Nevada Department of Health and Human Services

and the

Division of Health Care Financing and Policy

Medicaid Opt Out

White Paper

January 22, 2010

OPTING OUT OF MEDICAID

The national health care reform debate has shed light on many important issues related to the uninsured and the financial sustainability of Medicare, Medicaid and private health coverage. An honest discussion about health care reform is needed, but it is not occurring. States, which are inherent partners with the federal government in providing health coverage, are watching from the sidelines as Congress shifts the burden of funding expanded coverage to the states at a time those states can ill-afford it.

The following analysis summarizes the Department of Health and Human Services' estimates for the impact proposed health care reform will have on Nevada Medicaid. It also assesses the fiscal and personal impact associated with Nevada opting out of the Medicaid program and creating a safety net program funded entirely by state General Funds.

Due to a lack of resources and the time necessary to conduct a comprehensive review, this analysis does not offer thorough consideration of many areas that will also be affected by the state dropping out of the Medicaid program, including:

- Complete fiscal impacts to hospitals and local governments that will still be mandated under federal law to provide emergency care to individuals even though Medicaid is no longer available as a pay source
- The full effect of taking billions of dollars out of the state economy by turning back the federal share of funding Medicaid
- A comprehensive review of other state programs, such as quality assurance and inspection programs, that will no longer be able to access federal funding

Because Medicaid has been in place as a significant pay source within the health care industry for so long, much of the industry touches the program in one way or another. A complete analysis of the effects of dropping the program is essential to fully understanding how such a change would affect the state as a whole.

WHAT IS THE COST OF THE CURRENT NEVADA MEDICAID PROGRAM AND HOW IS IT FUNDED?

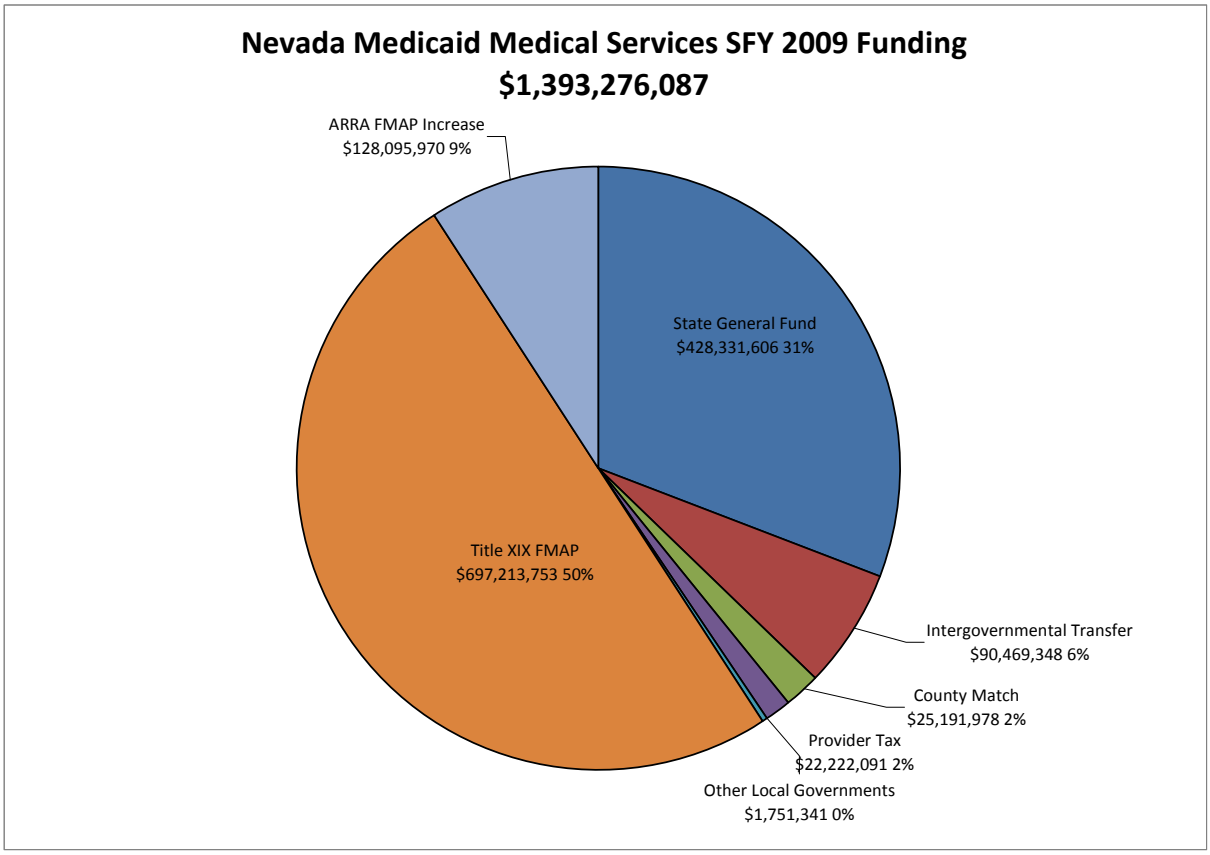
Medicaid is jointly funded by the state and federal governments, but administered by states. Federal financial participation in these programs is driven by a federal formula called the Federal Medical Assistance Percentage, or FMAP, defined in section 1905(b) of the Social Security Act. States must pay the bills and get reimbursed by the federal government using a state-specific FMAP rate. For Medicaid medical services in Nevada, that rate is usually 50%. The "state share" of Medicaid is the amount not reimbursed by the federal government.

Increased FMAP under ARRA provides additional $400 million in federal funds to Nevada.

Under the American Recovery and Reinvestment Act (ARRA), states were provided significant fiscal relief by increasing the FMAP rate for medical services incurred from October 1, 2008 through December 31, 2010. For Nevada, the increased FMAP is 63.93% and will provide over $400 million in additional federal revenue.

Besides state and federal funding, Nevada Medicaid also receives revenues from county government, local government entities, and provider taxes. These other sources of revenue provide the state share to help pay for a variety of Medicaid services including:

- hospital and long-term care services for county indigent patients;
- supplemental payments to hospitals serving Medicaid patients and the uninsured;
- supplemental service payments to the University of Nevada School of Medicine;
- increased fees to nursing facilities serving Medicaid clients;
- school-based medical and administrative services; and
- case management services for county child welfare and juvenile justice programs.



The 2010-2011 biennial budget for medical services by revenue source for Nevada Medicaid is provided below:

2010-2011 Biennial Budget in millions

Revenue Source	2010	2011	Biennium
State General Fund	$439.0	$547.9	$986.9
Intergovernmental Transfer	$82.2	$86.3	$168.5
County Match	$21.0	$26.7	$47.7
Provider Tax	$20.0	$20.0	$40.0
Local Governments	$3.0	$3.9	$6.9
Title XIX FMAP	$784.3	$816.4	$1,600.7
ARRA FMAP Increase	$125.7	$56.9	$182.6
TOTAL	$1,475.2	$1,558.1	$3,033.3

Medicaid covers a number of different groups of Nevadans. These include groups generally considered aged and/or disabled:

- Aged and disabled individuals that meet income and asset requirements;

- Individuals who qualify for nursing home care but receive services in home and community based settings;
- Individuals who are medically indigent in hospitals and nursing homes paid for by Nevada counties; and
- Low-income Medicare beneficiaries.

Other groups include families and children:

- Low-income families with children;
- Children and pregnant women below certain income levels; and
- Children in the child welfare system.

There are other smaller coverage groups, including: Low-income women with breast or cervical cancer; children aging out of foster care up to age 21; and, children with severe medical conditions served at home ("Katie Beckett" group).

Services for aged and disabled Nevadans represent 63% of spending, but only 26% of caseload.

Spending on these different coverage groups is not distributed evenly. In SFY 2009, 63% of total medical spending was for the aged and disabled, which represented 26% of the caseload. Families and children represented 37% of spending in SFY 2009 and 74% of the caseload.

WHY ARE STATES CONSIDERING OPTING OUT OF MEDICAID?
Impact of National Health Care Reform on the State

While there is a general acknowledgement that America's health care system is broken, there are many opinions as to how to fix it. The growing burden of the uninsured -- escalating out-of-pocket costs and premiums, and the cost of federal medical entitlements (Medicare and Medicaid) -- demand something be done to address these issues. Congress' current efforts have focused primarily on expanding access to health insurance to citizens, primarily though the expansion of Medicaid and the creation of a new system for individuals to purchase private insurance called Health Insurance Exchanges.

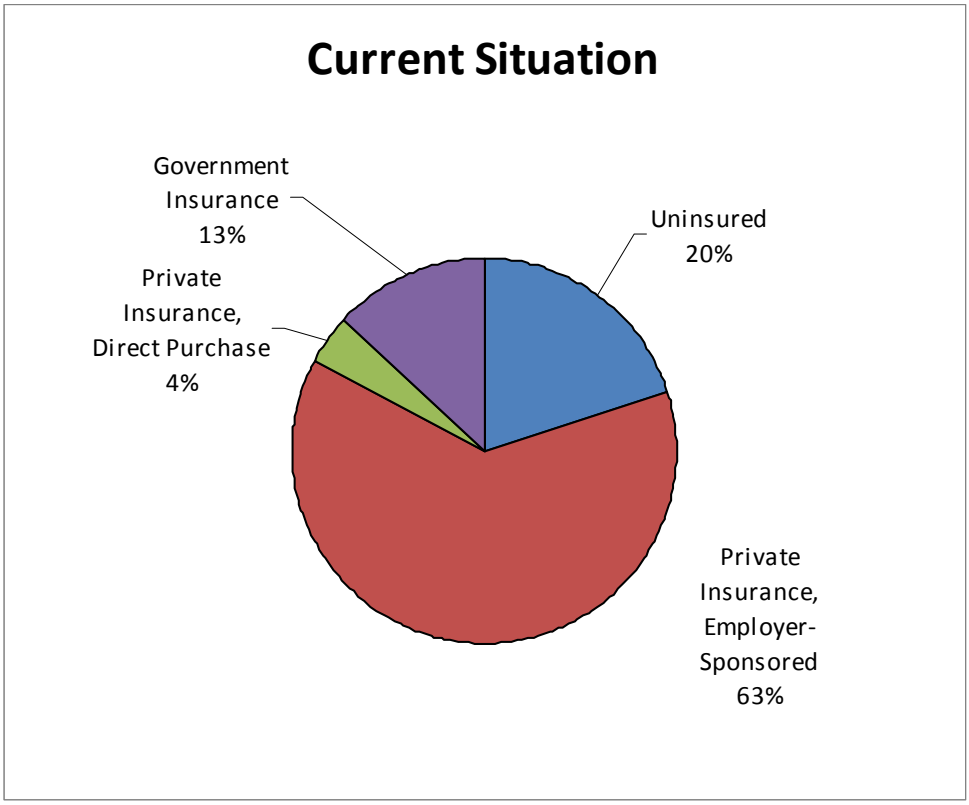
Subsidies are not proposed for very low-income individuals and families who are presumed to get coverage through Medicaid.

There are several key provisions in both the Senate bill (H.R. 3590), the *Patient Protection and Affordable Care Act,* and House bill (H.R. 3962), the *Affordable Health Care for America Act,* which seek to expand access to health insurance and define what coverage must include. Key provisions of both health reform bills include:

- An individual mandate to obtain health insurance. Failure to do so results in a tax penalty.
- An employer mandate to provide coverage. The Senate and House bills differ with the Senate mandating coverage to employers with 50 or more employees and the House bill mandating all employers to either provide coverage or pay into the Health Insurance Exchange. Both bills include employer penalties.
- Establishment of *Health Insurance Exchanges*. Individuals without insurance and some employers can purchase commercial insurance, possibly including a "public option," through the Exchange. "Affordability credits" and individual subsidies will offset the cost of purchasing this coverage for low-income individuals and families. However, these subsidies or credits are not available to very low-income individuals and families, as it is presumed they will get health coverage through Medicaid.

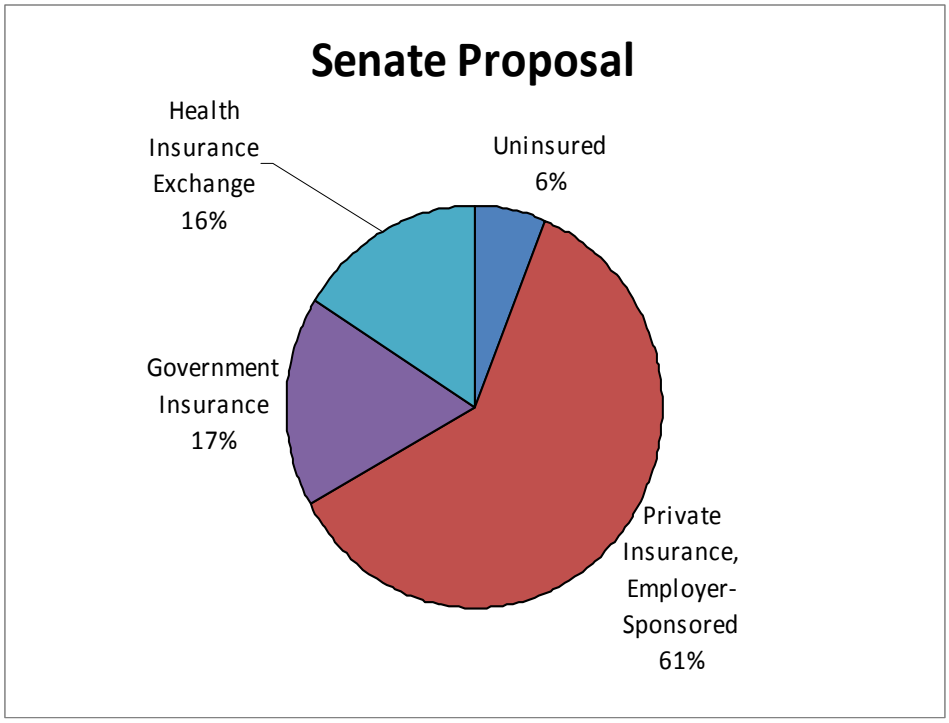
- Imposed changes to health insurance coverage including:
    - Limits on out-of-pocket costs and no lifetime benefit limits;
    - Coverage of preventive services and immunizations;
    - Definitions of basic coverage, including mental health and substance abuse services
    - No exclusion for pre-existing conditions; and
    - Limits on insurance company administrative costs and profits.
- An expansion of the Medicaid program. The House bill expands Medicaid to 150% of the Federal Poverty Level (FPL), and the Senate bill expands coverage up to 133% of the FPL.

In 2009, approximately 20% of non-elderly Nevadans lacked health insurance for at least one month of the year. The remaining 80% obtained coverage through their employers, other private insurance, or from public programs like Nevada Medicaid and Nevada Check Up, our state's Children's Health Insurance Program (CHIP).



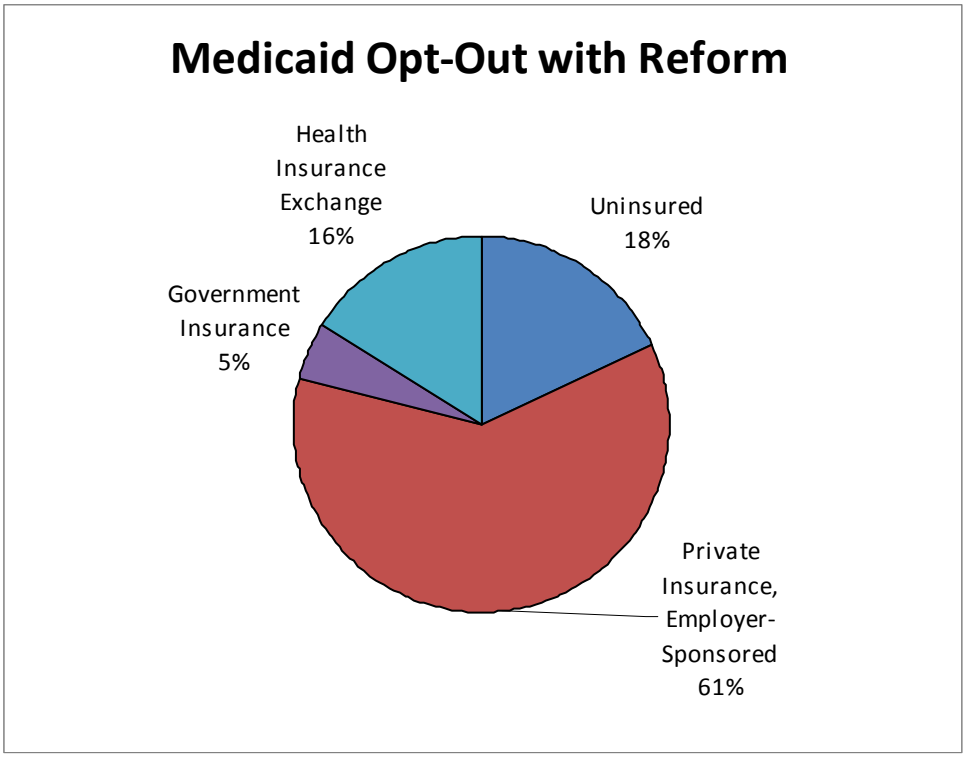
In 2009, one out of five non-elderly Nevadans did not have health insurance for at least one month during the year.

The potential effect of the Senate Health Care Reform legislation is summarized in the pie chart below. In essence, the number of uninsured drops significantly due to the creation of the Health Insurance Exchange and the expanded eligibility for Medicaid, driving those who are currently uninsured into these two areas to attain coverage. It is important to note that this analysis accepts the Congressional Budget Office estimate of the number of remaining uninsured following the implementation of health care reform.



Pending health reform legislation seeks to cover the uninsured by making private health coverage more affordable and available, and expanding Medicaid.

Finally, the below pie chart estimates the distribution of insured and uninsured in Nevada if the Senate Health Care Reform legislation becomes law and the state implements the Medicaid Opt Out proposal outlined in this white paper.



Dropping Medicaid would significantly change the face of the uninsured in Nevada. It is likely most Nevadans currently on Medicaid would end up uninsured due to a lack of financial ability to purchase through the exchange.

The three pie charts above incorporate the below assumptions:

Assumptions:	***Current Situation***	***Senate Proposal***	***Medicaid Opt-Out***
Uninsured	--	*6.0%*	*Remaining % after others computed*
Private Insurance, Employer-Sponsored	--	*61.0%*	*Same as under reform*
Private Insurance, Direct Purchase	--	*Move to HIE*	*Same as under reform*
Government Insurance (Estimate $500 million available for Long-Term Care and Child Welfare under Medicaid Opt-Out)	--	*16.6%*	*4.9%*
Health Insurance Exchange	--	*Remaining % after others computed*	*Same as under reform*

The Medicaid aspects of Congress' proposals have been, for the most part, overlooked, particularly as to how states would fund the estimated 15-20 million Americans added to the program. State costs for this expansion are not included in the $871 billion ten-year federal cost estimate of the proposed Senate bill (CBO letter dated Dec. 19, 2009).

Arguably, health care reform legislation currently being debated in Congress provides many benefits, particularly to those currently unable to afford private insurance coverage or who meet eligibility criteria for federal health care programs. However, the legislation imposes significant new costs on states through the expansion of the Medicaid program at a time states can ill-afford any new spending. It also imposes a host of new mandates on states limiting their ability to effectively administer the program, described in detail below.

These issues were highlighted in *Medicaid Meltdown: Dropping Medicaid Could Save States $1 Trillion.*[1] The authors argue that Congress is imposing new costs on states through the expansion of Medicaid at a time when states need to cut spending. The authors also suggest that states may take the "rational and reasoned" approach of opting out of their Medicaid programs.

The cost impact of federal health reform legislation on Nevada is estimated in the table below, based on the provisions of the Senate Finance Committee mark passed on October 13, 2009.[2] Specific provisions and related assumptions are taken into account:

- An expansion of Medicaid income eligibility for adults from the current household income standard of 25% of FPL, which for a family of four is $5,513 per year, to 133% of the FPL, or $29,326 per year. [3]

[1] Dennis G. Smith and Edmund F. Haislmaier, The Heritage Foundation, December 1, 2009

[2] The major Medicaid provisions of the bill have not changed significantly as they affect Nevada.

[3] Coverage of new eligibles will be 100% federally funded from 2014-2016.

- The individual insurance mandate would spur enrollment from a percentage of individuals who meet current eligibility standards but are not currently enrolled; this is called the "woodwork effect."
- We also assume a percentage of small employers will drop coverage and their employees would become Medicaid eligible.
- Finally, we estimate the administrative costs associated with implementing this Medicaid expansion.[4]

Health Care Reform State General Fund Cost

	2014	2015	2016	2017	2018	2019	Total
New Eligibles Added Medical	-	-	-	30,468,961	50,656,743	49,820,099	130,945,803
Woodwork Effect Added Medical	11,019,800	32,868,938	46,247,963	66,605,345	86,645,134	105,206,785	348,593,965
Reform Medical SGF Costs	11,019,800	32,868,938	46,247,963	97,074,306	137,301,878	155,026,884	479,539,768
DHCFP Admin Costs	1,194,484	4,510,248	6,231,530	6,706,949	7,144,025	7,337,452	33,124,688
DWSS Admin Costs	2,087,958	8,633,939	12,083,181	12,905,150	13,594,246	13,738,645	63,043,118
NOMADS Replacement*	7,500,000	7,500,000	7,500,000	7,500,000	7,500,000	-	37,500,000
Reform Admin SGF Costs	10,782,442	20,644,186	25,814,711	27,112,099	28,238,271	21,076,097	133,667,806
Reform Total SGFund Cost	21,802,242	53,513,124	72,062,674	124,186,405	165,540,149	176,102,981	613,207,575

The total six-year state general fund cost estimate for proposed Medicaid expansion is $613 million.

The total six-year state general fund cost estimate for the Medicaid expansion in the senate health reform legislation is $613 million. The six-year cost of providing Medicaid coverage to new Medicaid eligible Nevadans is estimated at $131 million. The cost of covering the "woodwork" group is estimated at $348 million. The bills also require significant administrative costs associated with development of new information systems and additional state staffing to handle Medicaid eligibility. Those costs are estimated at $134 million.

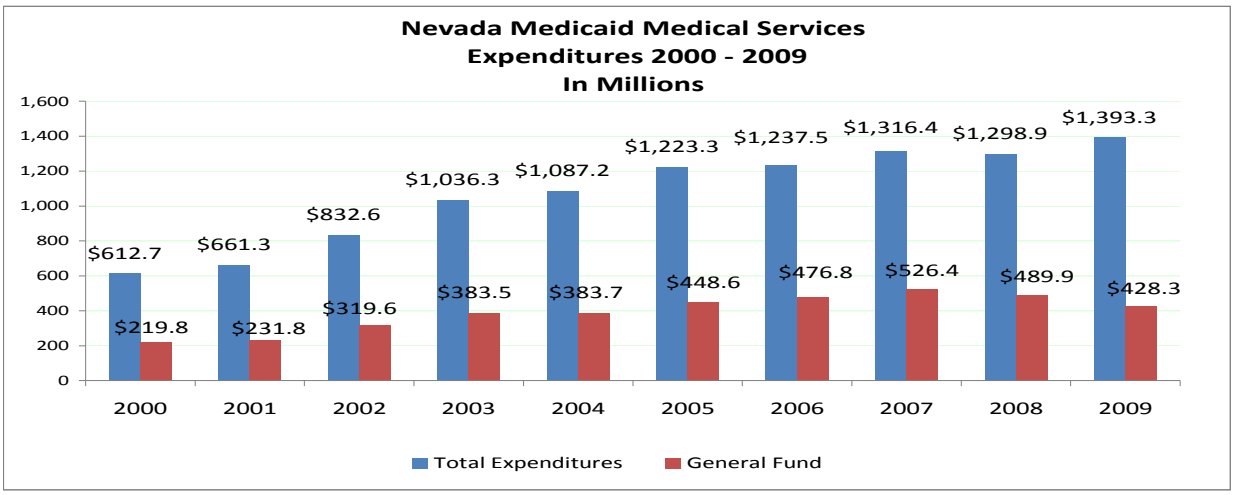
[4] In this estimate, we do not include the cost of developing and operating the proposed State Insurance Exchange.

In addition to the cost of the Medicaid expansion, there are numerous mandates in both bills which affect Nevada's ability to prudently manage this program. The most significant mandate is a Maintenance of Eligibility (MOE) requirement. States are not permitted to change income eligibility for adults until 12/13/2013 and cannot change income eligibility for children (Medicaid and CHIP) until 9/30/2019. Additionally, the House bill includes a new definition of "medical assistance" that many states worry will impose stringent new requirements that may result in higher provider payments.

Unsustainable Growth in the Current Medicaid Program

Medicaid caseload growth has exceeded all projections, primarily due to job loss and reduced employer coverage, crowding out spending for education and public safety.

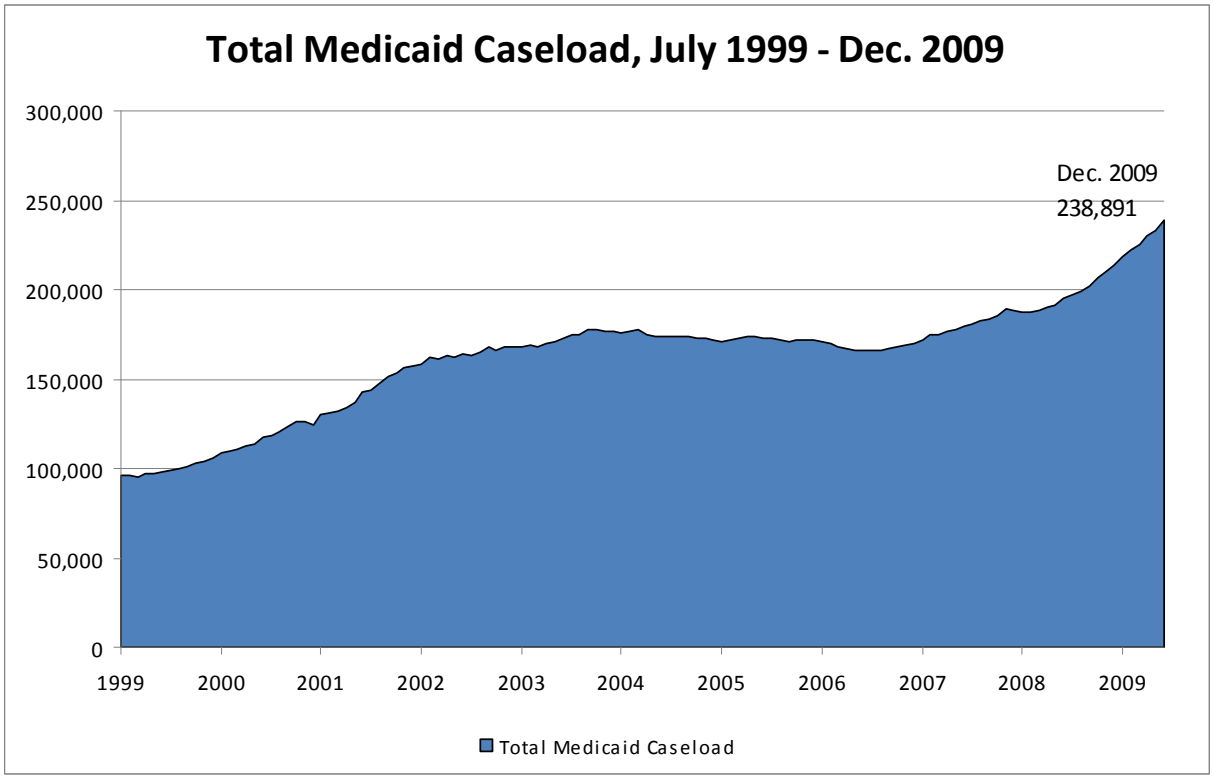
Notwithstanding the additional cost burdens imposed by current national health reform efforts, states have been struggling for years with the growing costs of their existing Medicaid programs. From State Fiscal Year (SFY) 2000 through December 2009, total Medicaid spending on medical services (federal and state funds) grew from $489 million to $1.34 billion, an average annual growth rate of over 7.7% per year.



Likewise, state spending on Medicaid medical services grew from $220 million to $428 million, representing an annual average growth rate of 9.6%. It is important to note that state general spending in SFY 2008 and 2009 was reduced by the increase in Medicaid federal financial participation through the ARRA. Despite this, growth rates in Nevada

Medicaid spending have exceeded all relevant price and population growth indices and thus should be considered unsustainable. This also "crowds out" spending in other areas such as K-12 education, higher education and public safety.

The primary driver for spending growth in the last decade has been caseload. While eligibility standards have remained relatively constant, the numbers of new eligible Nevadans has dramatically increased. Most of this growth can be related to two significant economic downturns in this time frame. As individuals and families lose jobs and employer-sponsored insurance, they often turn to Medicaid to provide medical assistance. From SFY 2000 through November 2009, Medicaid caseloads have grown from 96,000 to over 233,000 recipients, representing an average annual growth rate of 8.7%. Most of this growth is associated with increases in the families and children's groups.



There are also secondary cost drivers that contribute to the significant increase in Medicaid spending. From SFY 2000 through SFY 2009 medical spending increased

dramatically in selective service categories beyond what would otherwise be related to caseload growth. Some examples include:

- Personal care services spending increased from $3 million to $65 million;
- Spending for durable medical equipment, e.g. wheelchairs, and disposable supplies increased from $7 million to $21 million;
- Non-emergency transportation spending increased from $1 million to $8 million; and
- Mental health rehabilitation services were expanded in 2006 increasing spending from $6 million to $53 million.

Efforts are underway to curtail spending in these categories. However, it is also important to point out that spending cuts need to be balanced against providing reasonable access to services and making front-end investments to reduce long-term costs.

CAN NEVADA LEGALLY OPT OUT OF MEDICAID?

This is one of the most important questions in this analysis, and one that has not yet been reviewed by the Office of the Attorney General.

It is, however, generally held that Medicaid is an optional program for states. For example, Nevada "opted in" to Medicaid in 1967 with the passage of state legislation placing Medicaid in the Nevada State Welfare Division. In 1997, the Nevada Legislature created the Division of Health Care Financing and Policy to administer Nevada Medicaid. The enabling statutes are found in the Nevada Revised Statutes (NRS) section 422. NRS section 422.260 specifically accepts the provisions of the Social Security Act with respect to accepting federal Medicaid funds. Numerous other sections of NRS 422 also direct the Department to submit state plan amendments to modify or expand the program.

Arizona was the last state in the union to offer a Medicaid program to its residents. It implemented a limited Medicaid program in October 1982 as a federal research and demonstration project. The program was substantially expanded in subsequent years.

Federal statutes governing the provisions of the Medicaid program, including the mandatory and optional services and coverage groups, are found in Title XIX of the Social Security Act. A review of these statutes does not point specifically to the program being considered an option for states.

However, Section 1901(a) of the Act describes the general provisions of Medicaid. This section of the Act not only describes the general purpose but also indicates how federal financial participation in the program can be secured.

> *The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance.*

The requirement for states to submit a plan in order to receive federal funds suggests that submittal of such a plan is voluntary.

There is also federal case law suggesting the voluntary nature of the state's participation in Medicaid cited in The Heritage Foundation article by Smith and Haislmaier. Probably the most direct statement is made in the U.S. Supreme Court case, *Wilder vs. Virginia Hospital Association* (USC 88-2-43). In this case, the court says:

> *Medicaid is a cooperative federal-state program through which the Federal Government provides financial assistance to States so that they may furnish medical care to needy individuals. 42 U.S.C. § 1396 (1982 ed., Supp. V). Although participation in the program is voluntary, participating States must comply with certain requirements imposed by the Medicaid Act (Act) and regulations promulgated by the Secretary of Health and Human Services (Secretary). To qualify for federal assistance, a State must submit to the Secretary and have approved "a plan for medical assistance," 42 U.S.C. § 1396a(a), that contains a comprehensive statement describing the nature and scope of the State's Medicaid program. 42 CFR § 430.10 (1989). The state plan is required to establish, among other things, a scheme for reimbursing health care providers for the medical services provided to needy individuals.*

It is unclear what steps a state must take to elect to no longer provide Medicaid coverage. A very thorough legal review of all relevant state and federal laws would be necessary. We would also have to determine the sections of the NRS that would need to be revised or eliminated if the Nevada Legislature agreed to eliminate the program. Suffice it to say, the Nevada Legislature would probably need to eliminate most or all sections of NRS 422, and revise any related or referenced chapters.

An additional issue is the role of the counties in paying for indigent care. NRS 428.010 requires the counties to provide aid and relief to indigents who are lawful county

residents and have no other means of support or cannot obtain aid from other state, federal or private institutions or agencies. Consideration needs to be given to how the counties will bear the burden of individuals seeking their assistance because they are not longer eligible for Medicaid services.

IF NEVADA "OPTED OUT" OF MEDICAID, WHO WOULD BE COVERED AND WHO WOULD NOT?

If Nevada was able to opt out of Medicaid and chose to do so, there would remain a significant number of individuals who would not be able to obtain coverage under the current health reform bills. It is clear from both the Senate and House health reform bills that Congress did envision the possibility of states reducing Medicaid coverage and spending. Both bills try to forestall such state action by mandating that states maintain eligibility in the program, and both bills try to sweeten the deal by adding additional federal Medicaid funding for some aspects of the proposed expansion. However, Congress did not appear to envision a scenario where a state or states chose to act in their financial best interest by opting out of Medicaid.

Neither the House nor the Senate bill provides for credits or subsidies for citizens who would otherwise qualify for Medicaid.

This is evidenced by the lack of credits and subsidies in both bills for citizens who would otherwise qualify for Medicaid. The House bill provides affordability premium credits to individuals and families with incomes up to 400% of the FPL. However, these credits are not available to someone who is otherwise eligible for Medicaid. The House bill also provides cost-sharing credits to individuals and families, but those credits are only available to households with incomes between 133% and 400% of the FPL. Likewise, the Senate bill includes premium assistance credits to individuals and families with income above 100% of the FPL. Limits on out-of-pocket costs also start at 100% of the FPL.

The lack of subsidies and credits to very low-income households, and those who are Medicaid eligible, may create a significant potential coverage gap for those currently covered under the program, as well as those who would be newly eligible under health care reform. Presumably, some of these individuals may be able to obtain coverage through their employers or through the Health Insurance Exchange. The availability of affordable commercial coverage for this group after health reform is enacted is very difficult to determine. However, we must assume that there will be an increase in

Nevada's uninsured rate, at least temporarily, as individuals and families attempt to get health care coverage.

At the very least, there will be a dramatic shift in the socioeconomic conditions of the people in Nevada who are uninsured. A portion of the 20% of Nevada's current uninsured would be able to purchase insurance through the exchanges due to the federal subsidies. However, more than 200,000 of those currently enrolled in Medicaid would no longer receive state assistance under the proposal offered below and would not be eligible for federal subsidies to purchase insurance through the exchanges because their income is too low. Hence, the poor are the ones who would be left with no option and become uninsured.

While not addressed in either bill, we must also assume that without a Medicaid program, the Nevada Check Up program, Nevada's Children's Health Insurance Program (CHIP), would need to be terminated. There are currently 21,622 children enrolled in the program. Many of these children will likely qualify for Exchange coverage as the household income requirements for current eligibility is between 100% and 200% of the FPL. However, it is unclear, particularly, for the lower income households, whether the affordability credits and subsidies provided in the bills will be sufficient for them to afford Exchange coverage.

Another significant gap will be created if Medicaid ends for the aged and disabled currently eligible for Medicaid who would ostensibly not be helped by health care reform. Both bills in Congress do include a new voluntary long-term care insurance program, called the Community Living Assistance Services and Support (CLASS) Act. However, this provision of both bills will not meet the current and future long-term care needs of Nevada Medicaid recipients.

Therefore, we would propose to maintain the existing Long Term Care system (payment for nursing facility, intermediate care facility for those with mental retardation and related conditions and the home and community based waivers including the corresponding

medical care for these recipients) capped at its current enrollment level, as well as medical care for children under government guardianship (another group potentially excluded from health care reform), at full state dollars. This could be called the Nevada Safety Net for Health. We estimate the 2011 state general fund cost of providing safety net coverage to those currently receiving long-term care services and the child welfare population at $487 million. The chart below provides an estimate of those who would retain medical assistance under the proposed Nevada Safety Net for Health, and those who would lose Medicaid coverage:

	Aged and Disabled	Families and Children	Total
Avg Caseload Losing Coverage	54,900	198,600	253,500

	Aged and Disabled	Child Welfare	Total
Avg Caseload Keeping Coverage	7,000	8,700	15,700

Eliminating the Medicaid program would impact all other Medicaid recipients by removing the funding for their medical care. The changes above would affect the following:

- Medicaid coverage would be discontinued for 198,600 low income children and families, as well as 54,900 aged and disabled persons who are not in nursing facilities or in the home and community based long-term care programs. Again, it is unclear whether expanded employer coverage and the proposed Health Insurance Exchanges will be affordable and available for this segment of the population.
- These individuals would lose access to prenatal care, inpatient and outpatient hospital services, professional medical care, pharmaceuticals, infant and child preventive care, behavioral health care, dialysis, and Medicaid hospice care. These individuals would also lose funding for vision and dental care, home health care and medical equipment and supplies. For some of the most medically vulnerable and frail currently in Medicaid, it is also unclear whether Medicaid covered in-home support services such as medical equipment, supplies and personal assistance services will be available through Exchange plans.

- Medicaid assistance to low-income Medicare beneficiaries would end. Assistance with Medicare premium payments as well as help with out-of-pocket cost would discontinue for most of the 41,455 elderly and disabled persons who currently receive this benefit. Assistance with Medicare costs is not available in either health reform bill.

Eliminating Nevada Medicaid would also impact state and local government agency funding by eliminating federal Medicaid dollars as a source of revenue. Besides federal revenue losses to state sister agencies such as Mental Health and Developmental Services, local government agencies would also see a significant reduction in federal revenues which would challenge their missions to serve the general public. Some examples include:

- $7,316,861 for targeted case management;
- $1,867,616 for school based Medicaid administrative and medical services; and
- $2,966,929 for supplemental payments to the University of Nevada School of Medicine

This change would affect Nevada hospitals with the loss of $251,927,219 for supplemental payments to disproportionate share hospitals, supplemental hospital payments for upper payment dollars (UPL), and hospital claims for medical services.

It will also increase costs to counties as with more uninsured individuals there will be increased costs for indigent care for emergency medical services and long term care. In 2009, counties received $48,753,522 in federal and provider tax funding to reduce the cost of paying for institutionalized indigent individuals.

Elimination of the Nevada Medicaid program will also affect the ability of the State and private entities to receive numerous federal health care grant awards as many are tied to Medicaid participation. For example, this may affect the ability of the Bureau of Health Quality and Compliance in the Health Division from receiving their federal grant

for licensing and certification reviews of health care facilities. It will also affect the ability for Nevada providers to draw down federal funds to develop health information technology in Nevada.

Finally, assuming not all Medicaid eligible recipients get other health coverage, payments to providers will be affected. There is the potential for doctors, dentists, therapists, hospitals and other providers to see a reduction up to $135,784,019 per year. It will also eliminate Medicaid reimbursement of $2,617,695 to federally qualified health centers and $4,187,857 to tribal health centers. There will be a loss of funding for providers of Medicaid social based services such as personal care services, adult day health care and non emergency medical transportation, as these services will likely not be covered under the proposed Exchange plans.

CONCLUSION

This analysis merely scratches the surface on all the legal, financial and coverage issues associated with health care reform and the impact of opting out of the Medicaid program. Much more extensive legal and financial analysis is necessary. However, it is clear that forcing states to deal with the burden of funding health coverage to new Medicaid eligibles under health care reform is forcing some to consider what previously was unthinkable – opting out of the Medicaid program. While some losing Medicaid coverage under such a scenario may find coverage as a result of health care reform, it is clear that coverage may not be affordable nor cover the services needed by many. A Nevada Safety Net for Health would provide continued medical assistance to the most vulnerable, individuals in need of long-term care services, and children in the child welfare system. However, neither this safety net nor coverage through the current health reform bills will address all the needs of Nevadans currently on Medicaid. We believe a significant number of Medicaid eligible Nevadans, as many as 200,000 will not be able to obtain or afford coverage through the proposed Health Insurance Exchanges, and will merely add to the numbers of uninsured in the Nevada and increase the cost burden to providers, state and local governments to serve the poor. In addition another 40,000 Nevada seniors will not receive the supplemental benefits to Medicare they currently receive from Medicaid.