38,520,077	42,793,044	43,253,449	48,910,169
Utilization					
Small Employer Insurance Program	2,400,000	4,800,000	7,200,000	9,600,000	9,600,000
Pregnant Women	20,239,831	22,219,007	24,356,538	26,664,961	29,158,336
Medically Needy	9,000,000	9,000,000	9,000,000	9,000,000	9,000,000
Administrative Expenditures [2]	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000
Balance of Funds Available	4,126,111	501,071	236,506	(4,011,512)	(848,167)
Unused Dollars	4,126,111	501,071	236,506	0	0
Cummulative Unused Dollars	4,126,111	4,627,182	4,863,688	852,176	4,009

Allotment Neutrality Test

	2005	2006	2007	2008	2009
SCHIP Funds Available	14,801,858	13,686,080	20,503,096	18,416,112	16,329,128
Utilization					
Employment Based Premium Assistance (50%)	1,200,000	2,400,000	3,600,000	4,800,000	4,800,000
Pregnant Women (0%)	0	0	0	0	0
Medically Needy (60%)	5,400,000	5,400,000	5,400,000	5,400,000	5,400,000
Total Utilization	6,600,000	7,800,000	9,000,000	10,200,000	10,200,000
Variance To SCHIP Funds Available	8,201,858	5,886,080	11,503,096	8,216,112	6,129,128

[1] 2009 includes a transfer of 1,134,765 from IAF 'cash reserve'

[2] Amount for Administrative Expenditures is a 'placeholder' only and may be higher.

The Sources and Uses Statement indicates that there would be a positive annual ending balance in the initial years of the program. The actual amount of balance may vary depending upon how quickly each of the program's elements enroll participants. However, based on the pro forma outlined above, the early years of cash balance would be used in later years to fund the minor shortfalls.

As a guard against unusually high balances accruing in the "HIFA Match Fund," the Technical Working Group recommends that flexibility in the financing be included in the proposal. This flexibility is discussed in the following section.

Funding Flows

The Technical Working Group recommends that the financing for the proposal be administered through a newly created "HIFA Match Fund." The operation of this fund is conceived to provide the maximum flexibility to direct available dollars to the health care system where the need is greatest.

The design of this new Fund is contained in Attachment 2B. Attachment 2A is included to depict the current flows of the two current property tax levies.

Attachment 2A depicts the operation of the existing IAF and Supplemental Funds. Each fund is separate, and each fund has an exclusive revenue source and purpose. As

previously discussed, the current IAF fund has excess revenues and maintains a cash balance while the Supplemental Fund spends all its resources annually.

Attachment 2B depicts the proposed operation of both the newly conceived HIFA Match Fund and the newly combined IAF/Supplemental Fund.

Reviewing the IAF/Supplemental Fund first, the concept for the operation of the fund is that it will first address the claims that are submitted under the provisions of the IAF fund. Payments will be made according to the revised fee schedule recommendation, and any remaining balance (after reserve for working capital) would be used to pay claims on a pro rata basis submitted under the provisions of the Supplemental Fund. The fund would be supported by the funds currently identified for the IAF.

The HIFA Match Fund would receive revenues from both the Supplemental Fund and an equal amount of funds from the state. These revenues would each be deposited into their own holding accounts within the fund. As the waiver program requires funding for program operation, the match account within the fund would draw equally from the two holding funds. These combined dollars would in turn be matched with federal funds.

If at the end of a period there remained funds in the two holding accounts, these funds would revert (after an allowance for working capital). In the case of the state funds, the monies would revert to the state. In the case of the Supplemental Funds, the monies would revert to the combined IAF/Supplemental Fund. These monies could then be used to increase the percentage amount that the Supplemental Fund claims were compensated.

In constructing the operation of the HIFA Match Fund in the manner that the TWG has constructed it, any dollars that are not needed for the waiver program can be redeployed to other uses. Reasons that all the monies in the HIFA fund may not be needed could include slow program starts and/or overestimates of program participation.

Not depicted on Attachment 2B but contemplated by the Technical Working Group is the possibility of a transfer from the IAF/Supplemental Fund to the HIFA Match Fund. This could occur if the medically needy program element of the waiver is successful in diverting claims from the IAF/Supplemental fund. In that case there could be excess resources in the IAF/Supplemental fund. If there were also unsatisfied demand in the medically needy or other elements of the waiver program, the IAF/Supplemental funds could be transferred (with or without state match) to the HIFA fund to draw down additional federal funds to satisfy that demand.

The Technical Working Group also felt that similar flexibility should be provided to the HIFA Fund. That is, if one program element of the waiver were highly successful in attracting participants (say the pregnant women expansion) and another element were less successful (say the medically needy program), then funds could be redirected from the less successful element to the more successful element, for example from medically needy to pregnant women.

The TWG envisions that the decisions for funding transfers – be they from the HIFA Fund or within the HIFA Fund – be overseen by a Board. The Board could either be advisory in nature or a governing board.

The TWG recognizes that there are important implementation issues which must be addressed as the waiver moves forward. Among the issues are:

- Administration of the waiver by DHR and the role of the counties and others in program administration and monitoring.
- Ensuring that as a demonstration, the correct information is being collected to evaluate, refine and improve the waiver.
- Developing the process that ensures the waiver maximizes federal funds to the greatest extent possible and offers insurance coverage to the greatest number of people.

ATTACHMENT 1

Insurance by Establishments and Employees - MEPS Survey

	State of Nevada, private-sector data by firm size, 2001	Total	Less than 10 Employees	10-24 Employees	25-99 Employees	100-999 Employees	1000 or more Employees	Less than 50 Employees	50 or More Employees
IIB1	Number of employees	912,657	95,348	68,344	118,535	170,100	460,330	235,857	676,800
IIB1A	Percent of number of employees	912,657	10.4%	7.5%	13.0%	18.6%	50.4%	25.8%	74.2%
IIB2	Percent of employees in establishments that offer health insurance	90.8%	54.1%	70.8%	84.7%	98.8%	100.0%	66.7%	99.2%
IIB2A	Percent of employees eligible for health insurance in establishments that offer health insurance	75.3%	79.5%	86.6%	74.1%	70.7%	75.5%	78.0%	74.6%
IIB2A1	Percent of employees eligible for health insurance that are enrolled in health insurance at establishments that offer health insurance	83.2%	78.5%	80.7%	83.7%	78.2%	85.7%	82.7%	83.3%
IIB2B	Percent of employees that are enrolled in health insurance at establishments that offer health insurance	62.6%	62.3%	69.9%	62.0%	55.3%	64.7%	64.5%	62.2%
Employees offered but not enrolled	Number of employees in establishments **that offer health insurance**	828,693	51,583	48,388	100,399	168,059	460,330	157,317	671,386
	Number of employees **eligible** for health insurance in establishments that offer health insurance	624,005	41,009	41,904	74,396	118,818	347,549	122,707	500,854
	Number of employees eligible for health insurance **that are enrolled** in health insurance at establishments that offer health insurance	519,173	32,192	33,816	62,269	92,915	297,850	101,479	417,211
	Number of employees eligible for health insurance **that are not enrolled** in health insurance at establishments that offer health insurance	104,833	8,817	8,087	12,127	25,902	49,700	21,228	83,643
	Percent of employees that are enrolled in health insurance at establishments that offer health insurance	62.6%	62.4%	69.9%	62.0%	55.3%	64.7%	64.5%	62.1%
	Estimated percentage of employees influenced to 'take-up' health insurance [1]	20%	20%	20%	20%	20%	20%	20%	20%
	Estimated number of employees influenced to 'take-up' health insurance	20,967	1,763	1,617	2,425	5,180	9,940	4,246	16,729
	Percentage of individuals less than 200% FPL uninured by firm size	53.2%	49.7%	49.0%	54.1%	53.5%	59.5%	51%	56%
	Estimated number of employees eligible for the subsidy influenced to 'take-up' health insurance	11,156	877	792	1,312	2,771	5,910	2,165	9,330

[1] This percentage is based on a review of the available literature.

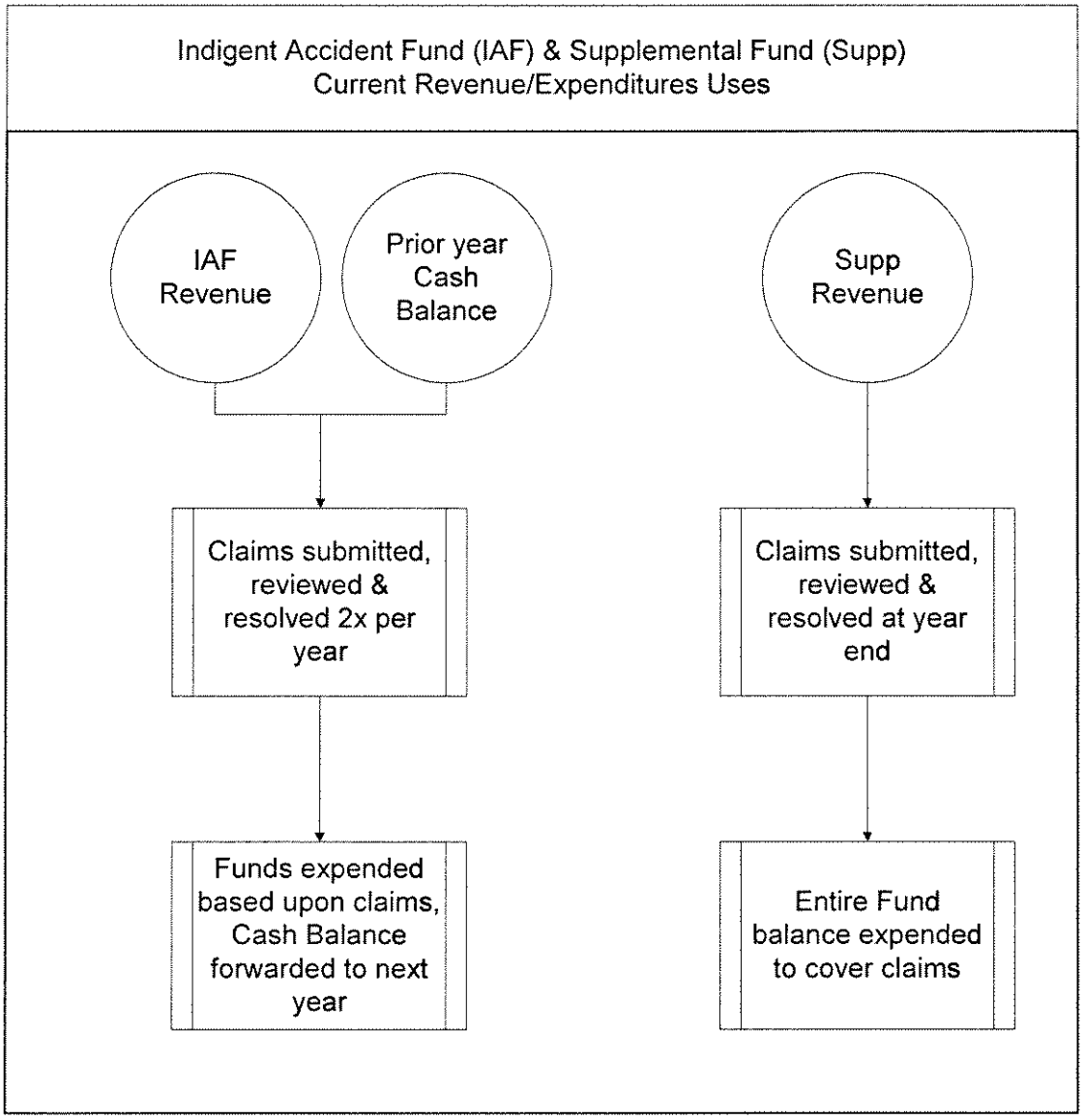
ATTACHMENT 1

	State of Nevada, private-sector data by firm size, 2001	Total	Less than 10 Employees	10-24 Employees	25-99 Employees	100-999 Employees	1000 or more Employees	Less than 50 Employees	50 or More Employees
IIB1	Number of employees	912,657	95,348	68,344	118,535	170,100	460,330	235,857	676,800
IIB1A	Percent of number of employees	912,657	10.4%	7.5%	13.0%	18.6%	50.4%	25.8%	74.2%
IIB2	Percent of employees in establishments that offer health insurance	90.8%	54.1%	70.8%	84.7%	98.8%	100.0%	66.7%	99.2%
IIB2A	Percent of employees eligible for health insurance in establishments that offer health insurance	75.3%	79.5%	86.6%	74.1%	70.7%	75.5%	78.0%	74.6%
IIB2A1	Percent of employees eligible for health insurance that are enrolled in health insurance at establishments that offer health insurance	83.2%	78.5%	80.7%	83.7%	78.2%	85.7%	82.7%	83.3%
IIB2B	Percent of employees that are enrolled in health insurance at establishments that offer health insurance	62.6%	62.3%	69.9%	62.0%	55.3%	64.7%	64.5%	62.2%
Employees currently not offered	Number of employees in **establishments that do not offer health insurance**	83,964	43,765	19,956	18,136	2,041	-	78,540	5,414
	Estimated percentage of employees employed at employers influenced to begin offering health insurance [1]	10%	10%	10%	10%	10%	10%	10%	10%
	Estimated number of employees employed at employers influenced to begin offering health insurance	8,396	4,376	1,996	1,814	204	-	7,854	541
	Number of employees **assumed eligible** for health insurance in establishments **that do not offer health insurance**	6,323	3,479	1,728	1,344	144	-	6,126	404
	Number of employees **assumed eligible** for health insurance **that would be enrolled** in health insurance at establishments that do not offer health insurance	5,260	2,731	1,395	1,125	113	-	5,066	336
	Percent of employees that could be enrolled in health insurance at establishments that do not offer health insurance	6.3%	6.2%	7.0%	6.2%	5.5%	-	6.5%	6.2%
	Percentage of individuals less than 200% FPL uninured by firm size	53%	50%	49%	54%	53%	59%	51%	56%
	Estimated number of employees with employers not offering health insurance that would 'take-up' health insurance and be eligible for the subsidy	2,799	1,358	683	608	60	-	2,583	188
	Total Potential Pool of Uninsured Workers that are/could be eligible for health insurance subsidy	13,955	2,235	1,475	1,920	2,832	5,910	4,748	9,518

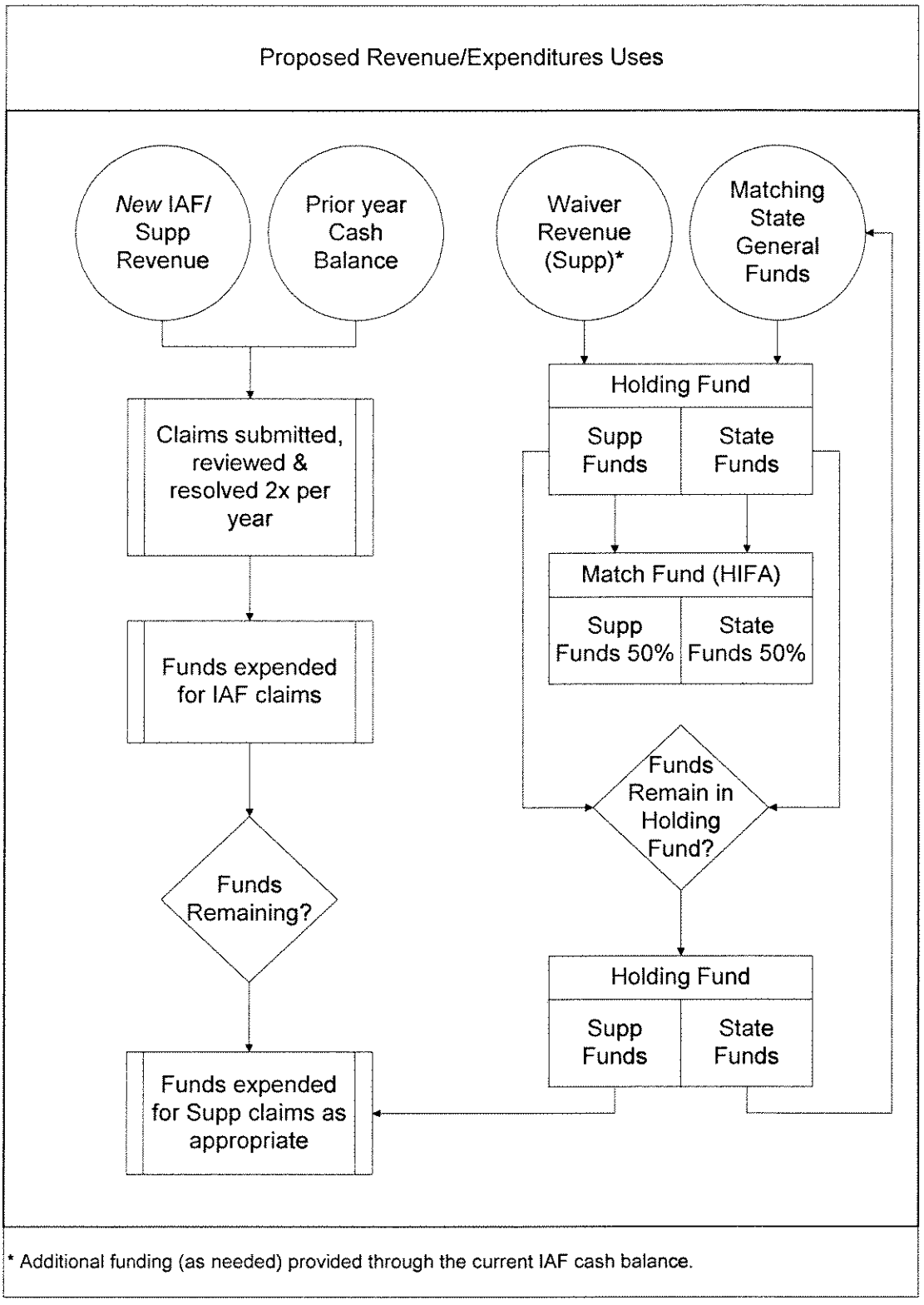
Note that figures above represent employees only, spouses not included; Also does not address deductions for non-qualified aliens

[1] This percentage is based on a review of the available literature

Attachment 2A
Current Fund Utilization
IAF and Supplemental Fund



Attachment 2B
Proposed Fund Utilization
HIFA Match Fund



APPENDIX C

Suggested Legislation

The following Bill Draft Requests will be available during the 2005 Legislative Session, or can be accessed after "Introduction" at the following Web site: http://www.leg.state.nv.us/73rd/BDRList/page.cfm?showAll=1.

BDR 38--736	Establishes program for extending health care coverage to certain persons using a Health Insurance Flexibility and Accountability initiative waiver.