[LB85 LB134 LB647]

The Committee on Banking, Commerce and Insurance met at 1:30 p.m. on Tuesday, February 27, 2007, in Room 1507 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB647, LB134, LB85. Senators present: Rich Pahls, Chairperson; Chris Langemeier, Vice Chairperson; Tom Carlson; Mark Christensen; Tim Gay; Tom Hansen; Dave Pankonin; and Pete Pirsch. Senators absent: None. []

SENATOR PAHLS: Good afternoon. I want to welcome you to the Banking, Commerce and Insurance Committee meeting. My name is Rich Pahls, I am from Omaha, and represent District 31, and I am honored to serve as the Chair of this committee. The committee will take up the bills in the order posted, that would be LB647, LB134, LB85. Our hearing today is your part of the legislative process. This is your opportunity to express your position on the proposed legislation before us today. And to better facilitate today's proceeding, I ask that you abide by some of the following procedures. If you take a look at the chart on the wall, that would be some of the major ones I will go over. If you do have cell phone, we ask you to turn that off. We do have an on-deck chair the senator is sitting it. That is great. And we do have a testifiers box up here, so do put your testifier sheet in that. The introducing senator typically introduces the bill. Following the bill being introduced, we will hear testimony from proponents, opponents, and neutral testifiers. And, of course again, we will strive to give equal time. And since we do have a number of people that are new to this committee, make sure that you spell your name for the record. We do need that. That makes it much easier for those of us running the meeting. If you have written testimony, we need at least ten copies. If you do not have ten copies, let me know now and I will have the pages run that off so when you do get up here, we will have that ready. If you do need ten copies...great. Looks like everybody is prepared, appreciate that. If you are following other testifiers, will you please listen to their comments, because we are going to ask you, it's like the last thing on the board over there to be concise, because it does look like we will have a number of people speaking today. To my immediate right is Committee Counsel Bill Marienau; to my immediate left is Committee Clerk Jan Foster. And we will start over here with senators to let them introduce themselves. []

SENATOR CARLSON: Tom Carlson, District 38, from Holdrege, home of the Holdrege girls' basketball team that will take the first step toward the Class B State Championship Thursday, at Pershing Auditorium. []

SENATOR PIRSCH: Wow. I have got nothing like that. I am Pete Pirsch from the 4th District in west Omaha. []

SENATOR GAY: Tim Gay, District 14, Papillion/LaVista. []

SENATOR CHRISTENSEN: Mark Christensen, District 44, Imperial. []

SENATOR HANSEN: I am Tom Hansen, District 42, Lincoln County, home of Gerald Gentleman Power Station. []

SENATOR PAHLS: All right. We need all the help we can to advertise in the state of Nebraska, you can see we are doing our part. One of our pages is Kristine Kubik from Prague, Nebraska; and Cora Micek from Hastings, Nebraska, they are over to the side. And as I said, we will take up the bills starting with the first bill which would be LB647. Senator Johnson, and I do have a number of testifiers that I will call on and then those not on this list can testify afterwards if at all possible. Thank you. []

SENATOR JOHNSON: Senator Pahls, members of the committee, I actually sat on your committee for the last four years, as well, and joined Senator Jensen, who will testify after me. One of the things that we found and were indoctrinated to right away was the fact that we should stay away from mental health parity. In other words, treating mental health insurance like other insurance. The theory was, basically, that if you included this, the cost of other insurance would go up so high that we would actually end up with fewer people having insurance, and we would not accomplish what we had intended to. Last year the Legislature contracted for an actual study, that you will hear about from the people following behind me, that does address this problem statistically as best the actuaries are able to determine this. I think that you will be surprised by the findings as we were. And because of these findings, I think that perhaps is now the time to rethink and perhaps redo what we have done in the past regarding mental health parity. I think that you will be quite surprised by what these numbers will show. As a matter of fact, these numbers are intended to make you understand why we should stop this discrimination that is now present in our mental health laws. So I would invite you to listen very carefully, particularly to Senator Jensen behind me who will describe how this process came about, and then to the actuary to follow who did the study as I think that it will be an eye opener to you. [LB647]

SENATOR PAHLS: Any questions for the Senator? Seeing none, Senator, I am assuming you are going to be around for the... [LB647]

SENATOR JOHNSON: I probably will have to pass because I have other duties, but I will try to be here. Thank you. [LB647]

SENATOR PAHLS: Okay. I understand. Thank you, Senator. The next testifier should be Senator Jim Jensen. [LB647]

JIM JENSEN: Senator Pahls, members of the Banking, Commerce and Insurance Committee, my name is Jim Jensen, that is J-e-n-s-e-n, a former state senator, still as chairman of the Behavioral Health Oversight Commission, and I was the introducer of

the bill which funded the study and then also commissioned the study that will be presented right after me. I spent 12 years in the Legislature, all 12 of those years serving on this committee. And I was consistent, and a lobbyist will probably tell you that, in opposition to mandates as mandated insurance coverage. I know what they do. As a business man since 1960, I certainly know that insurance costs continue to go up, continue to go up at a very alarming rate, and I also am concerned that as costs go up, then you have more people who actually drop out of the insurance pool and do not carry it. Many times the state must then pick up that cost. I also carried one of the highest voting records with the Chamber of Commerce, in my 12 years, of any of my colleagues on chamber supported issues, and I can imagine what their position on this bill would be. But there is a couple of things since coming to the Legislature, I certainly, being in the health committee all those years, began to look at behavior health issues, mental health issues. And also recognize the role of the state and government in mental health issues in that, number one, there isn't any money in performing mental health services, so that leads off part of it. And secondly, the insurance companies, in many cases, either have set caps, or limits, or just did not include those services. And yet mental health is a malfunction of brain activity. Tell me what a stroke is? What happens? And so you have two problems of the brain, one we cover in our insurance, and one we either limit or we don't cover at all. Then that cost is so often passed onto government to pick up the cost, because certainly if it becomes severe and persistent, that individual sooner or later will need assistance either from the state, in some manner, or from Medicaid. And also during my time in the Legislature, we looked at other states and certainly in going to conferences, we found that to have parity was an increase, but a very small increase, as this study will tell you. So there are two things: (1) look at the numbers, look at that cost; and (2) look at the fairness of that policy. And I hope that you will decide that this is something that really insurance, if you are carrying insurance, should cover from that fairness point. And then I would hope that you would do the right thing by voting this bill to the floor. I originally came in the Legislature really was completely ambient on mental health issues. It was not something that I knew a great deal about, that I was interested in, but in the Health and Human Services Committee as we began to look at those issues, I found out that there was really three things that were going on. One, that the consumer had great difficulty in finding access for services, had a great deal of problems in paying for those services. The family members would go through a tremendous maze trying to find services, and again, if they had any insurance, in a very short period of time it was gone and then the state picked that up. And then law enforcement, of course, they struggled with trying to provide services also. I think this would go a long way. I think it would actually save the state some precious taxpayer funds, and I think it is the right thing to do. So I would certainly encourage you to take a good close look at the study that was prepared, and then to move this forward. Be glad to answer any questions that you might have. [LB647]

SENATOR PAHLS: Do we have any questions for the Senator? Senator Hansen. [LB647]

SENATOR HANSEN: Thank you, Senator Pahls. Senator Jensen, it is great to have you back. Has this type of legislation been introduced in the past in your tenure when you were here? [LB647]

JIM JENSEN: Well, in my tenure, just thinking back, I think I only voted for maybe two mandates in that 12-year period. One was to mandate mammograms for women. The second one to a partial parity bill that Senator Jennie Robak from Columbus every year submitted, and Dave Landis, who chaired this committee at the time, I think, become tired of that bill introduction every year and said, is there something that we can do with this, and sat down with some of the insurance companies and worked out a partial parity bill. And that was introduced and I did vote for that. So other states have done this, and like I said, they found the cost very minimal, and I think it can work here in Nebraska also. [LB647]

SENATOR HANSEN: Okay. Thank you. [LB647]

SENATOR PAHLS: Seeing no more questions, thank you, Senator. It was good seeing you. [LB647]

JIM JENSEN: Thank you very much. [LB647]

SENATOR PAHLS: The next person that I will call, and if I mispronounce your name, I apologize for that, would be Steve Melek. And will have you spell your name to make sure we get it correct. [LB647]

STEVE MELEK: (Exhibit 1) Senator Pahls and members of the Banking, Commerce and Insurance Committee, Steve Melek, M-e-l-e-k, and it is a privilege to be here before you today to not only present the results of my report, and I have several copies here if anybody needs a copy of the report, but I thought additional what might be helpful, because my understanding is maybe you don't have as full of background in the mental healthcare history and healthcare itself, I could spend just a few moments being concise and framing this report. I am an actuary. That means I am a risk expert. I work pricing, health insurance plans for self-insured employers, insurance companies, and I have been an actuary for 30 years. And I have been in the healthcare business that long, and I have been will Milliman, the largest actuarial consulting firm in the U.S., for the last 17 years, and for the last 12 years I have had the pleasure of really specializing in behavioral healthcare, and it has been very interesting to me to see what has occurred in the last decade. And I think there are a few myths out there about parity, and I just want to address a few of those. But I first got involved in this when the Clintons were introducing the Health Security Act back in the earlier '90s, and that was when the Managed Behavioral Healthcare Association wanted to first raise federal parity, and it didn't fly then and it is starting to fly again now, I suppose. But a lot has changed in the

last 10-20 years, and just a brief history as to how do we get where we are today. Back when healthcare costs were going through the roof in the eighties, nineties, what did employers need? They needed cost control. So substantially what happened was managed care, and I know Nebraska may not be a huge managed care state, but fee for service system was costing so much money, managed care came in with two premises. One, negotiate with providers and get discounted fees, and two, don't provide everything that a doctor wants to order. So some sort of utilization management, management controls, and they were very good at doing that with medicine, medical, surgical, physical care because it is far more black and white than behavioral healthcare. So the manage care firms managed that very effectively. As an actuary I saw a spectrum of costs that were saved as much as a third of total healthcare cost there for medicine. Behavioral side was different. People didn't know how to manage mental health and substance abuse like they did appendectomies, or skin rashes, or cancer. And a whole new industry formed that managed behavioral healthcare industry as psychologists and psychiatrists said, we can manage this stuff, and they did it on a risk basis. They took over the risk from the insurance companies, and a whole industry formed, and this industry covers more than 100 million lives, at least at its peak, and maybe it is starting to falter off a little bit in the last couple of years. But they managed the behavioral healthcare side, and as I said, observing as an actuary, the savings that was potential if you really produced best practiced medicine was a third of the savings on the medical side, it was double that on the behavioral side. Now why is that? Why would you eliminate two-thirds of the prior cost of behavioral healthcare while there was a lot of inefficiencies and unnecessary care in the system? So back in the early '90s, late '80s, mental healthcare was very expensive and there was no controls over it. So what did health plans and insurers do? They put in the caps that you are wrestling with today. They said, if we can't control how often a patient needs to see a therapist, twice a week for 50 weeks a year, or how long an emotionally disturbed child may stay in the facility, 60-90 days straight, very high costs, what we will do, since we can't control the utilization because it is very subjective, is we will put these limits on. So many days per year in the hospital, so many visits per year for therapy, etcetera, etcetera. So the result of that is in the last 10-12 years, what I will call specialty behavioral healthcare costs, that is behavioral healthcare, mental health, and substance abuse, and alcoholism delivered by specialists, psychiatrists, psychologists, social workers, licensed therapists, those sorts of individuals, those costs have been reduced by 50 percent in the last 10-12 years on an absolute basis. If they were costing $10 per person per month before, it is costing $5 per person per month. The delivery system has changed in the last decade. So that is one premise I just want you to understand, is the cost have come down a lot since the early projections of what parity is going to cost. The second significant trend, as well as specialty behavioral healthcare costs coming down, is because it was managed separately, there is almost a silo in the delivery system. Physical healthcare here and mental healthcare over here, and these systems don't talk to each other really well. So as a result, you have got individuals that have to kind of split how they get healthcare, and there is, with the higher copayments and the inside

limits on mental health benefits, there are hurtles that they have to jump through to get to the specialty behavioral healthcare. The other phenomenon that has occurred as specialty behavioral health services, we have gone from $10 to $5, the cost of psychotropic drugs, psychotropic drugs is the class of drugs to treat all the different mental health conditions out there, has tripled. Now why is that? Well, newer and better drugs, direct to consumer advertising, and the fact that the specialty behavioral healthcare organizations are not at risk for those drugs. So you almost have a perverse incentive for patients, if they are not at risk over here from the people managing that, to go to the general medical sector, and that is where most of those drugs are prescribed. One of the myths is psychiatrist write all of those drugs. Well, that is not true. Primary care doctors, general practitioners prescribe more than two-thirds of those drugs, and that is in the general medical community. So when people talk about mental healthcare, behavioral healthcare costs, in the analysis I did, which I will present in a moment, and in analyses that are done around the country, they focus on the specialty behavioral healthcare costs. How much does is cost for those facility stays, for the suicidal patients, for the detox and rehabilitation of drug abusers, the schizophrenic patients and all of that, it is the specialty care. That cost is a small piece of the total cost of caring for people with mental health disorders. More people will go to the general medical setting to get treatment for mental health conditions than will go to the specialists. Why is that? Stigma, higher copays, benefit limitations. It is easier and less expensive to go to a primary care doctor to get an antidepressant, an antipsychotic, ADHD drugs for the kids, etcetera. So there is a lot more care, a lot more cost being spent in primary general settings than in the specialty setting. The bill you are talking about, the analysis I did was on a specialty setting, because that was the task at hand. I just want you to understand the broader picture that there is more money being spent over here, and one of the reasons why there is more money being spent in the general sector is because of the restrictions in the specialty sector. And I want to add a couple more facts and then I will present the results. There have been some studies, very scientifically and academically done, that measure minimally adequate treatment between the general medical sector and the specialty behavioral sector, and how much of us want to just cross that minimally effective treatment threshold, when we go to a doctor, we want to certainly go better than that. But specialty behavioral providers perform minimally adequate treatment, that is a minimum treatment on psychotropic drugs or psychotherapy, the two major forms of treatment, 44 percent of the time. Forty-four percent of the patients that walk in those doors get minimally effective treatment. That is not so good. But there is all kinds of reasons, and I can explain more if you are interested in that. But I want to compare that to the general sector where more patients go than the specialty sector, 13 percent get minimally effective treatment, effectively 1 out of 8. You say almost got one out of half get effective treatment over here, and one out of eight are going here, but with all of these limitations over here, how many are you forcing into the general medical sector because of the expense and stuff? The second fact that I wanted to just describe is what happens with a lot of mental conditions, at first. It has been scientifically proven that, and I am an actuary so I am just presenting

the facts as I understand them because I deal with the finances, but on the clinical side, 80 percent of patients have depression first exhibit physical pain. They don't know what is going on with their bodies. They have physical pains, backache, headache, stomach pain, joint pain, dizziness, and where do you go when you have physical pain? You go to a primary care doctor. So that is where they go to get treatment of symptoms. The other interesting fact is that the average time between the onset of a depressive disorder and proper clinical diagnoses of that depressive disorder is six to eight years. So patients have this pain or whatever discomforts that are occurring, emotional, physical, they go to the primary care doctors, get lots of symptomatic treatment and relief, but our healthcare delivery system in primary care doctors are not well-trained to screen, diagnose, and treat mental health disorders, so they just have five minutes with the patients and they treat them for what is hurting them, and they send them home with a script of some sort. And I think those patients are better served in the specialty setting by the physicians and practitioners that specialize in treating that. So we have these inside limits and we have higher copays for those patients. The bill in the legislation in the early days, back in 1992-93, when these first national studies started coming out, the cost numbers that were tossed around were from a low of a 4 percent increase in employer healthcare costs, to a high of 10 percent or more. If you raise the lid on mental health and substance abuse treatment, costs are going to go through the roof. And there was credibility to that argument back then. Today, I would present that the cost have come down significantly. Why? Healthcare delivery has changed. Behavioral healthcare delivery has changed. Patients don't go in for one, two, three months at a time. They go in for a few days to get stabilized, and the delivery system has changed to provide alternatives that are less restrictive, less costly, partial hospital programs, intents about patient programs, etcetera. I built all of that into our pricing here. So that with the, remember, $10 in the old days, $5 today? How much would $5 today go up with the legislative bill that you are addressing here, the behavioral healthcare parity? The other interesting item, before I get to the results, while physical healthcare trends have gone up more significantly in the last five years, mental healthcare trends have still been pretty flat. So what you have got is it came from $10 down to about $5, and after copayments and stuff, a lot of health insurance plans are only incurring maybe $3 in specialty behavioral healthcare costs. The total healthcare cost keeps on going up and up, and the $3 is pretty well staying flat, $3, $3.25, $3.50, so as a percentage of total healthcare costs, mental health gets lower every year. It is just what has been happening in the trends. There is not a lot of new technology in mental health. It is just professional services for the most part. So with the results, a typical actuarial approach to modeling the impact of a change in healthcare is to take representative plans from the covered population, use them as representative plans, take the specific benefits, and do a before and after modeling approach, and that is what we did. We looked at all the major players in Nebraska, Mutual of Omaha, Blue Cross, and even United, and Coventry, and we modeled five plans. We looked at their current medical, surgical benefits, and their current mental health benefits. We changed the design to lift the limits on mental health benefits, and substance abuse benefits, and equalized the

copays. Essentially equalized everything. To go from the current limited benefits to unlimited benefits. Most of the benefit designs today, I think, have a limit of 30 days per year in a facility, after 30 days no coverage. A lot of the plans for outpatient services, you have either 20 visits to professionals, or 30 visits, some even have 50 visits. So what you are doing there, in both cases under the bill, is to make them unlimited, unlimited stays in the hospital, unlimited treatment by professionals, and the other significant change is no difference in deductibles, no difference in copayments. If it used to be it would cost you $10 to go to a primary care doctor, and cost you $50 to go to a psychologist. It is not $50 anymore, it would be $10. And you wouldn't be limited to 20 visits or 30 visits, you could go once a week, if you wanted, it all year long. After we modeled all of these costs, there is two major drivers of the cost of parity: How high are the benefits to start with, and I think in Nebraska you have a moderate level to start with; and how aggressively managed are those benefits? In other words, with aggressive management you get patients out of the hospital as soon as you can into less restrictive, less costly care, and if you are more restrictive on the outpatient side, when somebody wants to see somebody, they precertify the visits. And you call the 1-800 number, and they would allow you to go 6 visits, or 8 visits, or 10 visits, and have to repeat that process every time you ran out of your 6, or 8, or 10. We looked at a variety of different sources to get what our best estimate was of the populations degree of healthcare management in Nebraska, and on average, when we look at the spectrum at Milliman, you have got on the far spectrum the most expensive is a loosely managed delivery system, very little utilization management. And then the other spectrum it is very tightly managed, very aggressive management. We pegged Nebraska, for the most part, towards the middle, especially with your PPO plans, and the HMO plans might be a little bit more aggressive than PPO plans because they have a closed panel of providers. Across the whole population with the five representative plans, the cost of full mental health parity, we estimated, an increase to total healthcare costs of between 0.3 percent and 1.0 percent, depending on the plan. Now you could have some plans that could be outside that range because we only picked five aggregate plans that we thought represented. But if you collapsed all those plans according to all the members, the average is 0.6 percent. Now that is a far cry from the 4-10 percent of 12 years ago, but that is because of these various factors. Mental health costs are much lower than they used to be, there is much more management of those costs than there used to be. So adding parity you won't see lengths of stay in hospitals going from 7 days to 70 days. There are just going to tweak up a little bit, because a lot of the practice of healthcare management is already in place among your providers. Certainly some will get readmitted and have more benefits, and certainly some of the sicker patients will access and need this additional care, but it is not going to cost a real lot of money. One of the other practices of health insurance plans is if costs are getting higher, they respond. They can respond in one of two ways, tighten the management of the benefits, or pass those costs onto the employers and the employees. We also looked at some of those scenarios, and looked at the 6 percent increase in cost and said, if they were to tighten management, how much would that 6 percent come down, because they would be a

little more restrictive and granting services as being medically necessary. And nothing in the bill prohibits medical necessity criteria, from what I understand, so that it still needs to be necessary for the health of the individual. But the 0.6 percent cost, which is roughly $2 dollars per person per month roughly for a single, a family, $5 per person per month in cost, with increased management, if companies elect to do that, it goes down to 0.2 percent, about a third of the cost increase. So now you are talking about 50 cents per person per month, 50-60 cents for a single. There have been other options that some states have followed that said, well, let's pull substance abuse away from behavioral healthcare because that is different, and you have got patients with substance abuse that may go again, and again, and again through therapy, and that is we did look separately and if you pulled substance abuse away from full behavioral healthcare parity, you save about a tenth of a percent, but that is not a significant amount of money. And the other factor that we presented here, and then I will stop, is that the prior parity bill required health plans that offered mental health benefits to offer parity for serious mental illnesses, and there is the serious mental illnesses, there is a couple of handfuls, perhaps, of diagnosis of those, major depression, schizophrenia, panic disorder, autism, things like that. But if that is already in place amongst the plans, that also limits the cost increase, because we looked at nobody having parity benefits compared to everybody getting parity benefits, and if people with serious mental illnesses already have parity benefits within their health plan from the Blues or from whoever it is, those people are not going to incur any cost increases. So you put them on a side and say, what is the rest of the population going to cost? And there the 0.6 percent, again comes down, it rounds to about another tenth of a percent. So in essence, we are talking about a bill that is going to cost, however you move things around, about half of one percent of healthcare costs, in our best estimates of projections. Certainly individual employers could be different, an individual plan with real low benefits to start with could be different, but in the aggregate that is the degree of increase that we are expecting with our best estimates of the projections for your state. And I am glad to answer any questions that you might have. [LB647]

SENATOR PAHLS: Senator Christensen. [LB647]

SENATOR CHRISTENSEN: In this study, if I read this right, it talked about exempting anybody under 50 employees small, but in here it includes everybody in the bill, is that correct? Am I reading it right? [LB647]

STEVE MELEK: I think we did not have draft language in the bill when we did our report, so our report was based on 50 and larger groups, and they would exclude ERISA plans. So small employers, individual coverage, and self-insureds would not be covered, but even if they were covered, unless the small group benefit designs are substantially different than the large groups, the cost estimates we have got in our analysis would still hold for the small group plans. Now sometimes you see small groups that have leaner mental health benefits or, perhaps, no mental health benefits,

and in that case, it would be a more significant increase for those employers. [LB647]

SENATOR CHRISTENSEN: That is what I anticipate. I have a small business that wouldn't have that in there that I pay a little higher percentage than a larger company, and that is why I wondered. I just read it that way. I guess you answered the rest of my questions. Thank you. [LB647]

SENATOR PAHLS: Senator Hansen. [LB647]

SENATOR HANSEN: Thank you, Senator Pahls. That was the same question I had. I just and I just wanted to make it clear that if we accept the results of this study, we have to assume that it is 50 and over, correct? [LB647]

STEVE MELEK: Groups of 50 and over, yes. [LB647]

SENATOR HANSEN: Yes, because that is what is stated. [LB647]

STEVE MELEK: That is correct, and if we had included small groups in here, what we would have done is looked at the current average benefit levels for mental health and behavioral healthcare within small group plans and said, how much of an increase would that be. I will say that if there were no benefits currently incurred and you went to a full parity benefit, you can look at the costs in the table and in the appendix. I am sorry, it is not even in the body of the appendix. It is in the table itself on page...well, we don't present the full behavioral healthcare costs. Okay, here we do. It is in the appendix. If you are looking at a similar comparison to mine here, page 24. I am having a little trouble seeing the title on this because of the logo on this paper, but the total cost after parity across all the plans is about $6.04. Do you see that in the table? So another way to look at that is to say if we had no benefits at all, what would it cost us to go to parity, $6.04. What is an average per person, per month healthcare cost today in Nebraska, and I think our estimate based on all the info we gathered was approximately, round numbers, $300 per person, per month. Worst cost scenario, 0 to full, that is a 2 percent increase in cost. So what we are saying is for all the group plans that have a bunch of coverage already, it is going to cost half of a percent. If you had to add it to a plan that had no coverage and they had benefits similar to the average PPO, HMO in the state for $300 costs, $6 over $300, that is 2 percent. If that makes sense. [LB647]

SENATOR HANSEN: Okay, and then follow up. Okay. In your testimony explaining your study, you said it was an average of 0.6 percent increase and the range was 0.4 to 1, so actually the range is 0.4 to 2 then, if we include under 50? [LB647]

STEVE MELEK: If you include under 50 benefits, and there were some small group benefits that had no mental health benefits, yes, I would push the upper end of that

range to say as high as 2 percent, to go from 0 mental health benefits to full behavioral benefits. [LB647]

SENATOR HANSEN: But, again, the study was done on 50 employees or more. [LB647]

STEVE MELEK: Correct. Correct. [LB647]

SENATOR HANSEN: Okay. Thank you. [LB647]

SENATOR PAHLS: Senator Gay. [LB647]

SENATOR GAY: Yeah. I have got a question as far as 27 pages, I won't be able to read this now, but I will. But the question I have is when you looked at your findings and you took that group, you mentioned something about the two silos, you have got primary care here and specialist here. The question I had is with some of the stigmas attached to some of these things, and everyone is going to primary care first, and they may not be the best, obviously, to utilize this. Were you factoring in, won't people still go to the primary care physician, and what is going to drive them to the more behavioral health end of the insurance program? I guess I just look at that, how does this make them start utilizing better methods for treatment? [LB647]

STEVE MELEK: Well, that gets into changing the delivery system itself. But I will say for the study we have what I would call induced demand adjustments to the utilization and cost of the special behavioral healthcare, and I called them hurdles before. But if the copay went under parity from $10, it used to be $50 and now it goes down to $10, consumers are more likely to say, I can afford that. I can't afford to go to a therapist 8 times at $50, because my budget can't handle it, but maybe I can go 4 times at $10 and get healthier there, rather than get no care whatsoever. So we did factor in induced utilization, so it is in the study, but utilization does go up, especially for outpatient services because of that reduction in the copays. [LB647]

SENATOR GAY: Okay. Would the insurers then probably encourage that, too, then? If it is better treatment, wouldn't they want to kind of push people to be cured and be done with them? I mean done as much as they can, but would that be an inducement, too? Would the insurers probably... [LB647]

STEVE MELEK: Well, yeah. What we had to be cautious about with our study was sticking to evidence and facts, but if you were asking my reasonably informed opinion about what is the best for the healthcare delivery system, I would absolutely say, yes. If you get patients healthier by being cared for by specialists, let's get them cared for by the specialists. It is not to say the primary care docs are bad. They are just not as trained, and equipped, or have as much time to care for the special kind of conditions

that they have got to face. What I slightly addressed in this study, which we try to stay away from because there is a lot of need for further study in this, but as an example we have done work and others have done work to compare what the effect of mental health conditions are on patients with a chronic medical condition. I will take diabetes as an example. The average diabetic costs $500 per month in healthcare costs total, $500. More expensive than the average American, that is the average diabetic. The average depressed diabetic costs $1,000 per month. That extra $500 is not in treating depression. Maybe $100 of that extra $500 might go towards treating the depression. The extra exacerbation, if you will, of the medical condition, and this also applies to cancer, hypertension, pulmonary disease, cardio disease, etcetera, mental health problems, mental health illnesses cause people to take lesser care of themselves. The diet, exercise, doing the right thing, they are depressed, they don't get out of bed, if we get those patients healthy, we are going to reduce costs on the medical side. I didn't put it in the study because it has not been proven. But I will tell you that there are more and more health plans moving their products in that direction. They are saying we need to get these silos reintegrated because there is no reason to treat the depressed diabetic for their diabetes over here and for their depression over here, if they get any treatment. There is a lot of numbers that say a lot of people with mental disease don't get any treatment at all because of stigma and other kinds of roadblocks and stuff. Anyway, I think the best delivery system is, yes, get the systems collaborating and get the patients that need those specialty services the services, and because, again, we were looking at the short-term cost impact. The short-term cost impact is half a percent, perhaps as much as 2 percent, but I would like to be before some committee in the next year or two with facts that show when mental health parity got installed here, medical costs went down by X percent and we proved it. That proof is still waiting to be determined. [LB647]

SENATOR PAHLS: Steve, just let me ask you a question because I know this is a lengthy document and we could spend all day, probably, going over this. Will we have access to you if we have questions or does somebody in Senator Johnson's staff, do they have a pretty good understanding of this information? [LB647]

STEVE MELEK: You absolutely can have access to me. I am glad to talk to anybody and answer any questions, and I don't know about the Senator's staff and their expertise on the results and the process. [LB647]

SENATOR PAHLS: Okay. But I am sure they should probably understand that if they are promoting this. One more question, let's say we would move everybody over. Do we have adequately trained or educated personnel to handle the move from the general practitioner to the specialist in your estimation of the state Nebraska? [LB647]

STEVE MELEK: I am not sure I quite follow the question. [LB647]

SENATOR PAHLS: Well, you are saying so many of them are going to the primary care,

but they should be going over here to the more trained person. [LB647]

STEVE MELEK: Yes. [LB647]

SENATOR PAHLS: Do we have adequate people in the state of Nebraska in this area in your estimation? [LB647]

STEVE MELEK: That is not something I studied. Do you have an appropriate number? I can give you a general answer. Do you have an appropriate number of psychiatrists, psychologists, social workers, licensed therapists, etcetera. My gut feel is that you have an adequate number of licensed therapists, social workers, perhaps psychologists. Where you are likely to have a shortage is psychiatrists and especially child psychiatrists. We see, too, many professionals have left the careers because psychiatry just got squeezed so badly with this movement to managed behavioral healthcare. But I think as far as psychologists and therapists, today psychiatrists for the most part are medication managers, and that is what the primary care docs are doing. The difference is psychiatrists do it a lot better because they spend more time with the patients and educate the patients. The primary care docs don't have time or knowledge of all of the intricacies of psychotropic drugs. [LB647]

SENATOR PAHLS: Okay. I do see that we have a few more questions. I am just saying that we probably will need to see Steve again at another time outside of this committee meeting, but let's have a few more questions over here. Senator Pirsch. [LB647]

SENATOR PIRSCH: No, and I appreciate and I will be quick with the question. You said that there would be just a modest rise in the total healthcare costs with covering the mental health. Is that modest rise predicated on an assumption that there will be savings in the physical types of medicine that you talked about with the increase in these kind of mental health coverages? [LB647]

STEVE MELEK: The analysis we did and what is presented in the report, the 0.6 percent aggregate increase ignores potential future savings in medical cost offsets. If you have costs to primary care doctors go down, we talk about it but we don't include it in our 0.6 percent because it is somewhat speculative, and there have been lots of arguments in that realm. So we stayed away from the arguments that said without that what would the costs go up by, and that is where we got to 0.6 percent. My gut feel says that give it a couple of years and, I think if you did increase the costs of 0.6 percent, even as high as 1 percent in the top of our range for large groups, you very well may recover that, perhaps, even more a couple of years down the road as patients get healthier. [LB647]

SENATOR PIRSCH: Okay. Has this been undertaken, this type of extended coverage? Is this the first impression in the state of Nebraska? Have other states kind of been in

this same situation and gone down that path? [LB647]

STEVE MELEK: Yeah. Unfortunately the analysis seems to always be, and it frustrates me as an actuary, but the analysis always seems to focus on the specialty behavioral healthcare costs only as if that is the only way you spend money treating mental illnesses. So the states, California or any other states that has had parity for a while, even Colorado, we had serious mental illness parity about six years ago and now we are starting to talk about complete mental health parity. And we did a study of that, by the way. I didn't address here, but the cost of the SMI parity in Colorado was 0.1 percent, and that was using real data. We looked at the cost before and after, and proved it was only 0.1 percent. That is not in this report. But every time I have a chance, I tried to encourage the actuaries of the health plans, or if I am working with associations or anybody is to stay, let's look at all the costs of mental health before and after parity, primary care, emergency room, psychotropic drugs, and specialists, and see what happens. [LB647]

SENATOR PIRSCH: Okay. Thank you. [LB647]

SENATOR PAHLS: Senator Carlson. [LB647]

SENATOR CARLSON: Thank you, Senator Pahls. Just one question. I appreciate your testimony, appreciate your background as an actuary. In the paragraph here where you indicate the premium increases by 0.6 percent to $1.85 per member. Then the next statement, for every 100,000 fully insured lives, out of pocket costs are estimated to drop by $780,000. Explain that a little further, would you? [LB647]

STEVE MELEK: Okay. So you are talking about the out-of-pocket costs? [LB647]

SENATOR CARLSON: Yes, and maybe you don't have it. It is our statement of intent that we are looking at here. [LB647]

STEVE MELEK: Okay. Yeah. I think I have it at 65 percent decrease in the insured out-of-pocket cost per member, per month, and if you look at a 100,000 population, that would reduce out-of-pocket cost by $780,000. Yeah. What is going on there is the drop in out-of-pocket cost for the insureds is because the copays are going down. The $50 per visit copay may be going down to $10, or the deductible may be going down. So with mental health parity, the health insurance plan is covering more, the insured member has to pay less. So there is a twofold impact on out-of-pocket costs. If we first looked at when you increase benefits and you reduce copays, the first thing that is going happen is utilization will actually go up because it is less costly for the insured. So if the insureds per 1,000 went from 300 visits to 350 visits, you would think out-of-pocket costs are going to go up because you have got more visits. But out of those 350 visits, if the cost out-of-pocket went from $50 to $10, well you just cut it by a factor of 5 and it

goes way down here. So you have got more visits at less per visit, so that drops the insured out-of-pocket cost because the health plan is now paying for that cost. So one aspect of that is the insured population will be paying less for their care for mental healthcare or for behavioral healthcare than they would have without the parity bill. Does that make sense? [LB647]

SENATOR CARLSON: Well, it does. And then I see that then there is the speculation that results in lower cost from the primary physician and that is where some of that is caught back really. [LB647]

STEVE MELEK: Yeah, that is the part that we wanted to mention in the report. There is some evidence out there that primary cost would go down, but we didn't really build it into the net results of our analysis, but we wanted to put it on the table just for an educational complete report. [LB647]

SENATOR CARLSON: Okay. Thank you. [LB647]

SENATOR PAHLS: Yes, Senator Christensen. [LB647]

SENATOR CHRISTENSEN: Thank you, Chairman Pahls. Steve, in here it exempted alcoholism and substance abuse. Could you show us a study how that would effect this the same way as having the under employees groups of 50 to the committees sometime? [LB647]

STEVE MELEK: Sure, and I think in our report we had included all behavioral healthcare parity and not just mental health, but we also presented a scenario by which if you only included mental health, at least in the report that I am looking at here... [LB647]

SENATOR CHRISTENSEN: Yeah, only mental health is what I see, but in the bill it includes alcoholism and drugs, so that would distort the numbers. So I just wondered if you could give us the information sometime. [LB647]

STEVE MELEK: Okay. Well, I think I have it here. [LB647]

SENATOR CHRISTENSEN: Maybe I missed it. [LB647]

STEVE MELEK: Our complete behavioral healthcare analysis, mental health plus substance abuse, that is the 0.6 percent number that I spoke of earlier. If you pull the substance abuse out of that 0.6 percent, because the vast majority of behavioral healthcare cost is really outpatient, mental health therapy, and medication management visits by psychiatrists and stuff, that 0.6 percent drops about by 20 percent, drops out to about 0.5 percent when you round it or so. But it is about 15 percent actually, I think. So

if it was going to cost you $2 per person, per month for full behavioral healthcare, it is going to be about $1.70 to exclude substance abuse. And I think the number is actually in here. It goes from $1.86...okay, actually got the PMPMs in here. I should have looked at them. From $1.86 to $1.76. So you don't save a whole lot but pulling out the substance abuse. [LB647]

SENATOR CHRISTENSEN: Okay. [LB647]

STEVE MELEK: Part of the reason for that is, is that there is a lot of comorbidities between mental health and substance abuse, too. So if you exclude substance abuse, unfortunately sometimes the healthcare gets delivered with the depressive or anxiety disorder so they get access to the benefits anyway. So I don't know that there is a lot of...I know there are other reasons to avoid substance abuse parity, but from a cost perspective, I don't think cost is the big driver. [LB647]

SENATOR CHRISTENSEN: Okay. Thank you. [LB647]

SENATOR PAHLS: Thank you. Appreciate your testimony, Steve, and like I say, if we have questions either ask you or Senator Johnson's office. [LB647]

STEVE MELEK: I would be happy to. Thank you. [LB647]

SENATOR PAHLS: Appreciate it. The next testifier would be Louise Jacobs, Louise, I am sorry. Okay. Well, Brad, Nebraska Advocacy Service(s). Brad, would you spell your name for us and you may begin. [LB647]

BRAD MEURRENS: (Exhibit 2) You bet. Good afternoon Senator Pahls and members of the Banking, Commerce and Insurance Committee. For the record, my name is Brad Meurrens, M-e-u-r-r-e-n-s, and I am the Public Policy Specialist and registered lobbyist for Nebraska Advocacy Services, Incorporated, the Center for Disability rights, Law, and Advocacy. I am here today to offer our strong support for LB647. We are pleased to see such positive projections coming out of the Milliman study. The study is consistent with the experiences of other states around the country that have instituted behavioral health insurance parity, that the increased premiums and costs, if any, associated with insurance parity are minimal, even under a mandated benefit scenario. And I have been asked today to bring some points and highlights about the federal legislation that is currently circling the Senate, right now, about mental health parity. And I will leave my abbreviated comments talking about (LB)647 for subsequent testifiers. But on the federal level, legislation has been introduced in the Senate to provide behavioral health parity for insurance plans that include behavioral health benefits, mental health and substance abuse, and it is Senate Bill S.558. Nebraska should not wait for action on the federal level. Nebraska must enact behavioral health insurance parity now. Although S.558 contains many of the same prescriptions as LB647, it differs from LB647 in

several significant areas. First, S.558 does not mandate that insurance plans contain mental health and substance abuse benefits. Rather, if plans provide mental health and substance abuse benefits, then those plans would have to equalize all the plans financial requirements. S.558 does not specify behavioral health conditions, but relies on state law for the definition, and Nebraska's law is insufficient. S.558 would not preempt state laws mandating coverage of behavioral health benefits, and states that elect through statute or regulation to adopt the federal standards would not be subject to preemption. This concludes my testimony this afternoon. I would be happy to entertain any questions the committee may have. [LB647]

SENATOR PAHLS: Do we have any questions? Appreciate the information you have provided us. Okay. Senator Gay. [LB647]

SENATOR GAY: You had mentioned other states have this? [LB647]

BRAD MEURRENS: Um hum. [LB647]

SENATOR GAY: Which states? [LB647]

BRAD MEURRENS: Well, at last count I think it was around 34 or 35 states, and there are states that have a more robust or comprehensive parity legislation. There are states who are in our sort of level which have the limited parity. There are some states, a few, that have lesser parity requirements, and then there are, I think, about four or five that don't have any...or actually maybe two or three that don't have any. Vermont, I think, is the state that, sort of, has led the nation in instituting comprehensive parity. But I can certainly get you that information with all the states and their different parity laws, not a problem. [LB647]

SENATOR GAY: Sure. Thanks. [LB647]

BRAD MEURRENS: Okay. [LB647]

SENATOR PAHLS: Thank you. Any other questions? Thank you, Brad, appreciate your information and your testimony. [LB647]

BRAD MEURRENS: You are welcome. [LB647]

SENATOR PAHLS: The next person would be Tammi Williams from the Nebraska association of the mentally ill. Tammi. [LB647]

TAMMI WILLIAMS: (Exhibits 3 & 4) My name is Tammi Williams and I live here in Lincoln, Nebraska, born and raised. I work in the city as an environmental health and safety engineer. I have a masters in public health and I work for a manufacturing plant.

Until about two years ago, if I ever thought I would be speaking in front of some state senators, I would have thought it would be on an environmental issue, but things changed and instead I am here as a member of NAMI Nebraska, the National Alliance on Mental Illness, and most importantly I am here as a mother of a teenager that we nearly lost two years ago because of her problems with depression and descent nearly into suicide. I have given you a copy of our story, it is a difficult one, and I am not going to go through it. I don't think I could, and it is too long to cover in this brief amount of time. But I urge you to read it, as well as the letter that comes from Ruth Few, the president of NAMI Nebraska. Those are the two handouts you received from us today. However, I would like to draw your attention to a few of the highlights in our testimony. My daughter was 17 when she became ill. She was a senior in high school here in Lincoln. Before that, she had been a very successful student. She was in the National Honor Society. She had been an officer in the student association, had a part-time job, lots of friends. But when her depression set in, she just gradually withdrew from everything. She quit working. It became harder to keep her going to school. Her grades plummeted, and we got her into treatment. We started, as you have heard this morning, with the regular side, going to her family doctor, and eventually made our way into the mental health practitioners field. Finally we reached the point where Lydia admitted that she was scared for herself, and as much as we were for her, because she just plain didn't want to live anymore and she was admitted to the hospital in February of 2005. We discovered upon her admission that she had actually started cutting herself, perhaps you have heard of self-injury as an attempt to relieve her inner pain. It is very similar to people that have troubles with other types of abuse, alcohol, drugs, or just some different forms of self-abuse, but it was one that was a little bit harder to treat. She was a very sick girl at that time. Over the next two months, she was hospitalized three times, and finally the doctors decided that Lydia needed to be placed in a residential treatment program. The first thing they told us was that our insurance wouldn't cover residential treatment. So they asked us to sign away our parental rights, to turn her over to the state. They said if you do that, we can get her into a treatment program. Well, I had paid close attention to our insurance. At my work, I had been told when I was hired that this, even though we are a manufacturing company, we manufacture in the healthcare field and we want you to have good healthcare for your family. In fact, that is one thing you should not have to worry about is healthcare for your family. So I told the doctors, well, I am not so sure about that. Let me go back and check my insurance. So I did. I went back and checked, yes, they did have coverage for residential treatment. The doctors started trying to place her, and they couldn't place her in Nebraska for various reasons as I cover in here, mostly no availability. Other reasons as well, but the biggest one was no availability. So they asked us again. We started looking outside the state, and the insurance started balking at that and they said, well, even though it was a national insurance plan, they said, no, she needs to go somewhere in Nebraska. Why can't she stay in the hospital where she is here at Bryan LGH and their CAPS (CAP) program. That program is just meant to stabilize very ill people, and she had already been there most of two months. So once again, the doctors asked us to turn custody

over. This was the second time. Make her a ward of the state. They told us that one of these facilities would have to take her as soon as a bed came open if we would make her a ward of the state. Well, by then we weren't so sure we wanted to because after hearing from these facilities, we thought, they don't really have a program for someone quite as desperately ill, suicidal, and especially self-injuring as our daughter was at that point. So we said, no, we want to find better treatment for her. The doctors said, well, we have tried. They told me, the child's psychiatrist that works for the CAPS (CAP) program, that my insurance was the most difficult they had ever worked with in her long history with the state and with working with insurance. She said she honestly didn't know what to do. So, at this point, I took a leave of absence from work. Now you have not only one person nonproductive in the state, but another paid employee, and I began working the phones. I started calling our insurance company saying, you know, your books say this. We can't get treatment here. Let's take her outside the state, and I got nowhere. So I went back to my human resources manager. She called our corporate offices in New York City. Finally I was put in touch, after nearly two weeks, with the corporate person who managed the contract with this national healthcare company, and was responsible for hiring the company. I should backup and say that our company was self-insured. They simply hired this other company to administer it, and this person was in charge of that self-insured contract. So this person intervened with our insurance company and authorized them to cover my daughter's treatment at any treatment facility in the U.S. that our doctors approved of. Of course, it had to be a licensed facility, recognized by the doctors as a good one, and finally she was approved to go there. This was after almost two months of fighting to get treatment, two weeks off work on the phone, and three different requests that we turn her over to the state. Well, in the end, we ended up getting her into treatment, first in Arizona for a treatment program that covered depression, and after Lydia had been treated for already eight weeks in the hospital, another six weeks at that facility, she finally began to respond to the treatment, and began to feel a little hope, and actually started wanting to live again. By the time she was ready to come home from there, Lydia was well recovering from her depression. However, the self-injury is quite addictive, and she was very addicted to it, and not ready to give that up. So her treatment team recommended another placement in a self-injury program in Chicago, and we did manage to get the approval for that, and Lydia was treated there for another four weeks. She came home successfully treated for that in June of 2005. That has been nearly two years ago now. Lydia has been out of the hospital since then. She has been recovering. We believe that without this good treatment paid for by our insurance, she very well might have ended up in the Regional Center with no desire to get well, had she even lived through it. We did go through two suicide attempts during this time. And I feel like I am here despite my insurance, rather than because of my insurance, and there is a number of reasons that I would like to speak in favor of this bill today. Despite my company's excellent insurance, we couldn't get approved treatment for Lydia until I took time off work, and enlisted the help of our corporate HR director. I have made a list here of all the things that my daughter missed out on because of her illness. Probably the hardest one was that it was her senior year

and she missed her graduation. But she did manage to finish school and she did graduate. She has come home and she slowly got well. For the first month she didn't do much of anything, but then she went out. She got a job. She still has that job a year and a half later. After another six months of working, she started back to school, and she attended Southeast Community College last year for two quarters, and then this last fall she attended at Union College. She is not attending this semester. She is taking a little break, but she has completed a year of college in the year and a half that she has been out. My point here is that the treatment does work. It saves everybody money, as you have heard from the previous testimony. And to echo the second speaker, Senator Jensen, it is simply the right thing to do. Thank you. [LB647]

SENATOR PAHLS: Do we have any questions? Tammi, I just have a question. You said you went to two out-of-state facilities. Is it because Nebraska had no facility to offer you help? [LB647]

TAMMI WILLIAMS: Nebraska had facilities that would treat depression. Most of them were full. The very good ones we tried to get into, they had waiting lists. They did not have a good program for self-injury at that time, at least not that we could find. And it was complicated by the fact that she was 3 months shy of 18. But I remember one facility saying, well, they really felt that her self-injury and suicidality problems were so great, they didn't want to expose the other adolescents in the program to her. They were afraid that she would be a bad influence, I guess. I don't know. But yes, we felt that there was a lack of available treatment in Nebraska, lack of beds. [LB647]

SENATOR PAHLS: Okay. Did you feel that you were treated adequately by the personnel when you talked to them? [LB647]

TAMMI WILLIAMS: At the hospital? [LB647]

SENATOR PAHLS: Right. Did they say we can't help you, I mean, were you... [LB647]

TAMMI WILLIAMS: Most of the time, yes. Actually the worst treatment that I got was from my daughter's case manager from our insurance company back in New York City who, when the first time I spoke to her, demanded to know how I got her phone number and wondered why I called. She said she only talked to doctors, not to parents and would I please not call her again. That was when I got my corporate human resources people involved, and the staff here treated us very well. At first I felt they didn't communicate very well, but I think it was more just they were used to parents not asking questions, and when my husband and I made it clear that we would ask questions, they opened up quite a bit. My daughter still has the same psychiatrist that she was assigned the first day that she entered CAPS (CAP). So I was pleased with them. [LB647]

SENATOR PAHLS: Well, thank you for your testimony and for being a good mom.

[LB647]

TAMMI WILLIAMS: Thank you. [LB647]

SENATOR PAHLS: The next testifier is Tom McBride. [LB647]

TOM McBRIDE: (Exhibits 5-8) Good afternoon, and I certainly appreciate the opportunity to testify. My name is Tom McBride, T-o-m M-c-B-r-i-d-e. As you were making introductions, I guess what I would say is I am from York, home of the water tower that looks like a hot air balloon (laughter). You are going to have a tremendous amount of testimony, and studies, and it isn't my intent to belabor anything. I am here representing the Nebraska Association of Behavioral Health Organizations, Nebraska Psychological Association, Nebraska Hospital Association, Children and Family Coalition of Nebraska, and Epworth Village, of which I am the executive director. You know it has been said that mental health, that this is not just a mental health issue with the mental health parity issue, but it is a public health issue as well. And I believe that mental health parity, we have been looking at this for a number of years, that we can use that to enhance the service delivery to those people within our state, that we can reduce cost associated to the state, via Medicaid. I would point you toward, in my written testimony, a study in the March 30 issue of the New England Journal of Medicine by the Department of Health and Human Services on the federal level, and what they did was they commissioned a study to look at seven large federal employee health benefit plans. They started parity of January 1, 2001. This was an 8.5 million covered lives. Twenty thousand of those, and each one the seven various benefit plans, they compared them to a matching group. It entailed looking at benefits, enrollment, medical, pharmacy, mental health, substance abuse. Five of those seven plans saw significant reductions in out of pocket spending. One saw a small increase, and own demonstrated an increase a little larger than that probably because they didn't have a managed care carve out in that. What they saw was overall growth in the use of mental health and substance abuse services, and spending was similar or less than the other compared private insurance populations. Pam Greenberg, who is the executive director of the American Managed Behavioral Health(care) Association, said this study takes away our opponents concerns that parity will increase cost and cause disruption in the marketplace. One of the things that as a not for profit agency, basically we are a small business. We have to operate like a business. About 11 years ago, we were interested in our healthcare policies, and plans, and the costs, and we opted to go the route of a self-insured plan that falls under the ERISA rules. And it has been a very successful plan for us. Every year we bid that out trying to get the best bang for our buck, and so we are always looking each year of tweaking our coverage a little bit making it a little better for our employees, and we are very close to mental health parity within the current plan we have, and we are very happy with the premiums and the response, the coverages that we have. I asked our current administrator if we went with from where our plan is now to full mental health parity in the 2008 contract, what would that do to

the policy, and their response to me was that you are very close to having parity as it is, but increasing that would be a total of one-half of one percent. Which, with Mr. Melek's testimony, is very close to what in his actuarial studies what he was seeing. I did some quick figuring on this, and for 150 covered lives, it amounts to $3,698.62, and that is with almost $250,000 in premiums and almost $500,000 in expected claims. Twenty-four dollars and sixty-six cents, per year per covered life, and I think that is a pretty tremendous investment. I would concur that with various studies I have read. They are in my written testimony and referred to at the end of that testimony, that without mental health insurance, I think, studies I have looked at go from $85 billion to $150 billion a year that the United States loses by loss of productivity and mortality. And I believe that Nebraska can lead the way with the introduction, with the passage of LB647. And with that, I know that there are a lot of people left to testify, I would answer any questions. [LB647]

SENATOR PAHLS: Do we have any questions for Tom? Thank you, Tom. [LB647]

TOM McBRIDE: Thank you. [LB647]

SENATOR PAHLS: What I need now, this completes my list here, I need a show of hands of how many proponents? I see one, two, three, four, five, six. Okay. Come on up Mrs. Anderson. [LB647]

LYNNE ANDERSON: (Exhibit 9) My name is Lynne Anderson, registered nurse. I am here today representing NNA, Nebraska Nurses Association. Nebraska Nurses Association represents over 20,000 registered nurses in this great state of Nebraska. We don't have our own water tower, however, and we are here to testify as a proponent for LB647. For too long, effective and comprehensive mental healthcare has been excluded or discriminated against by the health insurance industry. Not to put down the health insurance industry. That is a huge economic driver for Nebraska. It is human nature, it is common for all of us to be fearful, and exclusionary of those persons and conditions that we do not understand. In the medical field mental illness and substance abuse are no longer unknowable or untreatable diseases. They strike the rich, the poor, and all of us in between. Many of us have family, friends, neighbors, or coworkers who have suffered from a mental illness, and I include substance abuse in that description. The general population is not able to recognize those who have been appropriately diagnosed and successfully treated. Why? Because as a rule, people with mental illness don't go out talking about it because it is still considered shameful or a stigma to carry such a diagnosis. Cancer carried the same stigma before there was successful early diagnosis and treatment. People used to not admit that they had cancer. It would be some sort of other type of disease. We need to move mental health to the same category, and make early diagnosis and successful treatment readily available. Providing insurance coverage parity for mental healthcare and substance abuse treatment is a good start for that. At the national level which you just heard about,

mental health advocates, insurance companies, business groups, and those include: America's Health Insurance Plans, the National Retail Federation, the National Alliance on Mental Illness, and the U.S. Chamber of Commerce, support legislation mandating that both mental and physical illness be treated with similar benefits. Those of you who wish to read a little about that, it appears in the Wall Street Journal, February 13th, the day before Valentine's Day issue, entitled "Mental Health Nears Parity," that is the national level. Passage of LB647 would level the playing field and allow fair share of costs to be borne by our health insurance carriers instead of by Nebraska taxpayers. Currently, if a person requires mental healthcare and cannot pay for the care, the responsibility ultimately falls on Nebraska's state programs. Not only is this unfair to Nebraska's taxpayers, but the cost of care, at the time of advanced disease, is much more expensive than if the illness had been diagnosed and treated early. And I think you heard a good example of that with this lady who did have health insurance that would cover, but the difficulty it was to access that coverage. I will give a personal example of the successful treatment of mental illness. I have had cancer, so it was not me. I got the cancer bit. But a close friend of my family is very bright, very well educated. She has got a master's degree in nursing, and very personable. About four years ago, she had an episode of previously undiagnosed bipolar disorder that led to delusions, hallucinations and the wild spending of money. This led to her arrest and incarceration. Our jails hold many of our mentally ill. And then subsequent diagnosis and successful treatment in jail, early treatment. So I really have to commend the prison system. It did finally make the diagnosis after she had been in jail, in horrible conditions for at least four months. She was known by the other inmates as crazy, and finally the jail personnel also recognized that. She was treated with Lithium. She became then aware of what was really going on, which really upset her because now she knows she has got a bad disease. After using all of her assets, she was released from jail actually to the custody of my husband and I, but after her using all of assets to pay off the accumulated debt, which was about $250,000. She has been able to undergo successful treatment, return to work as a nurse educator. She is now happily married, has her own home, and if I brought her in the room with me today, which I would have done, she agreed to come, except she is working, you would not see that there is any difference with her and the rest of us, many of us here in this room. She is now working full-time and paying taxes. She continues on medication and now sees her psychiatrist only every two to three months. She is getting good care. This is what successful diagnosis and treatment is all about. It is taking people who just if they had another type of disease, heart disease, cancer, whatever, diagnose them early, treat them early, we get successes and they continue or go on to be contributing members of our society. LB647 can move Nebraska faster to this goal, and we urge the committee to advance it out of committee. Thank you very much and I would be happy to entertain any questions you might have. [LB647]

SENATOR PAHLS: Senator Gay. [LB647]

SENATOR GAY: I have got a question, Lynne, you have first hand knowledge sharing that story with us, appreciate that. Earlier I asked a question of the actuary, and a professional nurse you should help me with this but is somebody, in this lady's case she had delusions, hallucinations, and some of those things, took the extreme case to be incarcerated before somebody said, hey, she has got a problem. It goes back to the point, insurance or not, is the medical community coming together and a primary care physician realize, gee, this is not really what I can cure. Are they working together? Because I do not care if you have insurance or not, some people just will not go seek treatment. But in your professional opinion, what is going on in a short summary that they are...even if we do this, are they working together? [LB647]

LYNNE ANDERSON: Right. Okay. What happens if we do it? The big picture is just as people with cancer who would not even see a doctor because cancer meant you were going to die. We bring this out, insurance covers it, it becomes part of the mainstream, your brain now is part of your entire body. People are better trained because as we heard, we have a shortage of psychiatrists. Why? Because psychiatrists have trouble making a living because people cannot afford to go to the psychiatrists. It is kind of a negative reinforcement. But if we move this forward, it becomes less of a stigma, more people are successfully treated. When they are successfully treated, they will talk about the fact that they were successfully treated. It gives people hope that there is hope, and they will, and their families or whoever see these behaviors can encourage them and get more of them to be seen. As that happens and the stigma is off, we get much better research, which gives us better diagnosis, better treatment. So it is all a positive reinforcement cycle. And no, it doesn't solve every problem immediately, but it puts us in the right positive reinforcement to solve it long term. [LB647]

SENATOR GAY: Thank you. [LB647]

SENATOR PAHLS: Thank you for your testimony, Lynne. Thank you. [LB647]

LYNNE ANDERSON: Thank you. [LB647]

SENATOR PAHLS: Be sure you spell your name, please. [LB647]

CHERYL CROUSE: (Exhibit 10) I'm Cheryl Crouse, C-r-o-u-s-e. This is my service dog, Hercules. Good afternoon, Senators. I would like to speak in favor of bill (LB)647. I am a person who has had mental illness for the past 25 years. There were some years that I did not need medication or therapy, in the beginning. But as I have grown older, the need for therapy and medication management has been needed more often. At this time, I need to see my therapist at least once a week, and my psychiatrist once a month. My insurance allows me 25 visits per year between my psychiatrist and my therapist, that is all, and I must pay 40 percent of the cost, and they pay 60 percent. After those 25 visits, it all comes out of my pocket. As of today, in 2007 I have had 11

visits--that is, ten to my therapist, costing me $360; and one to my psychiatrist, costing me $90. May 1, I will run out of mental health benefits. Will I still need care? Yes. What would happen if I do not go? Probably suicide at some point. Right now, I actually need more visits, but my therapist has me e-mail her twice a day so that she knows how I'm doing. I attempted suicide last August, after my father, my only sister, and my daughter all disowned me within two days. I was so devastated that I could not see any reason to continue living. Life was just black. So to keep close tabs on my moods, my therapist has me e-mail her with my feelings and my moods twice a day, so that she can catch a mood swing quickly. Most therapists would never do that for their client for free. Kaye cares deeply and does what she has to do for her clients. But can she treat me for free after May 1? No, she can't. She deserves to be paid, just like you would want to be paid. My mental illness has kept us poor. We should be at a place in our lives where we would have a tidy nest egg toward retirement, but we are over our heads in debt. My prescriptions for my psychiatric medications run about $1,000 every three months, and that is with insurance coverage. After May 1, my mental healthcare will cost us $480 a month. My physical insurance pays quite well. For office visits, we pay only $25 per visit if the physician is in network and if the visit is preventative, diagnostic, or to a specialist. If it is out of network provider, I have a $300 deductible and must pay 40 percent of the fee. My annual out-of-pocket maximum is $2,250 per year. My mental health will come to $4,834, approximately, this year, if I only see my psychiatrist four times during the year for a 15-minute medication checkup. If I need to see her more often, it will skyrocket far past that. Where is the equity? I have no out-of-pocket maximum on my mental health coverage. Is mental health less dangerous than my medical health? No, it's far more dangerous. The last nine months have been a nightmare for me that just never seems to stop. I've been suicidal more than I've not been suicidal. I try to stay out of the hospital, because my insurance only covers 80 percent of that, and time on a psychiatric ward is very expensive, and I've had very traumatic experiences on a psychiatric ward. I'm safer at home. My psychiatrist and therapist agree with me. Please, pass this parity bill. I need parity in mental health. We need parity in mental health in Nebraska. The time is now. If you wish to discuss this more with me, I would be glad to. Do you have any questions? [LB647]

SENATOR PAHLS: Do we have any questions for Cheryl? Seeing none, thank you for your testimony, Cheryl. You are making us think. Thank you. [LB647]

CHERYL CROUSE: Thank you. [LB647]

DIANNE SWANSON: (Exhibit 11) Good afternoon. My name is Dianne Swanson, S-w-a-n-s-o-n. I have a story to share that has some similarities to Tammi's, but you will see it has a very different ending. The emotional toll on a family that has a person with mental health concerns is huge. As parents, our lives revolve around our 16-year-old son's need. Last year, his obsessive-compulsive disorder had grown so serious that we tried not to leave him alone. He needed someone there to coach him through all his

episodes, even though we didn't always know what to do. The struggles our son had, first with his obsessions and compulsions, followed by outbursts of anger that sometimes became rage at the situation his life had become, kept our daughter, then a senior in high school, out of the house whenever possible. It was only after he had been admitted to the Menninger Clinic in Houston, Texas that we saw how dramatic stress on the family had been. It had affected all relationships in the family in a negative way. Almost immediately, our daughter started staying home throughout the evening. My husband and I had time to talk. The house was much quieter, because no one was in the middle of a fit of anger. We no longer had to have multiple contacts per day with his school. There was so much relief, because we had a break from our daily lives, and we knew he was in a place that we could help him, if anyone could. We looked forward to a time to heal the family while he was being helped in Texas. Our son's therapist and psychiatrist recommended inpatient treatment. We had looked first at any option we heard of in-state, followed by a national search. We had been turned down by in-state facilities because of the complexity of his case. We found there are only two places in the country that have care for adolescents with severe OCD, and only one is considered inpatient. Since insurance would only cover inpatient, our decision was made. We had reached the point where medication, therapy, and day-patient hospitalization were not enough to help him. In January 2006, our son agreed, desperately, to go to the Menninger Clinic. We took out a second mortgage on the house so there was plenty of cash on hand, since the Menninger policy is payment in advance. We weren't sure how much coverage our insurance company would provide for an out-of-state hospital. We were not prepared for what was to come. According to our insurance policy, and following the current Nebraska law, obsessive-compulsive disorder is one of the six serious mental health conditions identified with equal coverage. Preadmission certification was not approved by our insurance until our son was seen by the Menninger doctor first. We were shocked to find that his certification was denied by insurance, not because of his OCD diagnosis, but because they felt his illness was not serious enough to warrant inpatient treatment. The overwhelming stress returned, with almost daily contacts with insurance, as well as many phone calls to therapists, Menninger staff, and any source we thought might be a financial option to help us fund our son's stay in Texas. After the two allowed appeals, we were given a total of six weeks of reimbursement. We knew our son would not be staying the additional four months the doctors recommended. He was discharged the end of April because we had only two weeks of our $80,000 loan remaining, and Menninger wanted us to save that money for future medical expenses, because they were feeling very sure we would need that again. Our family is comfortable financially, compared to many. I cannot imagine how difficult it would be to see a child or a spouse struggle with a mental illness and not have the financial resources to help. Our costs are ongoing, with at least weekly visits to the therapist, psychiatrist visits, and many medications our son takes on a daily basis. Another long-term hospitalization for our son will mean he would need to use all his college funds, plus probably apply for disability to cover costs. There is no question in my mind that insurance should include coverage for mental health, as well as

physical health. There is a stigma for many that is associated with getting help for a disease that they feel they should be able to control without help. It is only made worse by the fear that the cost for treatment would be so high they cannot possibly afford to even seek treatment. My husband and I made contacts with at least 30 agencies, health facilities, and mental health organizations last year, trying to find some potential source of help or funding for our son's hospitalization, so we could keep him there longer, as well as aftercare that Menninger staff felt we would need. We found a great deal of surprise on the other end of the phone at the questions we asked that they could not answer, and the number of contacts we had already made that somebody would suggest we try. This told us how many people in our situation must feel that their hands are tied, and they give up much sooner, probably out of a lack of confidence or social resources to help them through such a search. Nebraska laws should be written in such a way that coverage for mental health problems is guaranteed, and there is no opportunity for an exception to allow insurance companies to not carry through on the financial help the policy promises, as our provider did. This bill would be a first step. But to be really effective, we need to strengthen other parts of Nebraska insurance laws, as well. Thank you for allowing any citizen of the state to testify on issues they feel strongly about. I'd be happy to answer any questions. [LB647]

SENATOR PAHLS: Do we have any questions? Seeing none, I thank you for your testimony. [LB647]

LESLIE BYERS: (Exhibit 12) Good afternoon, Senator Pahls and members of the committee. My name is Leslie Byers, L-e-s-l-i-e, Byers, B-y-e-r-s, and I am the family liaison at Uta Halee-Cooper Village, as well as a mother of a child who has experienced the mental health system across Nebraska since she was seven years of age. Today, she is 21. Although she originally began manifesting symptoms of her illness that was finally diagnosed at age ten as bipolar disorder, but she began originally manifesting symptoms of her disorder at age two. I am in definite support of LB647, because I believe it makes good economic and compassionate sense. Both my husband and I are college-educated professionals and have good careers. As a result, we have been able to obtain health insurance through our employers. However, we have learned over the years that there is a major disparity between the mental health benefits versus the medical health benefits for our daughter. For example, upon my daughter's first inpatient hospitalization at the age of eight, this was her first suicide attempt, she had to be released before her doctor felt she was ready, because we'd reached the maximum number of days that they would allow for a psychiatric inpatient hospitalization stay. My daughter was suicidal, but they were releasing her home. In addition, we soon found out that there was a limit on the number of annual outpatient therapy sessions we could have. As the previous speaker had mentioned she needs hers weekly, my daughter needed hers weekly, as well, a lot of time. Her insurance allowed twice a month, and that included both the therapist and the psychiatrist. That obviously was not enough. These restrictions resulted in my daughter not receiving the adequate level of care she

needed, based on the severity of her illness. Therefore, she progressively got worse. Then in 1996, at the age of ten, we maxed out our daughter's not only annual, but lifetime inpatient psychiatric mental health benefits. Can you imagine? We just had no opportunity when she went into a crisis, when she went into a rage, when she was suicidal. We could not, even though the doctors wanted to, needed to treat her inpatient, we could not have that service. Therefore, our only option to get the treatment she needed was to take the advice of her psychiatrist and other mental health professionals, and turn to the juvenile courts to grant access for services. As Tammi had mentioned, they were told many times by the professionals that, you need to relinquish custody of your child. Well, I wish my story was like Tammi's. I wish we were able to advocate and get for the services early. It took eight years from initial onset of the symptoms to the proper diagnosis. Even then, we couldn't get the inpatient residential treatment that she needed, because our insurance wouldn't provide it. So we did succumb to the advice of the professionals, and she was made a state ward. My husband and I thought we were doing the right thing with this decision, but we soon found out how limited our ability to be a part of our daughter's life became, and how limited we were in the decision-making process of her treatment, and how limited we were in just being able to maintain the health and wellness of our family. I believe this only serves to further harm and risk the preservation of families. As a business professional, I often wondered why kids with mental illness are served through the courts. My daughter was never charged with a crime, nor were her father and I ever neglectful or abusive, so it didn't make sense to me as to why we had to get involved with the courts simply to get mental health services for our child. I certainly don't believe that...nothing against judges and attorneys and so on, but their primary expertise is not mental health. I can't help but think that having my family involved, my daughter involved in the court system simply to receive mental health services is putting undue and additional burden on the courts and the taxpayers. Bottom line, my daughter had to get to the severest stages of her illness, she had to become a severe danger to herself and others, before she finally received the appropriate level of treatment, but of course, that meant we had to relinquish custody, rather than getting the adequate services earlier. I can't help but believe, if she'd gotten the services when she was...the proper services, when she was six, and seven, and eight, and nine, and ten, and eleven, and so on, that she wouldn't have been in two inpatient residential treatment settings, she wouldn't have had seven inpatient hospitalizations in an eight-month period, she wouldn't have had to suffer as long as she suffered, our family would not have had to suffer as long as we had to suffer. And as was previously testified by the nurse, the costs at this stage of the most severest needs, my daughter also not only was very suicidal, she was also a cutter, that's the highest level of cost that the state is paying for. So I believe that when we can get the right treatment early on, early intervention, then we are saving money for the health insurers, we're saving money for the taxpayers. Thank you for your time, and I'd be happy to take any questions. [LB647]

SENATOR PAHLS: Senator Gay. [LB647]

SENATOR GAY: Leslie, thank you for coming today and sharing that with us. I missed the first part of it, but you mentioned some things that kind of struck a chord with me. One was, prior to this, I was a county commissioner and dealt a lot with juvenile justice, and we had always, for 12 years, said, go get money from the parents, go get money from insurance, do whatever, and your case is an example of what we're looking for, but if it's not there. [LB647]

LESLIE BYERS: Well, can...? [LB647]

SENATOR GAY: So I had a note to write...to check with our juvenile court judges to see how many cases where, you know, the taxpayers wouldn't have to forego, parents would be happy to. Kids get in trouble. Kids usually can have other cases that are leading to that. But I appreciate you, I just wanted to say, appreciate you coming here today and sharing that with us, because it kind of reinforces what I've been going back for, and it's nice to share that with us. Thank you. [LB647]

LESLIE BYERS: Let me respond to that in the sense that, when she was made a ward of the state, the statute is what was called a voluntary placement. Through no fault of the family members, the child is a danger to herself and others. That does not change how you are treated as a family. You are put into the system, you are lumped into a category of parents that has a child that's a state ward, so the automatic assumption, default assumption across the board by the judges, the attorneys, guardian ad litem, case managers is, you must be the problem and we need to protect you from your child. That's why I say it really harms the preservation of the families. But what I found very interesting was, when she was first placed into the system, the first thing the case manager said to my husband and I was, well, does she need any clothes, we can get a voucher. And we said, no, we're going to pay for her clothes, we'll pay for all of her medical needs, we'll pay for all of her orthodontic, all of everything she needs except what our insurance won't cover. We did also pay child support. And so I think the...in that case, the state is not managing that relationship with the families. But I think, bottom line, there needs to be a better partnership with the families and the professionals, but not through the courts. [LB647]

SENATOR GAY: But they deal with this quite a bit, quite honestly, because one thing leads to another, and that's where people end up. Your case is different than a lot of others. But thank you. [LB647]

LESLIE BYERS: Thank you. [LB647]

SENATOR PAHLS: Any more questions? Thank you, Leslie. Appreciate your testimony. [LB647]

KATHY HOELL: (Exhibits 13-14) I'll get there eventually. Thank you. Hello, Senators. My name is Kathy Hoell, it's H-o-e-l-l, and I'm actually here representing The Arc of Nebraska and the Statewide Independent Living Council. You've heard all kinds of really good testimony about why parity is important to us. To avoid redundancy, I'm not going to repeat it. But our two organizations very strongly support the idea of parity in the state of Nebraska. And the only one point that I would like to make is, there has been a proven coexistence of physical disabilities and behavioral health issues, whether it's substance abuse, depression, or whatever it is. And a lot of times, when this happens, if you have a physical problem, it's hard for you to get treatment for a behavioral health problem, because your insurance will not pay. I can go to any hospital I want in the country and get treatment for my physical problems, but behavioral health would be a totally separate issue. And so I just really urge you to pass this on to the floor, because we need to have parity in Nebraska. I'd be glad to answer any questions. [LB647]

SENATOR PAHLS: Okay. Do we have any questions for you? Thank you. It was good to see you again, Kathy. Thank you for your testimony. Do I see any more proponents? Could I just have a hand of those who have yet to speak? Proponents. Okay. Then we are ready for the opponents. Just have you come forth, please. You may begin. [LB647]

JENI ALM: Good afternoon, Senator Pahls and members of the Banking, Commerce and Insurance Committee. My name is Jeni Alm, J-e-n-i A-l-m. I am the director of group insurance products for Blue Cross and Blue Shield of Nebraska. I've been asked to testify today because of the negative impact this legislation will have on the small employers, should it pass. LB647 would have a significant impact on the insurers' small group market. We estimate that premiums in the small group market for employers with 1 to 50 employees will go up 2 to 5 percent. We will not know the full extent of the premium impact with the expansion of the drug and alcohol coverage, however, until this bill is played out. For every 1 percent we raise insurance premiums nationally, between 200,000 and 400,000 individuals will become uninsured. Currently, 11 percent of Nebraskans are uninsured. That number will definitely increase if this bill is advanced. With the significant national effort to insure all people, this bill goes against the grain of what we're all trying to accomplish. Currently, 46.6 million Americans are uninsured. Experts predict the number of nonelderly uninsured Americans will grow to 56 million by 2013. Last year, Senator Hagel commissioned a healthcare working group to study the current state of healthcare in the nation. The number one recommendation from this group was that all Americans have a basic health plan. The number six recommendation was that Americans have choices in the selection of their healthcare. If you allow this bill to advance, you're effectively limiting healthcare choices for your constituents, because the language of the bill covers all group plans that are not exempted by ERISA. This will be mostly the small employers in the state. This means that all small group plans will look the same. If they are all the same, there is no chance for a small employer to shop around for plans and choices that lead to better rates. Currently, Blue Cross/Blue Shield of Nebraska does offer some plans without mental

health benefits, so that our customers have choices and the opportunity for lower premiums. With national estimates that healthcare insurance will increase significantly over the next five years, please seriously consider if an additional mandate is the best way to address this situation. Blue Cross and Blue Shield of Nebraska already provides coverage, mental health coverage, for serious mental illness. Serious mental illness includes schizophrenia, schizoaffective disorder, delusional disorder, bipolar disorder, major depression, obsessive-compulsive disorder, and any mental health condition caused by a biological disorder of the brain that substantially limits the life activities of the mentally ill person. We also provide coverage for substance abuse with a contract limit of $10,000. Please consider that the enactment of this bill will further increase the cost of providing insurance to all Nebraskans. LB647 is asking you to extend this coverage to any mental health condition that falls under the Diagnostic and Statistical Manual of Mental Disorders, or the DSM. If this bill advances, you will force small employers to cover things such as circadian rhythm sleep disorder jet lag, a type of disturbance in the sleep cycle due to a new time zone; occupational problem, job dissatisfaction and uncertainty about career choices; or religious or spiritual problems, distressing experiences involving the loss or questioning of faith. These are just a few examples of the broad category of issues covered by the DSM. In conclusion, please strongly consider how this bill will affect health insurance accessibility in Nebraska. Again, according to our analysis, this bill will increase premiums from 2 to 5 percent for the small employer. This is a conservative estimate with the unknown impact of expanded substance abuse coverage. Thank you for your time and consideration of this matter. I'd be happy to entertain any questions. [LB647]

SENATOR PAHLS: Senator Carlson. [LB647]

SENATOR CARLSON: Senator Pahls. Jeni, when you first started your statement, you indicated that a 1 percent increase in premium would result in 200,000 more uninsured? Did I get the figure right? [LB647]

JENI ALM: Nationally, correct. [LB647]

SENATOR CARLSON: Could you expound on that a little bit, where that comes from? And oftentimes, we hear figures that are scary figures, and maybe you know, maybe you don't, but if you do could you tell a little bit about where that comes from? [LB647]

JENI ALM: Yeah, the source of that statistic was from the Lewin Group, and the study was "Effects of State Reforms on Health Insurance Coverage of Adults." I don't have the copy of the study in front of me, but I'd be happy to provide it if you would like to see more. [LB647]

SENATOR CARLSON: Okay. Thank you. [LB647]

SENATOR PAHLS: Jeni, I would ask you to provide that for us. That would be... [LB647]

JENI ALM: Okay. [LB647]

SENATOR PAHLS: Senator Carlson...Senator Christensen. [LB647]

SENATOR CHRISTENSEN: Thank you. Do you offer the policy like (LB)647 to anyone that wants to buy it to the side, if it isn't offered by an employer? [LB647]

JENI ALM: We do. We have several plans that have full parity type endorsements on them. We provide insurance for several large employers, specifically, that have very similar to these full parity plans, with the possible exclusion of substance abuse. Most employers do not cover substance abuse at full mental parity. [LB647]

SENATOR CHRISTENSEN: So does it take the employer to be willing to offer this to the people to purchase it, to decide if they want it? Or is that more of an option on your end? [LB647]

JENI ALM: Well, we cover...we will offer benefits whatever the employer wants to pay for. So we can price whatever benefit they are willing to purchase to pay for their employees. What we are most concerned about with the passage of this bill is that we would no longer be able to offer the choice to those smaller employers who did not want to cover mental illness, and who would be able to save some percentage off of their premiums. [LB647]

SENATOR CHRISTENSEN: So if I have Blue Cross/Blue Shield insurance, and my employer didn't offer this insurance to me, parity, can I ask him, the employer, to buy it to the side? [LB647]

JENI ALM: Well, it wouldn't an additional just for you; it would be across the entire group policy. [LB647]

SENATOR CHRISTENSEN: So everyone would have to be willing to pay for it then? [LB647]

JENI ALM: Correct. But we do offer individual policies that would cover mental illness, as well. [LB647]

SENATOR CHRISTENSEN: But then how is that cost compared to this? [LB647]

JENI ALM: Well, this bill does not address the individual policies, as you know. Typically, the individual policies would be more expensive, because there's not the giant

pool that we pool all of our employer policies through. [LB647]

SENATOR CHRISTENSEN: Okay. Thank you. [LB647]

SENATOR PAHLS: Senator Pirsch. [LB647]

SENATOR PIRSCH: There's a total universe of mental illness problems. A number of years back, we, the Legislature, had apparently passed...allowed for coverage of...required mandatory coverage of a number of different serious mental illnesses, including schizophrenia, schizoaffective disorder, delusional disorder, bipolar affective disorder, major depression, and obsessive-compulsive disorder. In the total universe, number of cases, I guess, how...what percentage of those cases would be composed of these...those elements I just read? [LB647]

JENI ALM: Unfortunately, I don't have the exact percentage in front of me. I did do an analysis of the mental parity bill back in the late nineties when that first came around. I'm formerly a member of our actuarial department at Blue Cross, so I was involved in the analysis of that. And at that time, about 40 percent of all costs associated with mental illness came from one of these...the six serious illnesses. Since then, though, it has been expanded to cover any illness that's seen as detrimental to the life activities of the person, so that would probably encompass another large percentage. But what that number is, I couldn't tell you off hand. [LB647]

SENATOR PIRSCH: I'm sorry, it's been expanded, the mandatory coverage has been expanded from those I read? [LB647]

JENI ALM: Yes. And I believe the exact language is, any mental health condition caused by a biological disorder of the brain that substantially limits life activities of the mentally ill person. So it's not just those six areas anymore. [LB647]

SENATOR PIRSCH: So that would seemingly bring it even to a higher percentage. And I know a lot of this is by extrapolation. [LB647]

JENI ALM: Correct. [LB647]

SENATOR PIRSCH: This was quite a little while ago. But could you just comment briefly upon the effect then of this mandatory coverage upon your industry? When this went into effect, did it cause any ripples, any problems? [LB647]

JENI ALM: A lot of employers took action before the bill went into effect by heightening copays on some of these disorders. The main concern across everybody was the increased utilization that we would see by covering these the same as any other illness. As a result, the primary care copays in many circumstances were raised, that we didn't

have the $5, $10 office visit copays that we had 5-10 years ago. We now see more the $20, $25 office visit copays standardly. So that was a front action that the employers took, was to raise the basic copays across the board, to circumvent those costs. [LB647]

SENATOR PIRSCH: Did you experience a drop in those number...total number of individual covered under these type of policies as a result of that? Or do you know off hand? [LB647]

JENI ALM: Not off hand I don't know. You know, the uninsured market is highly difficult to study, because we don't know exactly why people are uninsured, if it's lack of accessibility to their employer healthcare, or too high of a contribution, self-employed. So we have a hard time putting our finger on exactly why and how many of those were uninsured as a result of the mental parity bill in the nineties. [LB647]

SENATOR PIRSCH: Okay. Thank you. [LB647]

SENATOR PAHLS: Seeing no more questions, thank you, Jeni, for your testimony. [LB647]

JENI ALM: Thank you. [LB647]

GALEN ULLSTROM: (Exhibit 15) Senator Pahls, members of the Banking, Commerce and Insurance Committee, for the record, my name is Galen Ullstrom. That's G-a-l-e-n U-l-l-s-t-r-o-m. I'm senior vice president and registered lobbyist for Mutual of Omaha Insurance Company, appearing today in opposition to LB647. You've heard a little bit about the history of the legislative debate on mental health coverage in Nebraska, which really began about 1993 or '94, when there were bills in, frankly, similar to what we have today, which would impose full mental health coverage and mandate mental health coverage across the board. The Legislature, for approximately four or five years, did not advance any of those bills, determining two factors: one, that the costs of those bills would be a burden on employers to provide the coverage; and second of all, that because of federal law, ERISA, that these bills would not impact the number of people that a number of the proponents felt they would. I'd argue that those issues are the same today. We argued back in the mid-nineties that the cost of providing full mental health parity was between 8 and 12 percent. We increased rates in states that did enact mental parity on those approximations. While, because of managed care techniques and different mental health practices, those percentages might be reduced, in the same time, the premium...the total healthcare premium has increased significantly. So what was 8 or 12 percent of a premium back in the mid-nineties, now, 2 and 3 percent of that is the same number. So you're talking about real dollars of increases, even though the percentage might be less. I wanted to mention something about ERISA, and this is the federal law that...this is the first opportunity I think we've had to address this committee

on a mandated benefit. ERISA is known as the Employment Retirement Income Security Act of 1974, and it was passed by Congress in 1974 at the bequest of a number of employers who were having major problems having uniform benefit packages throughout the states, because of state mandates and state...different treatments of their employee benefit package. So Congress stepped in and effectively said, if you have an employer welfare plan, an employer, it's a multi-state plan, it is only regulated by Congress; the states cannot regulate your plan, to allow for uniform benefits. The one thing they did say, though, is they said, but because insurance has been traditionally regulated by the states, because of the McCarran-Ferguson Act, we are going to carve out insured plans. So the bottom line is, no matter what Nebraska Legislature or any state legislature does, it will not have an impact on a fully insured plan. And the reason that is significant is, in past years when we've talked about mandated benefits, the move to self-insurance, as states put more mandated benefits in, grows. We used to be, probably 60-plus percent of our business was self-funded, self-insured; the remainder was fully insured. In Nebraska now, we have approximately 84 percent of our business is self-funded, for Mutual of Omaha. To put that in a number, we've got about 50,000 lives covered in Nebraska, that does not include dependents, and of that, only about 5,000 are fully insured plans. So no matter what is done in Nebraska with this bill, it still allows those employers who are self-funded to opt out and provide any coverage they want. And the importance of this is that in the testimony today, a number of the proponents expressed that their plan was self-funded, and so this would not...this bill, (LB)647, would not apply to those plans. It would still be up to the employer to make a decision whether they want to cover those individuals or not. But what it does mean is that the majority of people who are not self-funded are the small employers. And it's very significant that the study that was done, the actuarial study by Milliman, specifically exempted...or, it assumed that applied to only 50 and over. So you don't have self-insured business in the 50 and under. You very seldom have many self-insured plans under 100 lives, but you have some. Nebraska law right now technically exempts plans of 15. The existing law we have, which is providing coverage for serious mental illness, says that it does not apply to 15 and below. I think that probably still works. It is a valid elimination, because we technically don't have a mandate in Nebraska. We have the ability to cover mental illness or not. If you cover mental illness, then you have to provide coverage for serious mental illness. If you move it to a mandate, because of another federal law called HIPAA that was passed, which says...it regulates small employer groups from 2 to 50 lives. It says, whatever coverage you provide in one segment of that market--let's say, 25 to 50--you have to provide the same coverage for below. So you can't bifurcate your coverage and have different coverages from 2 to 5 lives, 2 to 10, 2 to 15, than you have from 15 and over. So this limitation, I think, in Nebraska, if we were to enact (LB)647, the bill would apply from 2 on up; it would not exempt from 15 to 2. So that is another point of saying, you know, well, we tried to say it has an impact on small employers, we tried to exempt 15 to 2; if this mandate passes, that exemption, I think, would go away. So the only...and to put that in perspective, a lot of states, we...at 15, we go down further. A lot of states exempt

50 and below, a couple do 100 and below. So at 15, we're one of the lowest as far as covering very small employers. The other thing that this bill would do is it would throw out the reliance on biologically based or serious mental illnesses, and refer to the ICD-9 or the DSM. And what...I can just show you, this is 24 pages of diagnosis; this is over 400 codes in the DSM. What I've passed out today is some of the coverages that, if we cover...if we had full coverage under the DSM, that would have to be covered. And I think you can see, while I'm not trying to minimize the coverages, I would think you would look and see that these are not what you consider serious mental illnesses. And they were not the type of illnesses that the proponents of this legislation spoke of today, but yet, we would have to cover these. I think, in concluding, a number of other states have laws out there, but of the 18 states that mandate coverage for mental illness, most limit them to serious mental illness, as Nebraska, and none include all of the diagnoses included in the DSM and the ICD-9s. So we would be going probably the most liberal coverage in the country if we were to enact the bill as it is. We talked about, a little bit, about the federal law. Nebraska doesn't have a bad law on the books now. In fact, the federal law that was mentioned by the proponents, it was mentioned that it was supported by the America's health insurance plans, the chamber of commerce, it is a lot like what Nebraska has currently, and it simply provides that it doesn't mandate coverage, but it provides, if you provide coverage you have to provide coverage according to what you determine in the plan, and then you have to provide parity of those plans. But it also has an out, which Nebraska doesn't have, that if premiums are going to exceed...go up by 2 percent in the first year or 1 percent thereafter, you can opt out of the law. So this is years later. It's coming out of a Congress that has been very attentive in the change of...to healthcare. Senator Kennedy has been a strong proponent of healthcare. He is the sponsor of this bill. And yet, this bill would be somewhat similar to what Nebraska has on the books now. So I think the concern that we have, as was mentioned before, is that this will increase the number of uninsured. It will do it primarily in the small employer market. Healthcare costs are going up because of trend. There was an article last week in the World-Herald, out of the L.A. Times, that there's a study that healthcare costs might double by 2016. We've done a study. I've been serving on an uninsured task force for the last three years, organized by the Department of Health, which is somewhat similar, I think, to a bill you've got coming up that would establish another task force. Bottom line, what we've tried to do is look at who are the uninsured, and focus on basically the working uninsured, and focus of why employers are not providing coverage. And based upon a survey that was done just recently, in fact, it should be released this month, to small employers in the state, of whom only 39 percent provide coverage, the primary reason small employers don't provide coverage is cost. And so any increase, whether it's 2 percent, 3 percent, 4 percent, is going to have a significant impact on whether they provide coverage, and those small employers are the ones who this bill is ultimately going to get at, because large employers have the ability to self-insure and get around it. So with that, I'd be glad to answer any questions I could. [LB647]

SENATOR PAHLS: Senator Langemeier. [LB647]

SENATOR LANGEMEIER: Chairman Pahls. And Mr. Ullstrom, thank you for your testimony. We've heard in our testimony today, anyway on the proponent side, that those that do have coverage, seems to be inadequate. They are needing more care, they are needing more visits than the policies are designed to handle. That makes me a little concerned to mandate that we have this coverage. Would that not be an accurate statement, that these policies are poorly designed to meet the needs of the mentally ill? [LB647]

GALEN ULLSTROM: Well, I think it depends on what policies. If you are talking, again, the ERISA plans, they can design them any way they want, anything the employer wants to cover. He can cover full parity now, or he can put limitations in. I think you...the actuary from Milliman & Robertson's testified that back when you were talking about mental illness, you did have limitations. We used to have a 30-day limit on inpatient coverage. We're probably now up to 50, as a recommended type of coverage for most, even ERISA plans. But you can go to full coverage. You cannot have any limitations if you want. The point I'm making is that...and those limits don't apply for serious mental illnesses. So we have a serious mental illness rider that, for those particular diagnoses that are covered under the law now, we would not have any limitation at all. It's only for the ones that are not, which would include a number of the ones in the DSM, we would have limitations, and those would apply. But for the serious mental illnesses, if it's a fully insured plan in Nebraska, we would have those covered. [LB647]

SENATOR LANGEMEIER: My concern is, if we mandate this and you go to the small business model that has to pick the coverage, the fact that they added on may not be a coverage that's suitable for any true care, and it would be misleading to the employees that they even have mental health coverage. [LB647]

GALEN ULLSTROM: Well, if in fact this bill was passed, we would have to provide that coverage to the small employer. We would not be able to allow any limitation, unless we allowed it for physical illnesses. And so...and there are conditions now on the physical side where we limit certain amount of physical therapy, we limit certain type of practitioner. You know, we do have limits on the physical side now; it's not that everything is unlimited. But we would not have...we would not be able to put any limitations, basically, on the mental health side. [LB647]

SENATOR LANGEMEIER: Okay. Thank you. [LB647]

SENATOR PAHLS: Senator Pirsch. [LB647]

SENATOR PIRSCH: Just kind of a bit of history, because of course, I've just served here since January 2. But back when Senator Jensen was serving on this committee

and HHS, they added these particular mental illnesses to covered type of illnesses. Could you just comment briefly about...did that have...and I think the previous testifier testified that sometime back that that would have constituted approximately 40 percent of the range of mental...the total spectrum of mental illnesses experienced. Granted, we're in a different situation perhaps today, but it seems significant nonetheless. Could you just comment upon the effect that that did have when that was implemented, either on the industry or on the population of those who were suffering from mental illness? [LB647]

GALEN ULLSTROM: Well, I think...you know, and I can't tell you the exact, from the industry's perspective and the employer perspective, because they are the one that pay the coverage. I think premiums did go up. I can't tell you exactly how much. From the perspective of the consumer, I think more things were covered, and they were covered without limitations. Again, these conditions and covering serious mental illness was negotiated, basically, because...with the proponents and the industry. I mean, we sat down at the urging of Senator Landis, who, if you know Senator Landis, is a big...is one in favor of compromise. And he asked us to get together, see if we can come to common ground so we could provide coverage, and unlimited coverage, basically, for the major conditions that we thought were out there, without subjecting it to potential abuses of covering things that were not as serious. And that's how we came up with this list. I think it was successful, and I think that the reason it's been proven to be successful, because you have other states now enacting laws like we enacted back in 2000 and 2001, using the same lists that we used, and the same criteria. So I don't think these lists are obsolete. I think we provide coverage for serious illnesses, and I think it...forgetting the ERISA issue, if these were fully insured plans, virtually all the conditions that I've heard mentioned today by the proponents would have been covered in an unlimited fashion under Nebraska law. [LB647]

SENATOR PIRSCH: Thank you. [LB647]

SENATOR PAHLS: Any other questions? Oh, did I hear you say something about compromises? [LB647]

GALEN ULLSTROM: We certainly did, in the year 2000. [LB647]

SENATOR PAHLS: Okay. Any other questions? Thank you, Galen. [LB647]

GALEN ULLSTROM: Thank you. [LB647]

JAN McKENZIE: (Exhibit 16) Good afternoon, Senator Pahls, members of the Banking, Commerce and Insurance Committee. For the record, my name is Jan McKenzie, spelled J-a-n M-c-K-e-n-z-i-e, here representing the Nebraska Insurance Federation as executive director and registered lobbyist, in opposition to LB647. But my arguments

and points are going to be a little different from what some of the other opponent testifiers have stated. I'm going to just talk plain talk about why we oppose mandates in general. Every mandated bill that we've heard, mandated benefit bill that we've ever heard before this committee, has merit. It has merit to the group of people who are affected by whatever the health malady is. But I want to talk to you a little bit more about why this doesn't work in Nebraska, as written in the bill. I handed out a nice little one-page sheet that came out of a recently released publication from AHIP, which is the national trade association for health insurance companies, and it's a summary of Nebraska. And what I want you to highlight is, just point-by-point, if you look at the top, in Nebraska, we have 1.32 million covered by private insurance in this state, with an 11 percent uninsured rate. And you've already heard that from previous testimony. But I want you to notice that 39 percent are fully insured and not self-insured, and this is the group of people we're talking about, potentially, that would be affected by this mandate. That 61 percent up there will not be touched at all. And in the study that you got, the Milliman study, they say on page 4, there are 315,000 fully insured lives in Nebraska in the commercially insured market. About 720,000 self-insured lives are exempt from state-mandated benefits. In Nebraska, 93 percent of our large employers provide health insurance; 33 percent of our small employers provide health benefits. And if you notice, on the black sheet, on the right side, we are 41st in the country in the number of small businesses who are providing insurance as a small employer. That puts us in the bottom 10 percent, I would say, and that's probably not a very good situation for us. I also wanted just to point out that there are averages here for health insurance premiums, and I compared Nebraska's small group market single and small group market family, because that's basically who we're targeting with this mandate in this bill. Our $10,920 per year for a small group market family health premium is higher than any surrounding state except Colorado. And likewise, it's higher in the single market than compared to any state around us, as well. We heard that the increase to include mental parity might only be 0.6 percent. That's assuming that you're in a group that's probably already providing some sort of mental parity. And if you are in a group that is not providing any, and I think you heard from my various...two of my companies, that they as insurance companies work with an insurance broker to design and sell plans, and manage plans for companies, whether they are self-insured, whether they are the state, whether they are the university, whether they are a small employer who goes to them and says, I want to provide my employees insurance; what can you...what kind of plan can I afford to give them? The other thing that can happen whenever we talk about mandates and we heard this years ago on contraceptive coverage, mandated contraceptive coverage, is what happens for many people and many employers is, when you mandate something it's covered, but suddenly my deductible goes from $500 to $1,000, or my copay goes from $20 to $50. And so out-of-pocket expenses increase, and the employee basically gets a probably less valuable benefit, and coverage that costs more out-of-pocket until they finally reach their deductible. In Nebraska, and I know this does not affect the individual market, but many, many self-employed people have policies that have at least a $2,000 deductible, if not higher. Those people pay

out-of-pocket a lot of money before they get anything covered, including the physical. So with that, I would just ask you to consider who this would affect. If we want to get to those 720,000 people, then we should be calling our Congress and asking them to pass the Senate version, because that would provide mental health parity to our ERISA plans in Nebraska. We do not want to create a situation where the federal government creates a mental health parity similar to what we have now in Nebraska for our ERISA plans, and a separate, more liberal plan for our small employers in Nebraska with this mandate. With that, I'd answer any questions that you might have. [LB647]

SENATOR PAHLS: Senator Carlson. [LB647]

SENATOR CARLSON: Senator Pahls. Jan, you just mentioned a figure, and somewhere I missed it. You said if we want to take care of 700,000-and-some... [LB647]

JAN McKENZIE: Oh, that is in the study that you were given from the actuary, Mr. Melek, on page 4. [LB647]

SENATOR CARLSON: Okay. Okay. [LB647]

JAN McKENZIE: It is the third paragraph. And so I'm citing directly from the study. [LB647]

SENATOR CARLSON: Okay, thank you. [LB647]

JAN McKENZIE: And remember, those are of lives of 50...groups 50 employers and more...50 members and more...50 employees and more. Senator? [LB647]

SENATOR PAHLS: Senator Langemeier. [LB647]

SENATOR LANGEMEIER: Chairman Pahls, thank you. And thank you for your testimony. In your final words there you said that we should get behind the Senate's version? [LB647]

JAN McKENZIE: The Senate's version is very similar to ours. [LB647]

SENATOR LANGEMEIER: Has the group you represented sent in a letter to support to our congressional representatives to that effect? [LB647]

JAN McKENZIE: No, sir, we have not. [LB647]

SENATOR LANGEMEIER: Do they plan to? [LB647]

JAN McKENZIE: I will have to ask my legislative committee at the 4:30 meeting this

afternoon. [LB647]

SENATOR LANGEMEIER: I would appreciate the response. [LB647]

JAN McKENZIE: We'll be happy to do that. [LB647]

SENATOR LANGEMEIER: Thank you. [LB647]

JAN McKENZIE: You bet. [LB647]

SENATOR PAHLS: Senator Gay. [LB647]

SENATOR GAY: Jan, I've got a question about, I guess, the market, free market system, if... [LB647]

JAN McKENZIE: Sure. [LB647]

SENATOR GAY: Prior, Steve Melek, the actuary, was saying that there's two silos, primary and specialty, that are converging and blending together for more efficient. Is the insurance industry at some point, in your professional knowledge...I would assume they would work towards putting more of these programs in there. If you can stop something before it gets out of hand, why would they not...or are they going to work to merge these in together in the future, so we don't have to mandate it? Is...what's going on there? [LB647]

JAN McKENZIE: Right. Well, Senator, I think if you watch television on weekends, you'll see a lot of the E-insurance advertisements for various products. And I know individual companies, and each company tries to create products in their market that they think they can sell, either to individuals or to groups, or to large groups, and each of my companies in the federation have different markets, and sometimes compete in the same market. So I think you'll see that there are companies and groups out there who are looking at plans that, if they get a large enough group of individuals to purchase in, let's say, on something online, you see that they're talking about covering more preventative medicine than maybe used to be covered, well visits and things that in some cases an employee can't afford to provide. It's a tossup. If I give this to my employees, then I can't give them the wages that I'd like to give them. So because benefits and...health benefits and wages and retirement, all those things are a part of your worth as an employee to that employer, different employers look at those things differently. But there are all kinds of products out there. It just depends on what an employer feels they can afford. And in many cases, they do negotiate with their employees as to what they would like to see in their health plans. It's not one-size-fits-all. Sometimes people think it is. I think that medicine and specialized medicine and everything we've learned over the last five to ten years, I think,

is...continues to improve what's happening. [LB647]

SENATOR GAY: Thanks. [LB647]

JAN McKENZIE: Okay, thank you. [LB647]

SENATOR PAHLS: Thank you for your testimony, Jan. Could I just have a show of hands? How many more? Three? Okay, thank you. Four. [LB647]

RON SEDLACEK: Chairman Pahls and members of the Banking, Commerce and Insurance Committee, for the record, my name is Ron Sedlacek. For the transcriber, that's spelled R-o-n S-e-d-l-a-c-e-k. I'm here today on behalf of the Nebraska Chamber of Commerce and Industry, and we would like to register our opposition to LB647. Many of our...within our membership base, we have individual companies, and we have a great number of trade associations, particularly business trade associations, and local chambers of commerce. And many of those trade associations and the local chambers, in turn, try to provide group insurance benefits to their member businesses, or some of them have ERISA-type programs. You've heard a little bit about ERISA today, and the federal preemption issue. Nonetheless, we still have a number of chambers and, as I say, trade associations, that still try to offer this as a member benefit. Most of our small business membership, I would say as a general rule, that offer insurance, will offer a group help policy. If they can, they've been migrating more and more, we can certainly tell that just by anecdotal evidence, migrating to an ERISA-type program. It could be a VEBA, it could be a MEWA, those various...there are various plans that are available if they can find them. And the purpose is, is to try to maintain health insurance coverage for employees at an affordable level. That's the primary motivation. In that respect I'm here today, essentially, in representing the chamber, and delivering our message in regard to mandated health insurance benefits, is that we are the consumers. You've heard from the insurers. The Legislature can certainly pass that type of public policy that they feel is most beneficial for Nebraskans. But it's our smaller businesses that are actually the consumers of those products, and so we're here on that behalf. As being consumers, our businesses, of course, are buying these. Those that aren't on ERISA programs are buying these group health insurance plans. And it concerns them, every benefit, and as the previous testifier said. And been testifying on mandated benefits for quite a while, since healthcare insurance costs have been a major issue, and they have been one of the top issues among our membership, that and it seems taxation is always an issue. But the concern over rising healthcare costs is such that we feel that we must come forward and just convey to the committee our concern, that we want to keep insurance, health insurance benefits affordable, but also we want to keep health insurance benefits available, so that there is that benefit, that we can remain competitive, that we can offer those particular benefits to our employees. As medical costs continue to increase and certainly mandates, although well-intentioned, each and every one over the years, as I said, they have always been well-intentioned, they

certainly have merit. But the question becomes picking and choosing, as a matter of public policy, and trying to keep those costs affordable. And as we find...as costs increase, deductibles generally are renegotiated, copayments are increased, and there are occasions where some of the very small employers are saying, we can't do it. We'll offer you additional compensation; find your own individual coverage. Or, what we can offer you is just not competitive. And we'd like to...we would like to arrest that migration away from group health. And so for those reasons, we would oppose the legislation. I'd be happy to entertain questions. [LB647]

SENATOR PAHLS: Ron, are you telling me right now that there is a migration away from...in the small companies, for health, and this would further cause that to happen? [LB647]

RON SEDLACEK: I think that as... [LB647]

SENATOR PAHLS: Prices... [LB647]

RON SEDLACEK: ...healthcare costs increase and if this represents an increase, and by all indications, at least from the opponent testimony, it appears that it would represent an increase, it's going to have an effect. How many, I don't know. But that, in combination with the natural effect of inflation and the continuing rise in overall healthcare costs, it may be the proverbial straw that breaks the camel's back, in some cases, not necessarily wholesale across the board. But there will be an effect, I'm sure of that. [LB647]

SENATOR PAHLS: Do I see any questions? Seeing none, thank you, Ron. Appreciate it. [LB647]

RON SEDLACEK: Thank you, Senator. [LB647]

BOB HALLSTROM: Chairman Pahls, members of the committee, my name is Robert J. Hallstrom. I appear before you today on behalf of both the National Federation of Independent Business and the Nebraska Bankers Association. My remarks today in testimony will be limited to the effect on small business employers. Without repeating a lot of what's been said, we've clearly talked about the importance of affordability and availability of health insurance to the small business community, the impact that I think the witness from Blue Cross/Blue Shield indicated, that clearly, the actuaries from the insurance companies can price out anything that is mandated or forced upon them. I assume the insurance companies have some adverse impact if the market for insurance dries up and people are not purchasing insurance as they have in the past. But more directly, I think the impact is on the small employer and their employees. Clearly, we've talked today about higher copays, higher deductibles, the adverse impact that that has on the employees. I'd like to take just a little bit different angle. We've seen from the

testimony today that the impact on the larger, over-50-employer businesses...or, employee, businesses is about 0.6 percent. The Blue Cross/Blue Shield witness suggested that 2 to 5 percent would be for the market from 1 to 50 employees. Now, that widens that gap that we already face as small business employers who are, I think, admittedly from many studies, those that drive...the engine that drives the new jobs in the state of Nebraska and other states across the nation. But yet, it widens the gap in terms of the cost and availability of health insurance. If we have additional mandates that make it that much more pricey for small businesses to provide the health insurance benefits to their employees, it also adversely impacts their ability to compete with larger businesses in attracting new employees. So for those reasons, we think that the mandating of benefits interferes with what ought to be a voluntary negotiation between employers and employees of the entire fringe benefit package that they provide. A couple of things, also. And I certainly wouldn't take exception with the cost figures provided by the actuary, but I might bring one issue to the attention of the committee, in terms of one of the assumptions. I think the assumption that was provided in the testimony by the actuary was that the copays would automatically gravitate down from the higher level down to the lower level. From personal experience with the Nebraska Pharmacists Association, we've also had statutory provisions placed into law here in Nebraska when we had differential copays that were provided for mail-order pharmacy versus local community pharmacist, and when those laws were passed, we did not immediately and necessarily see that the copays and deductibles went down to the lowest common denominator, but rather, there was some balancing of those impacts. And I would just suggest that those that have done the study might want to review that assumption, because it may not actually work out in reality, at least based on the experience that we've had on a similar issue in the past. I'd be happy to address any questions the committee might have. [LB647]

SENATOR PAHLS: Bob, I see none. Thank you. [LB647]

BOB HALLSTROM: Thank you. [LB647]

JIM OTTO: Senator Pahls and members of the committee, my name is Jim Otto, O-t-t-o. I'm here on behalf of the Nebraska Retail Federation and the Nebraska Restaurant Association to testify and voice our opposition to LB647. I'll be very brief. You've heard all kinds of testimony. I don't know how I could add to that, except to say that the absolute number one problem that our members, both restaurant and retail, and I'm talking about small members, now, those that would have less than 15 employees, voiced to us is that, how can we afford...we just can't handle the increase in healthcare costs. And they always talk about health...excuse me, health insurance costs. They always talk about, you know, we got to figure out how to get this health insurance cheaper, we got to figure out how to get this health insurance cheaper. But the real reality is that health insurance costs are rising because healthcare costs are rising. I mean, the majority...I mean, it's not the commissions to all the people that are selling

the insurance that keeps going up; it's the cost of healthcare. And so we have to figure out a way to actually somehow get our handle around the cost of healthcare. And based on what we've been able to determine, and the previous testimony, this appears to impact the employer that has 15 or less employees the most, and as a result, we would be against it. With that,... [LB647]

SENATOR PAHLS: Any questions for Jim? Seeing none, thank you, Jim. [LB647]

JIM OTTO: Thank you. [LB647]

SENATOR PAHLS: Appreciate your testimony. [LB647]

CAMILLE FARRELL: I'm neutral. [LB647]

SENATOR PAHLS: Okay. We have one more...right. [LB647]

DAVE McBRIDE: (Exhibit 17) Senator Pahls and members of the committee, my name is Dave McBride. That's D-a-v-e M-c-B-r-i-d-e. I'm the executive vice president and registered lobbyist for the Nebraska Association of Insurance and Financial Advisors. I do have something I will pass out. Most of the points in my written testimony have been made already, and so I will limit my comments to really just two. One of the things in my handout is an issue paper from the National Center for Policy Analysis, which is a public policy research organization in Washington, D.C., just some background information on mental health parity that hopefully you will find of some interest. It is difficult for us, and I think most of the other organizations that are in here before you opposing this bill, to come in and oppose very well-intended proposals such as this. But our opposition, our reason for opposition is really the same as most of the others you've heard, and that's simply the concern over what this is going to do to the number of insured. The last paragraph of the written testimony that I passed out, referencing a statement in the statement of intent, that if premiums increase $1.85 per month for every 100,000 lives, if our math is correct, that is additional premium of $2.2 million for every 100,000 lives that somebody would have to come up with, be it individuals, or employers, small employers. And our concern is, pretty simply, that there are a lot of people that are close the breaking point now being able to afford or continue to afford to offer insurance. And as somebody earlier said, this...things like this may simply be the straw that breaks the camel's back and causes many to eliminate offering coverage. And that's really the extent of my remarks, unless there are questions. [LB647]

SENATOR PAHLS: Senator Carlson. [LB647]

SENATOR CARLSON: Senator Pahls. Dave, in this third paragraph, the National Association of Health Underwriters, to add between 8.4 percent and 11.4 percent to the cost of insurance premiums, that's really a spread from what the earlier testimony said.

Could you comment on that little bit? [LB647]

DAVE McBRIDE: I don't know that I have much else to add, except for the statistic. It's a quoted statistic from the organization, but I don't have much more background on how they came up with that. I can look into it some more if you like. [LB647]

SENATOR CARLSON: It's probably their experience with the companies that are their members? [LB647]

DAVE McBRIDE: I'm just taking a quick look, to see if... [LB647]

SENATOR CARLSON: Well, if you wouldn't mind, I'd like some information on that. [LB647]

DAVE McBRIDE: Okay, I'll see what I can find out, look into that a little more for you. [LB647]

SENATOR PAHLS: Thank you, Dave. Appreciate your testimony. Is that the final opponent? Now we're ready for the neutral. [LB647]

CAMILLE FARRELL: Senators, I'm happy to be here today. My name is Camille Farrell. That's C-a-m-i-l-l-e, Farrell, F-a-r-r-e-l-l. I am here representing a family, my own, with severe and persistent mental illness. I appreciate the time and, God knows, complications, and legislation, and study that the body of the Senate...the Unicameral has done over the past, for sure, ten years, and maybe before that. I've been involved for 11 years. One of our family members was diagnosed 11 years ago. I'm not going to go into my story. I am here for information. I have tried to get my hands around some of the fields that impact the care of the mentally ill, and I've been down several different alleys. I have been down private insurance, I have been down out-of-state care, the Menninger Institute when it was in Topeka, we have been in Omaha and a couple of hospitals there, we have been to Mary Lanning in Hastings, we have been to the Hastings Regional Center outpatient program, we have been in the private system, the public system, and our...right now, our family member is on Social Security disability and receiving care through Medicare and Medicaid. So my bridges are not to burn, I guess, other than I want to find some help, as much as possible, for folks with mental illness. Let's see, I made a few notes. I didn't plan to speak, but I figured, I sat here for two and half hours, by golly, I'm going to do this. So anyway,... [LB647]

SENATOR PAHLS: I'm glad you did. [LB647]

CAMILLE FARRELL: And you guys, too, have been here, everybody, all this long. So anyway, I'm going to try to be as concise as I can. A few years ago, within the last couple of years, I called many private insurance companies in the state of Nebraska to

see if we could get a private insurance policy for our 31-year-old family member. And of course, you can all guess, the answer to that immediately is, no, he has a preexisting condition. I have studied the CHIP's program, which is Comprehensive Health Insurance Program, which is available to all citizens of the state of Nebraska who are uninsured elsewhere, and I've looked closely, talked to consultants about it, and because they have a maximum lifetime policy of $25,000, it's not feasible for our family to consider that option. So, let me see. I've talked to several different places, and believe me, for listening to some of the folks who have been involved in this personally, it is terribly cumbersome. You receive great disrespect. You are put on hold until the cows come home, which all of us are now experiencing in this world of technology. There's no direct to anybody, hardly. So I guess I'm just saying, I can relate to what some of these folks that are in favor of this legislation so vehemently have stated, that it is just an abominable system to work through. Okay. My question today, or what I'm trying to learn today...I actually have to be honest, I only picked up LB647 at noon today, so I have not had a lot of time to study it. From my quick perusing of it, I feel like the first three portions, (sections) 44-791, 44-792, and 44-793, I don't have any problems with. But it is this last section that talks about, and I may not be understanding this properly, it says, these sections shall not be construed to prohibit a health insurance plan from providing separate reimbursement rates and service delivery systems, including but not limited to, mental health carve-out programs, and I heard one of the fellows talk about carve-outs, provided, if the separate reimbursement rates...and blah blah blah blah blah. Okay, what I want...what I guess I'm saying is, is this saying that indeed LB647 will allow insurance companies or insurance folks to carve out and tell their people what will they cover and what they won't cover? And I think the gentleman from Mutual of Omaha referred to that. But is it under 50, is it under 50...companies with under 50 employees, companies with under 15, that can carve out and tell you what they're going to cover and not cover, or have I read that totally wrong? Or...you don't have to answer me. I'll just leave you that question, okay? [LB647]

SENATOR PAHLS: Okay. [LB647]

CAMILLE FARRELL: So it's very confusing. And that leads me...I'm going to depart. That leads me to my bottom line. Please don't complicate this. If we're going to have new legislation, can we have it as clean and clear, and spelled-out as...so that consumers like me, citizens like me, can understand it and feel like we have...we're empowered in some way? And I don't know if that makes any sense, but that's kind of what I have to say. I will...I would welcome an opportunity to come to a session to study this piece of legislation in a sort of nonbiased way, or, again, listening to pros and cons. So at this point, I am very neutral on this piece of legislation. It's very confusing to me at this point. And with that, I thank you for your time. [LB647]

SENATOR PAHLS: Camille, before you leave today, give us your phone number, and we'll have somebody in contact with you... [LB647]

CAMILLE FARRELL: Thank you. [LB647]

SENATOR PAHLS: ...who can spend some time with you... [LB647]

CAMILLE FARRELL: Who would I leave that with? [LB647]

SENATOR LANGEMEIER: Right behind you, this young man in the gray suit. [LB647]

CAMILLE FARRELL: Okay, thank you. [LB647]

SENATOR PAHLS: Yeah. Yes. Any more neutral people? Seeing none, that concludes this session on bill (LB)647. We're going to take about a five-minute break, because we do have two more bills to cover. [LB647]

BREAK []

SENATOR PAHLS: I think we are ready for LB134, if I could get all the senators seated. []

SENATOR SCHIMEK: (Exhibits 1-3) I've got the wrong folder. Do you want to hear about the Department of Roads being renamed the Department of Transportation? (Laugh) [LB134]

SENATOR LANGEMEIER: Sure. [LB134]

SENATOR PAHLS: Well, you know, I've been told, Senator,... [LB134]

SENATOR LANGEMEIER: You know, we're going to vote on that later. What the heck, let's hear it. [LB134]

SENATOR PAHLS: Senator, I've been told, if you...to just move on. (Laugh) [LB134]

SENATOR SCHIMEK: It will just take a second. It's just around the corner. Besides, I've been waiting on you for three hours. (Laughter) [LB134]

SENATOR PAHLS: So you should have been very well prepared. (Laughter) [LB134]

SENATOR SCHIMEK: (Laugh) Touche. Well, I have good news for you, Senator. I don't think this will take a long time. This is a good reason why you should always let your aide take your file to the hearing. [LB134]

SENATOR PAHLS: They've been meaning to tell me to tell you that. [LB134]

SENATOR SCHIMEK: (Laugh) He volunteered, and I said, oh no. [LB134]

SENATOR PAHLS: Oh no, I'm so prepared, I'm so on top of it. [LB134]

SENATOR SCHIMEK: I'm so organized. (Laugh) [LB134]

SENATOR PAHLS: Sure, and you are punishing us intentionally. (Break) Are you ready, Senator? [LB134]

SENATOR SCHIMEK: (Laugh) Oh, we're having too much fun. [LB134]

SENATOR PAHLS: When you're ready, we are, Senator. [LB134]

SENATOR SCHIMEK: Thank you. Good afternoon. I'm DiAnna Schimek. I'm here representing the 27th Legislative District, and I'm introducing LB134, which is a bill which would encourage early detection of colorectal cancer by assuring insurance coverage for colorectal cancer exams and lab tests for persons 50 years and older, under most insurance policies or contracts. This bill was brought to me by the American Cancer Society, and I gladly accepted that responsibility. Colon cancer is the second leading cause of death from cancer in the U.S. It is estimated that 1,100 new cases of colon cancer will be diagnosed in Nebraska alone in the year...in this next year. More than 400 Nebraskans will die from colorectal cancer in 2007. When colon cancer is found at an early stage of diagnosis, I'm sure you all know this, that the five-year survival rate is more than 90 percent. Unfortunately, only about a third of colon cancers are found at an early stage, unnecessarily increasing the number of deaths. However, when adults and their physicians follow American Cancer Society guidelines for screening tests, many people will never get colon cancer, because precancerous polyps can be discovered and removed before they can become cancerous. In those instances where the polyps have already become cancerous, they can be easily removed during the screening test, thereby greatly improving survival. Requiring health insurance companies to cover colorectal cancer screening makes sense, because the number of people receiving these screenings will increase, and lives will be saved. Insurance companies pay out millions of dollars to treat patients for colon cancer. Today, the average cost of treatment is in excess of $125,000 per patient, with costs rising due to new and improved drug therapies. Screening can save thousands of lives and millions of dollars. It just makes sense. And if I could have a Page, I have just a little handout here, I believe this came from American Cancer Society, about why screening for cancer, colorectal cancer, makes sense, s-e-n-c...or, s-e-n-s-e, and why screening makes cents, c-e-n-t-s. In addition to that Mr. Chairman, I have a proposed amendment to the bill, which was brought to us by the insurance folks. And do you remember that little bill that you passed out of this committee that added the word "certificate"? Well, we decided we better put that in here, too. So that's a very, I think, noncontroversial

amendment. [LB134]

SENATOR PAHLS: You never stop. [LB134]

SENATOR SCHIMEK: No. (Laugh) Never. In addition to that, I'd also like to enter into the record...have entered into the record the letter from Bruce Dart, who's the Lancaster County Health Department executive director, so...in favor of. That concludes my testimony. [LB134]

SENATOR PAHLS: Thank you, Senator. Any questions? Senator Langemeier. [LB134]

SENATOR LANGEMEIER: Chairman Pahls, thank you. Senator Schimek, do you have any idea, what does a...this is out of my realm here. What does a screening test cost? What's a rough idea? [LB134]

SENATOR SCHIMEK: I cannot answer that at all. And I'm... [LB134]

SENATOR LANGEMEIER: I was just curious if that's $50 or 1,000 bucks. [LB134]

SENATOR SCHIMEK: No, I think it is much cheaper that 1,000 bucks, but I would prefer that you ask the American Cancer Society. And I'm thinking...I was thinking maybe you carried this bill once upon a time, but that is probably not true, in light of your questioning. Thank you. [LB134]

SENATOR PAHLS: No more questions? We will let...could I just see a hand of the proponents? I see one, two, three, four. Opponents? Seeing none,...just say something. Neutral? One. Okay. We will begin. [LB134]

SENATOR SCHIMEK: And I will waive closing, because I have another bill to introduce in another committee. [LB134]

SENATOR PAHLS: Okay. Take your stuff with you. (Laughter) We are asking you to please spell your name. [LB134]

ALAN THORSON: (Exhibit 4) Hi, I am Dr. Alan Thorson, A-l-a-n T-h-o-r-s-o-n. I am a volunteer and chief medical officer of the High Plains Division of the American Cancer Society, and second vice president of the national board of directors of the American Cancer Society. I am pleased to testify before you today on behalf of both the American Cancer Society and the Nebraska Medical Association. As a physician and researcher, I...who specializes in diseases of the colon and the rectum, I have the opportunity to see firsthand the toll that colorectal cancer takes on our state. I see patients with colon and rectal cancer every day, and I see the devastation that is wreaked upon patients and their families who develop colorectal cancer. I see the loss of many promising careers

and brilliant minds who should still be with us today because most of these cancers are, in fact, preventable, not only diagnosed at an early stage but preventable. In addition to the downside of that, I also have the opportunity to see the good side of colorectal cancer in the sense of screening, because I do see families who actually do get screening done, and those families are fortunate because they do prevent colorectal cancer and...or, if it develops, they are diagnosed in an early stage when they can be adequately treated. This year the American Cancer Society, my numbers will differ just a little bit from what Senator said earlier and I think that's probably because I have the most...accessed the most recent numbers which were just released last week, but the American Cancer Society estimates that there will be 920 new cases of colorectal cancer in Nebraska this year, and there will be about 350 deaths. Importantly, in Nebraska we should recognize that we have 282 towns in this state which contain 350 or fewer people. So every year we are wiping out one or, in many instances, several of our small towns in this state and will continue to do so unless we do something to try to prevent this scourge. Proper screening could significantly lower this number. Screening can decrease deaths due to colorectal cancer by preventing cancer through removal of polyps. If cancers are found in the screening process they tend to be found at an early stage. Colorectal cancer found at an early stage has about a 90 percent...excess 90 percent five-year survival. When cancer is found...colorectal cancer is found at a stage where it's already metastasized and spread to organs, there is a five-year survival of less than 10 percent. Unfortunately at the present time, less than 50 percent of all Nebraskans participate in colorectal cancer screening. Concomitantly with that, we find that only less than 35 percent of Nebraskans who are diagnosed with colorectal cancer are diagnosed at that early stage when it's most curable. Besides the loss of life associated with advanced colorectal cancer, diagnosing colon cancer late has significant economic implications. The Environmental Protection Agency has a book that estimates the cost of disease. I don't know if you're familiar with that. I have the web site on my handout for you if you wanted to check this out. But 1996 the EPA estimated the per patient lifetime direct medical cost, this is direct medical cost, does not consider lost time at work or other cost issues related to cost of care, the average colorectal cancer patient diagnosed at age 70.4 years had a cost of $141,160 in 1996 dollars. You can imagine with the costs of medical inflation that number is significantly elevated at this point. We also have significantly increasing costs of the drugs that are utilized to treat colorectal cancer. You may be familiar particularly with Bevacizumab or Avastin. The costs of that drug is up to $30,000 for a single eight-week course of treatment, making the cost estimates, as opposed to the $125,000 figure you just heard, somewhere between $250,000 to $400,000 for the treatment of a colorectal cancer in today's health market. This cost has become so great that we literally cannot afford not to take every possible step that's available to us to try to prevent this disease. Colorectal cancer is a model health...public health problem because, dealt with appropriately, it is truly preventable, and it is always much better to prevent a disease and not have to incur the costs of treating it, than try to treat it at a later date. Sadly, I see patients put off screening for any number of reasons, but a lack of insurance coverage for a screening

examination is an important one. Although the issues around colon cancer screening are a multifactorial and complex, an important contributing factor to low screening rates is a lack of uniform insurance coverage. Recent experience in this country supports this. Between 1999 and 2001, 11 states implemented mandated colorectal cancer screening. By 2004, the screening rates in those states with mandated coverage rose 40 percent faster than those states without mandated coverage. We also know that people with insurance are two to three times more likely to participate in screening programs than those without. Obviously, passing colorectal cancer screening insurance coverage laws is only one piece of the solution in fighting colon cancer, but it is a very important part of a well-planned strategy to reduce the needless pain and suffering from this disease. The American Cancer Society has a multipronged strategy aimed at defeating this disease. The ACS is working to increase public awareness, engage physicians so they talk to their patients about the need for screening, and reach out to our federal partners to leverage efforts against colon cancer. The Nebraska Medical Association has also actively engaged its membership with education on the importance of physician and patient participation in colorectal cancer screening programs, and it collaborates with a number of partners in patient education programs on colorectal cancer. There's much work to be done and we all have a role to play. Together we can make sure that more individuals are screened and the toll of this deadly disease can be slowed. Both the American Cancer Society and the Nebraska Medical Association are pleased to strongly support LB134. In closing, I would just like to ask the committee to carefully consider the differences in this particular disease with relationships to mandates. This is a disease that clearly has become so expensive that we truly can't afford not to do everything we can to try to prevent it and the screening program, a mandated screening program, is one important part of that process. As I mentioned, we've identified several steps that need to be taken and we're willing to participate in those other steps and ask you to participate with us by passing...forwarding on this legislation. I'd like to thank the members of the committee for the opportunity of presenting this lifesaving information to you this afternoon, and I'd be happy to answer any questions related to the medical part of this process, if there are any. [LB134]

SENATOR PAHLS: Senator Pirsch. [LB134]

SENATOR PIRSCH: Just wanted to thank you, Dr. Thorson, for coming here today and ask you just for a...I probably missed...and you were...you were saying the...when caught early, that it had a 90 percent plus rate of being cured. When caught in the late stages what was the figure then? [LB134]

ALAN THORSON: Less than 10 percent. [LB134]

SENATOR PIRSCH: Less than 10 percent. So okay. Thank you. [LB134]

SENATOR PAHLS: Senator Carlson. [LB134]

SENATOR CARLSON: Senator Pahls. Dr. Thorson, my limited knowledge of pharmaceuticals is incredible, but a $30,000 figure for drug treatment sounds like a crime to me. Why is it so expensive? [LB134]

ALAN THORSON: You know, I can't answer why it is so expensive. That's also, obviously, a very complex, multifactorial problem which is being addressed and looked at through a number of different avenues. But it has become very expensive, very expensive. [LB134]

SENATOR CARLSON: I did a little figuring here on the $141,000 in 1996 dollars at 6 percent, it would be somewhere near $250,000 today. What is cost of the test? [LB134]

ALAN THORSON: Okay, that question came up before. The cost of the test, screening, you can look at it a number of ways, of course, and the guidelines of the American Cancer Society offer us a number of options from the simple fecal occult blood test, which may or may not lead to further testing, and the fecal occult blood test is probably going to be $7 to $15. Okay? It has to be done every year very religiously. The most expensive screening test we have is the colonoscopy, depending upon where you have that done, it may be $1,000 or it may be $2,000. It's a fairly competitive market for that particular examination. That examination is, by far, the most accurate, will have close to 100 percent detection, as opposed to about 50 percent through the fecal occult blood test, and it only needs to be done once every ten years as a screening examination. So although the up-front costs are significant, they're spread out over a significant amount of time. More importantly, another way to look at this is what it would a health plan to implement screening along...a screening with using colonoscopy. And the study done for the American Cancer Society by the Lewin Group showed that screening...the screening costs per member, per month, utilizing colonoscopy as the screening mechanism, is 55 cents, and that compares to the cost of annual screening mammography, which is 75 cents, which is mandated. So we truly have a bargain here and I encourage everyone to take the opportunity to take advantage of this bargain that we have. [LB134]

SENATOR PAHLS: Senator Langemeier. [LB134]

SENATOR LANGEMEIER: Chairman Pahls. And thank you for your testimony. As you bring that up, that wide variety of costs between the different tests offered, should this legislation be narrowed down to a specific test? [LB134]

ALAN THORSON: You know, we debate that all the time at the American Cancer Society, and we find that it is important that we have those opportunities, those various opportunities, because of what is available to patients based on perhaps personal preference, perhaps religious or ethnic reasons, one test may better than another

perhaps because of the availability of the test to a certain segment of the population. We know that, as I mentioned, the cost of the fecal occult blood test is less but it's not as accurate. It becomes effective because it's done every year. The cost of the colonoscopy is more, but we know that its accuracy is twice, almost 100 percent, versus the 50 percent sensitivity for the fecal occult blood test. So I would encourage that that not be changed. Those are very well-thought-out guidelines for screening. They take into a lot of factors from a large number of different populations that have participated in the development of those guidelines, and they are pretty critical to the overall strategy that we have to help decrease the incidence of colorectal cancer. [LB134]

SENATOR LANGEMEIER: If our goal is to truly detect this, the blood test which you do every year, which is not that proven to be effective there, it really does not get to what we want to do. We want to detect if this is out there. I think we would be mandating something that relatively is worthless. [LB134]

ALAN THORSON: Well, in fact, we know that the fecal occult blood test by itself, could reduce mortality by 30 percent, which is not really worthless. I understand where you're coming from and, believe me, this is debated by very, very bright minds on the national level trying to determine what we should be concerned about. Do we make...do we cause confusion by having so many tests available? But in fact we know that, and we have, for instance, we have a pilot project here in Nebraska from the CDC, one of five sites in the nation, the only statewide project available that is funded by the CDC for this particular project. That would not be able to be done if we did not have fecal occult blood tests because of the limitations on costs. And we know that in the first year we were able to find one cancer...in this screening program we found one cancer diagnosed at an early stage, and we removed 13 polyps through the screening program that was utilizing fecal occult blood test. Now one could extrapolate that perhaps we prevented 13 cancers by removing 13 polyps. That's a little bit voodoo, because we know that not every polyp becomes a cancer, okay? But if you want to use that figure and you figure just the cost of treating cancer was just $100,000 instead of $250,000 or $400,000, just $100,000, we spent $40,000 in that program and we saved $1.3 million. So the leverage is terrific. It's not perfect, but it's better than not having done that program at all. So I, again, I encourage you to...I guess I would just...I would encourage you to accept those guidelines and I would reinforce to you that they have been very well-thought-out, and I could spend a day and a half going through all of the rationale for why those tests have been accepted and recommended by the American Cancer Society. But I know we don't want to spend that much time this afternoon, so... [LB134]

SENATOR LANGEMEIER: It is my rationale that will move this or won't move this bill as part of this committee, though, and that's why I have the concern about it. So thank you. [LB134]

ALAN THORSON: Okay. Well, I would be happy...I would be very happy if you wanted

to talk to me individually. Senator Pirsch has my e-mail address. I'd be happy to communicate with you by e-mail. American Cancer Society has a lot of information available, but it is not...I can just tell you it is not nearly as simple as it seems on the surface. [LB134]

SENATOR LANGEMEIER: Thank you. [LB134]

ALAN THORSON: Thank you. Any other questions? [LB134]

SENATOR PAHLS: Thank you. No. [LB134]

ALAN THORSON: Thank you. [LB134]

SENATOR PAHLS: Again, I'm asking people to be concise. [LB134]

DAVID HOLMQUIST: Yes. This is...I'm not going to read all of this, believe me. [LB134]

SENATOR PAHLS: Okay. (Laughter) [LB134]

DAVID HOLMQUIST: (Exhibit 5) What I've passed out is a packet that has letters in it from cancer survivors, a narrative from a cancer survivor from her journey through treatment. There's a pin similar to the one I have on my lapel, same as the one on my lapel, which is a pin that is in support of colon cancer awareness. My name is David Holmquist, H-o-l-m-q-u-i-s-t. I'm a registered lobbyist. I represent the American Cancer Society in Nebraska. Thank you for the opportunity to testify today in support of LB134. Colon cancer is the third most common cancer in the United States and the second leading cause of cancer death among men and women. Nebraska ranks 18th in the nation for colon cancer deaths. Only 36 percent of cancers are currently diagnosed in the earliest, most treatable stage, as you've heard Dr. Thorson say, and screening is essential to improving the statistic. Yet, only 46 percent of Nebraskans 50 years of age or older reported having recently been screened for colon cancer. Advancement and passage of LB134 is a sensible approach to decreasing the incidence of colon cancer in Nebraska. Caught in its earliest, precancerous stage, the cancer is almost entirely preventable, 90 percent. When insurance providers are required to cover colon cancer screening in policies, screening rates increase and the incidence of later stage cancers decrease. The outcome has been demonstrated repeatedly in the 19 states where these screenings are currently required in statute. I might also add, at this point, that in statute in many of these states, different from what we've included in this bill, it says, "screening according to American Cancer Society guidelines," and the reason for that is that ours are the guidelines that are adopted by the National Cancer Institute, the National Institutes of Health, and other organizations as being the most appropriate guidelines, the series of FOBTs, sigmoidoscopy, colonoscopy and so forth. I think LB134 can be thought of as a savings plan. It will save many people from suffering from

cancer, it will save numerous lives, and it also becomes a monetary savings plan. As you've heard, the medical costs for people with cancer are high on an individual and aggregate basis, and additional employer costs include lost productivity, short and long-term disability, and life insurance. You've heard that the figure is currently between $250,000 and $400,000 to treat a cancer, and advances in treatment and drug protocols have led to this enormous increase. By contrast, the cost to insurance providers for coverage of colon cancer screening, according to the guidelines included in the bill, is relatively low. The most basic component of screening is the annual FOBT, and that is the flexible...the fecal occult blood test. As you've heard, that's $7 to $15. The simple home test, combined with a flexible sigmoidoscopy every year, has a per member, per month cost of only 66 cents, so that little kit, there may be one in your packet or you've got one today, is a little...it's a paper package with an envelope with three test strips, that little kit will cost the insurance companies or cost the members 66 cents per month. Colonoscopy, on the other hand, is the Cadillac of colon cancer screening tests. The guidelines listed recommend a colonoscopy at age 50, and then every ten years thereafter if the patient is found to be free of precancerous polyps and is considered at low risk. And the cost for this most sophisticated test is even lower than the annual FOBT and that cost, as you've heard, is only 55 cents per member, per month. So we get a Cadillac test with a Chevrolet price tag. Each of the above per member, per month costs compare very favorably to what is now considered a standard of care across the nation, and that is the annual mammogram for women 40 years of age and older. The cost for that is 75 cents per member, per month. We wouldn't want to do away with it. We want to keep that going. We want to save women's lives. I'm happy to report that the language included in the legislation, in the amendment that Senator Schimek handed out, has been agreed upon by Nebraska's insurance providers and the American Cancer Society. Requiring this coverage will protect more people from suffering from colon cancer and will also protect insurance companies from noncompliant companies having a potential competitive advantage over compliant companies. In other words, in this day and age we can go out online and buy insurance, and if you buy insurance from a company in Texas, they don't necessarily offer this voluntarily. So they maybe can charge a little bit less and they have a competitive advantage over one of the local companies, Mutual of Omaha, Blue Cross/Blue Shield. So my understanding is that all of the insurance companies in Nebraska have agreed that this legislation is not something they're going to oppose. I urge the committee to advance LB134 to General File for passage by the Legislature. I also have...wanted to just call to your attention in this blue packet is a letter from Carol Becker. Carol had been here to testify. She had...she is a survivor of colon cancer. The reason she is a survivor of colon cancer, as a nurse practitioner, she knew when she turned 50 she should get the test. She went in to get the test. She had no symptoms. They did a colonoscopy. She was diagnosed while still under the anesthesia for the colonoscopy at a Stage III B with colon cancer at age 50. Had she not had the colonoscopy at that point she probably wouldn't be alive to tell her story today, a year later. Stage III B means that she's...it's an advanced cancer that has traveled to the lymph nodes but had not

metastasized, fortunately for her. So she's alive today. She would have been here, but she had a commitment back in Omaha at 6:00 and had to leave early. And I also have letters of...some letters of support that can be passed out from the Public Health Association of Nebraska in support of this measure. With that, I conclude my testimony. Is there...I would entertain questions. [LB134]

SENATOR PAHLS: David, I have one question. [LB134]

DAVID HOLMQUIST: Yes. [LB134]

SENATOR PAHLS: I heard you say that you are telling me that the insurance companies are not opposing this. [LB134]

DAVID HOLMQUIST: That's what I understand. Jan McKenzie, who represents the Nebraska Insurance Federation, came to me and said that she had talked with Senator Schimek. We were able to work on some language in the beginning of the bill that added that certificate language, and said we are not opposing the bill; if anything, we may testify in a neutral capacity. And I said, oh surely you can come in, in support. And she said, well, I'm not sure. And then we talked about the Internet issue that I mentioned and I wasn't aware of that. She said, you know, you could buy it outstate. So they understand that this is the most efficacious way to address the colon cancer issue. [LB134]

SENATOR PAHLS: Right. And just to let you know, I've had that procedure. [LB134]

DAVID HOLMQUIST: As have I. [LB134]

SENATOR PAHLS: I see no more questions. Thank you. [LB134]

DAVID HOLMQUIST: Thank you. [LB134]

SENATOR PAHLS: (Inaudible). [LB134]

LYNNE ANDERSON: This chair is so nice and warm at this time of day. [LB134]

SENATOR PAHLS: (Laugh) Been used today, hasn't it, Lynne? (Laughter) [LB134]

LYNNE ANDERSON: (Laugh) (Exhibits 6, 7) I'm Lynne Anderson, L-y-n-n-e A-n-d-e-r-s-o-n, a registered nurse, master's degree in nursing, advanced practice nurse. I am here today in support of LB134, speaking for Nebraska Nurses Association, and I only have a page here of testimony and you will all be very pleased to know I'm going to go right down to the very last paragraph, because everything else has pretty much been said, so we won't repeat that. I do want to, in light of the fact that we did

hear from the insurance companies, their opposition to mandates, and this is a mandate...and, Senator Langemeier, I really appreciate what you said about why not just have these screenings done the most appropriately; why not put that in the bill. And as Senator Pahls, I also have had this procedure. Mine didn't cost that much. I don't know why they gave me a great deal, but even better with the screening, and I just want to clarify that from the nursing standpoint looking at prevention, polyps progress slowly. Polyps are just like little warty-looking things in the intestines. If those are snipped off before they become cancerous then they do not become cancerous. So the colonoscopy can be a preventative treatment as well as a diagnostic procedure. And just wanted to kind of clarify that it's not just for early diagnosis of cancer, but can in fact, lead to prevention of when it gets those polyps snipped off early on. The mandate for mammograms, and being a woman in this midst of men at these roundtables, except for this nice lady, mammograms had the same kind of concern, why mandate something, it will lead to increased costs and all. Dr. Thorson just referred to the new statistics that just came out. I happen to have that statistics book, with the mammograms. And just making a comparison between mammograms for breast cancer and colon rectal screening, the mandate, and colon rectal cancer. With mammograms, looking at the statistics, the incidence initially went up. In other words, more cancers were found. There was kind of an outcry about does this mean we've got more breast cancer, or does it mean that we're just finding them earlier? Now in the newest edition, and some of you may have read in the newspaper accounts as well, the death rate from breast cancer has fallen 16 percent from when those required mammograms came about for the screening. So just as mammograms have led to a significant decrease in death rate of women with breast cancer, we would anticipate that with colon rectal screening being mandatory we would anticipate first we may see a surge in the incidence, in other words, the cancers that are found, because we'll find those early ones early, before they would have been found otherwise, but then what we could anticipate is a drop in colon rectal cancer deaths, as well as anticipate a drop in colon rectal cancer that needs that $30,000 drug because it's been snipped off early, before it becomes metastatic. So we do support mandatory colon rectal screening to be included in the insurance...health insurance coverage. [LB134]

SENATOR PAHLS: Any questions? Seeing none, thank you, Lynne. [LB134]

LYNNE ANDERSON: Thank you. [LB134]

SENATOR PAHLS: Yes. [LB134]

CARLY RUNESTAD: (Exhibit 8) Senator Pahls and members of the committee, my name is Carly Runestad, it's C-a-r-l-y, the last name is R-u-n-e-s-t-a-d, and I'm here today on behalf of the Nebraska Hospital Association in support of LB134. I know it's been a very, very long day, so I will be very concise. The written testimony that I've submitted has a number of studies and statistics, many of which you've already heard

today, related to the importance of colorectal cancer screenings. I would just stress that improving the health of all Nebraskans through disease and injury prevention has long been recognized as an important public policy goal of Nebraska's hospitals. And although Nebraska's hospitals are traditionally known as acute healthcare providers, health promotion and disease prevention represent a natural extension of their patient and community support. And as such, Nebraska's hospitals would urge you to support and advance LB134. [LB134]

SENATOR PAHLS: Senator Langemeier. [LB134]

SENATOR LANGEMEIER: Chairman Pahls. And, Carly, thank you for your testimony. [LB134]

CARLY RUNESTAD: Uh-huh. [LB134]

SENATOR LANGEMEIER: And just one clarifying thing, I should have asked this earlier, is as we're requiring the test screenings to be covered here, is it typical that once you get passed the screening portion and you're typically found to have cancer, is that typically covered in a policy or is that an additional rider you need to add on? Do you know? Is that something... [LB134]

CARLY RUNESTAD: You know... [LB134]

SENATOR LANGEMEIER: ...and I know I may have... [LB134]

CARLY RUNESTAD: Sure. Sure. [LB134]

SENATOR LANGEMEIER: ...should have asked that earlier. [LB134]

CARLY RUNESTAD: I actually am not sure about that, Senator, but I would be happy to check on that and get back to you. I would imagine that there is probably a few people even in the room that could answer that better than me, but I'd be happy to check on it and get back to you if the next testifier is not clear about that. [LB134]

SENATOR LANGEMEIER: Thank you. [LB134]

CARLY RUNESTAD: Sure. Anything else? [LB134]

SENATOR PAHLS: Okay. Seeing no more questions, thank you, Carly. [LB134]

CARLY RUNESTAD: Thanks. [LB134]

SENATOR PAHLS: Any more proponents? Okay, opponents? Neutral? [LB134]

MARK KOLTERMAN: Senator Pahls, my name is Mark Kolterman. I'm from Seward, Nebraska, and I'm here representing the Nebraska Association of Insurance and Financial Advisors. We're taking a neutral position on this bill for several reasons. First of all, how can you be against early detection of cancer? And I think we all know that if you detect it early, many lives can be saved and costs can be reduced. But the reason we're here taking a neutral position is the mandate aspect of this. I've been here since 1:30, when your committee started, and I listened to all the talk about the mandates at the previous hearing. I've been in the insurance business for 30 years and, Senator Christensen, I heard you ask about as an independent businessman, how many...how many things are covered and how will it affect the small business person. In the 30 years I've dealt with employee firms from anywhere from 5 employees, including self-employed one-person operations, all the way up to 1,500 employees, and every time you talk about a mandate, it increases the cost of insurance. And on almost on a weekly basis I have employers come to me and say, can I write health insurance, and they tell me, and I have to say to them, well, this is the cost, and in many cases they just can't afford it any longer. It's get...in many cases, it is getting cost prohibitive. And so, as an association, we very much favor the idea of early detection. Any time we can save a life and get to the problem ahead of time, we're 100 percent behind that. On the other hand, if it has to be mandated, there has to be a cost associated with it and that just keeps adding on to the cost of the insurance. And so that is why we're taking a neutral position. [LB134]

SENATOR PAHLS: Okay. [LB134]

MARK KOLTERMAN: Any questions? [LB134]

SENATOR PAHLS: Can you answer the question that Senator Langemeier had about... [LB134]

MARK KOLTERMAN: Most policies that I am familiar with can cover cancer and, in fact, most of the policies that I write, and most of them have been represented here today, they have the early detection coverage provided, colonoscopies and so I do not think that's a problem. [LB134]

SENATOR PAHLS: Senator Langemeier. [LB134]

SENATOR LANGEMEIER: Chairman Pahls, if I can follow up on that. When a policy that you write covers cancer, is that the way it would be worded, just cancer, and that would cover no matter what end of the spectrum it is? Or is it itemized to certain types or...? [LB134]

MARK KOLTERMAN: Yeah, I think it depends on the kind of policy. If you're going to go

on the Internet and buy insurance and try and cut your costs down, in many cases there is going to be a schedule of benefits, especially like somebody was talking about out-of-state type of policies that you can buy. Most of the policies that I see today are major medical types of coverage, and they cover most your cancers, that I am aware of, skin cancer. I just do not have anybody that has a problem with the coverage. [LB134]

SENATOR LANGEMEIER: Okay. I guess my follow-up question to that is if you're already covering it, wouldn't it be good public policy for your own company to have early detection to save you from the $250,000 to $400,000... [LB134]

MARK KOLTERMAN: Exactly. [LB134]

SENATOR LANGEMEIER: ...if you can do it with a blood test for $7? [LB134]

MARK KOLTERMAN: That is why we are neutral on this. We very much favor that. [LB134]

SENATOR LANGEMEIER: I understand. [LB134]

MARK KOLTERMAN: On the other hand, it's a mandate. [LB134]

SENATOR LANGEMEIER: Right. Thank you. [LB134]

SENATOR PAHLS: It is the concept of a mandate, is actually what you're disagreeing with. [LB134]

MARK KOLTERMAN: Exactly. [LB134]

SENATOR PAHLS: I see no more questions. Thank you. Oops. Oh. You got to hold it up high this time of day. (Laughter) [LB134]

SENATOR CARLSON: Okay. All right, Senator Pahls. [LB134]

SENATOR PAHLS: (Laugh) Senator Carlson. [LB134]

SENATOR CARLSON: Mark, you have been more active lately than I have in the health insurance area, but I heard you say that most of the policies that you handle would cover any form of test that would relate to cancer? [LB134]

MARK KOLTERMAN: That...yeah. I have yet to have anybody turn down a colonoscopy type of a test or blood test. [LB134]

SENATOR CARLSON: Okay. Because from what we heard in terms of the potential

savings by having it detected, it would seem to me like most companies would want to cover it. And I think you brought up a good point. If you're going to go on the Internet and shop, don't be too sure. [LB134]

MARK KOLTERMAN: Exactly. [LB134]

SENATOR CARLSON: There is a reason for low premiums. [LB134]

MARK KOLTERMAN: Exactly. And I think that is why you don't have any insurance companies here in opposition today. The companies that were here testifying earlier are all good, quality companies that do provide this kind of coverage. [LB134]

SENATOR CARLSON: Thank you. [LB134]

SENATOR PAHLS: I see no more questions. Thank you for your testimony. [LB134]

MARK KOLTERMAN: Thank you. [LB134]

SENATOR PAHLS: Any more testifiers? Seeing none, that will close LB134. I guess, Senator Schimek, she did waive, right? Yeah. Okay. Okay. [LB134]

SENATOR LANGEMEIER: Now bring her back. [LB134]

SENATOR PAHLS: Yeah, let's bring her back, right. (Laughter) Tell her we found some paper down here of hers. [LB134]

SENATOR CHRISTENSEN: Well, we saved the best for last. []

SENATOR HOWARD: Thank you. []

SENATOR CHRISTENSEN: You had a long wait, but... []

SENATOR HOWARD: Oh, I waited in Education. []

SENATOR PAHLS: Okay. Senator, I think we're ready for you, Senator Howard. LB85. []

SENATOR HOWARD: (Exhibit 1) Well, I'll try to make this concise. My brain is pretty full of school funding formulas right now too. (Laugh) Good afternoon, Senator Pahls and members of the Banking, Commerce and Insurance Committee. For the record, I am Senator Gwen Howard and I represent District 9. I am here before you to introduce LB85. The purpose of this bill is to establish the Nebraska Health Insurance Policy Coalition as an ad hoc committee of the Legislature charged with recommending

legislative remedies for uninsured and underinsured Nebraskans. Over the interim my office studied the issues of uninsured and underinsurance in Nebraska, with the intent of exploring legislative options based upon successes other states have had in addressing this growing problem. We looked at current percentage of Nebraska employers that make health insurance available to their employees, and the number of employed persons who are currently participating in Medicaid, as well as examining policy strategies that other states have used to try to increase the number of persons who have healthcare insurance. We learned that, like many other states across the nation, in Nebraska about two-thirds of employers make health insurance available to their employees. When employers who do not provide health insurance coverage to their employees were surveyed, 59.2 percent of the respondents cited that insurance was, this comes as a surprise, too expensive. Cost is a factor for consumers, as well as employers. Only 61.4 percent of full-time and 47.2 percent of part-time employees who are eligible for single coverage insurance actually enrolled in coverage in 2004, and the source of these statistics come from the Nebraska Department of Labor, Workforce Development. In Nebraska, approximately 200,000 people are eligible to receive Medicaid benefits each month. That's 11.5 percent of Nebraska's total population. Sixty-six percent of Medicaid recipients in 2005 were children and pregnant women. The Nebraska Medicaid Reform Plan completed in December 2005 reported that total state and federal expenditures for Nebraska's Medicaid system is almost $1.4 billion annually. In September of 2006 Nebraska Health and Human Services officials reported that 88,000, or roughly 44 percent of the persons who were using the Medicaid system cover their healthcare costs, are employed or are dependents of employed individuals. Over all, the percentage of individuals who are uninsured or underinsured continues to grow, and the cost of medical care for the uninsured is affecting all Nebraskans. State budgets are challenged to keep up with increasing costs. Consumers are struggling to meet rising insurance premiums and copays for care and prescription, and our medical care system is sustaining more losses each year. It's clear that a comprehensive solution is necessary to guarantee insurance to all Nebraskans, but I believe we can make a big impact on this growing social and economic concern by increasing access to insurance among two targeted populations, children and individuals who are employed. The Governor has convened the Nebraska Health Insurance Policy Coalition for the past few years, and they have made significant progress toward finding potential solutions. LB85, this is important, LB85 would simply continue the work of that coalition and charge them with making recommendations to the Legislature regarding potential remedies for this challenge. Continuing the work of this existing coalition is a way to streamline resources by not creating a new group to engage in the same work this group has already begun. One thing is certain. I do not believe that we can continue to wait for others to find solutions for uninsured and underinsured Nebraskans. We have an obligation to address this problem. We can either work together to find an effective remedy for those who want to be able to insure themselves, or we can continue to bear the social and economic consequences of people who cannot afford to pay for their own basic healthcare needs. The intent of LB85 is that this group generate specific solutions

for healthcare insurance. I think that our Legislature and our constituents deserve this. Now there is one amendment that was brought to us and seems perfectly reasonable and I'll just briefly give you this. LB85, regarding this LB, I have been contacted by a couple of advocacy groups that have requested that there be a designated position on the coalition, and that's the existing coalition, to represent potential insurance consumers. I am amenable to an amendment and I will pass this out that would require the inclusion of a consumer advocacy representative on the coalition, and it is just that simple. [LB85]

SENATOR PAHLS: Senator,... [LB85]

SENATOR HOWARD: Yes, sir. [LB85]

SENATOR PAHLS: ...I have a question. Now this commission has been...how long has this commission been alive? [LB85]

SENATOR HOWARD: That's a good question. [LB85]

SENATOR PAHLS: Well, I mean,... [LB85]

SENATOR HOWARD: And we're guessing here three years. [LB85]

SENATOR PAHLS: Okay, three years, and they would continue to... [LB85]

SENATOR HOWARD: They would be willing to continue. [LB85]

SENATOR PAHLS: ...they'd be willing to do this. This is not a...okay. [LB85]

SENATOR HOWARD: Not a new group. [LB85]

SENATOR PAHLS: Okay. And they would be willing. [LB85]

SENATOR HOWARD: But they would be accountable to the Legislature and... [LB85]

SENATOR PAHLS: Okay. Okay. That's my question. Senator Langemeier. [LB85]

SENATOR LANGEMEIER: Chairman Pahls. And, Senator Howard, thank you. This group is in existence. Do they fit this criteria that's currently in the green sheet? [LB85]

SENATOR HOWARD: I believe they do. That's why we looked at continuing to use them. They were all already up and running. The one factor that we need to include is a consumer, perfectly reasonable. [LB85]

SENATOR LANGEMEIER: Right. And then my other question, I have a couple of them, but my other question then, do you have a sunset date on this? Do you...you know, when are they supposed to have this legislation? [LB85]

SENATOR HOWARD: To have the information. That's... [LB85]

SENATOR LANGEMEIER: It really doesn't say whether it's this year or ten years from now. [LB85]

SENATOR HOWARD: That's an excellent point and definitely there should be a time frame for getting that. [LB85]

SENATOR LANGEMEIER: Okay. And then my last question I will quit with is the cost. Who is picking up the expenses of this group? [LB85]

SENATOR HOWARD: That would be borne by the state. That would be our cost. [LB85]

SENATOR LANGEMEIER: So there would be an A bill to come along with this. What do you expect that to be, roughly? [LB85]

SENATOR PAHLS: It says $13,000. [LB85]

SENATOR PIRSCH: Thirteen to sixteen is what this says. [LB85]

SENATOR CHRISTENSEN: Thirteen to sixteen. [LB85]

SENATOR HOWARD: Thank you. [LB85]

SENATOR LANGEMEIER: Oh, the fiscal note? A thousand? Okay. [LB85]

SENATOR PIRSCH: Thirteen to sixteen thousand. [LB85]

SENATOR LANGEMEIER: Thank you. [LB85]

SENATOR HOWARD: I need a lifeline this time of the day. (Laugh) [LB85]

SENATOR LANGEMEIER: I obviously need one, too, so thank you. [LB85]

SENATOR HOWARD: You're welcome. [LB85]

SENATOR PAHLS: Senator Carlson. [LB85]

SENATOR CARLSON: Senator Pahls. Senator Howard, we look at the purpose and I'm

just clarifying this, this is focusing on people that are healthy and insurable. Would that be correct? [LB85]

SENATOR HOWARD: Well, they are employed and we would like to think they are reasonably healthy, but the assumption is they could bear the cost of insurance, they could be insurable, yes. [LB85]

SENATOR CARLSON: Okay. [LB85]

SENATOR PAHLS: I see no...oh, Senator Pirsch. [LB85]

SENATOR PIRSCH: Just briefly, what...you said this particular committee is in existence currently. Are you serving on that? [LB85]

SENATOR HOWARD: I'm not. [LB85]

SENATOR PIRSCH: Do you...who does? [LB85]

SENATOR HOWARD: We've use them for information, but I am not on the committee...coalition. [LB85]

SENATOR PIRSCH: Is it composed in a manner different than that which is laid out here in the bill? I mean is there a legislative representative currently on that? [LB85]

SENATOR HOWARD: The coalition was appointed. My understanding is the coalition was appointed by the Governor and the makeup would be comparable to that that is described in the green bill. [LB85]

SENATOR PIRSCH: Okay. And it has been... [LB85]

SENATOR HOWARD: Oh, here is a list of... [LB85]

SENATOR PIRSCH: Oh. [LB85]

SENATOR HOWARD: Well, like magic. [LB85]

SENATOR PIRSCH: Stop the press. [LB85]

SENATOR HOWARD: It is a list of the people that are serving. [LB85]

SENATOR PIRSCH: But it parallels that in any event. Have...and it was...it has been in effect for the last three years, is that correct? [LB85]

SENATOR HOWARD: That's my understanding. [LB85]

SENATOR PIRSCH: What was the charge of this? I mean, were they supposed to formulate some policies for addressing both the child and the employed? [LB85]

SENATOR HOWARD: And to come up with workable recommendations, some valid recommendations regarding addressing the problem of the uninsured and underinsured to lessen the burden on the Medicaid program. It is to really look at offsetting the costs that we continue to bear and that continues to grow. [LB85]

SENATOR PIRSCH: So it was a broader kind of focus, just in general there. [LB85]

SENATOR HOWARD: Yeah. [LB85]

SENATOR PIRSCH: Okay. Thank you. [LB85]

SENATOR PAHLS: Senator Langemeier. [LB85]

SENATOR LANGEMEIER: One more question. [LB85]

SENATOR HOWARD: He is working too hard. [LB85]

SENATOR LANGEMEIER: No, I was reading the fiscal notes here and the fiscal note, there is two of them. Do you...do you know why there is two? [LB85]

SENATOR HOWARD: I don't. Why would there be two? [LB85]

SENATOR LANGEMEIER: I'm going to try and read this. The first one is...says it will be $13,000 to $16,000, but the second fiscal note says $80,000 to $75,000...$80,000 in '08... [LB85]

SENATOR HOWARD: That must be that cost of that consumer that is going to participate. (Laugh) [LB85]

SENATOR LANGEMEIER: That one amendment, it got expensive. (Laughter) [LB85]

SENATOR HOWARD: I don't know. [LB85]

SENATOR LANGEMEIER: Consumers are expensive, aren't they? [LB85]

SENATOR CARLSON: Good comment. [LB85]

SENATOR HOWARD: Quite honestly, I don't know why there would be, especially such

a vast difference. I'm not going to... [LB85]

SENATOR LANGEMEIER: May be something you'd want to look into. [LB85]

SENATOR PAHLS: Well, the FTE, it says the FTE. [LB85]

SENATOR LANGEMEIER: Right. [LB85]

SENATOR PAHLS: So that means they're actually going to... [LB85]

SENATOR HOWARD: Oh, to pay these individuals to participate on that. [LB85]

SENATOR PAHLS: Well, no, the FTE would be like you pay me a salary, full-time. [LB85]

SENATOR HOWARD: Okay. So one individual would be paid to be in charge of that. [LB85]

SENATOR LANGEMEIER: Something to look into. Thanks. [LB85]

SENATOR HOWARD: That's that consumer. I'm telling you what... [LB85]

SENATOR PIRSCH: Maybe they didn't include the health insurance on that one. (Laughter) [LB85]

SENATOR PAHLS: Well, it's getting time. I think we are finished with the questions right now. Thanks, Senator. [LB85]

SENATOR HOWARD: Thank you. [LB85]

SENATOR PAHLS: Do we have any proponents? Two, three? Any opponents? One? Anybody neutral? Okay, we have three proponents, let's begin, and one opponent. [LB85]

LYNNE ANDERSON: (Exhibit 2) Oh dear, forgot to fill that out. I will do that after. I am Lynne Anderson, L-y-n-n-e A-n-d-e-r-s-o-n, registered nurse, advanced practice nurse, and for this LB85 I am speaking as a citizen, interested person. I will...our Nebraska Nurses Association has elected to monitor this bill, but had not taken a position whether to support or to oppose. In introduction, I am the NNA representative to this commission that is currently seated, and I am very happy to have the opportunity to testify in support of this bill that has been introduced by Senator Howard. The healthcare delivery system in this country, including Nebraska, is in a state of crisis and change, as all of you know. The current commission, and I do have the report here which also has the commission

members in it. I did not bring copies for everyone, but can make that information available. The current commission was able to look at the population of uninsured in Nebraska, as well as the current and potential resources for insurance for those persons. The advantage to this commission was that varied groups were represented. Those included Nebraska Health and Human Services, Nebraska insurance commissioner, insurance executives, small business owners, child advocacy proponents, medical and nursing groups, and representatives of other interests and concerns. And one reason I am such a strong proponent of this bill is there have been many and continue to be many commissions and study groups looking at, say, Medicaid or particular kinds of insurance, looking at mandates to, for want of a better term, impose on insurance companies, but this commission had people from the entire table who came together, all with our own concerns, things that we had to offer and different perspective on the problem. We did in fact come up with some recommendations. Those were arrived at with great (laugh)...a lot of debate, shall we say? We did not come up with, because we did not have any mandate to come up with legislation, only recommendations and options to be considered. And for that reason, I think it would be very favorable for Nebraska, for the healthcare system, for such a commission to carry forward so that as different ideas, different proposals come up, that they can be examined within a group with different interests. I think that is what the real big...one of the big advantages of such a commission would be. The complex system of healthcare in Nebraska needs a commission that has an overview with all the issues and interests of each group considered so that a more workable system can be instituted. There is no simple solution, as all of you in this room know. This commission does not purport to produce a bit of magic, but to have the opportunity to do the best for Nebraska citizens. Given all the constraints and limited resources that are available, balance and communication is needed amongst these different groups. I also have included in this, and, Senator Howard, I apologize that I did not get to you earlier, I would like to respectfully submit that a named representative include an RN. RNs, registered nurses, work with the entire healthcare system, including insurers, patients, families, providers, healthcare facilities, and community resources. Our education has a focus on health maintenance and disease prevention, as well as care of those with illness or injury. I'd also like to mention and commend Dave Palm with Health and Human Services. He is the person who has been the coordinator and director, and has written the reports for this commission. Thank you all very much and I'd be happy to entertain whatever questions you might have. Yes. [LB85]

SENATOR PAHLS: Senator Pirsch. [LB85]

SENATOR PIRSCH: Oh, are you sure? [LB85]

SENATOR LANGEMEIER: Go ahead. I'll... [LB85]

SENATOR PIRSCH: I just had a question, because you've been working with kind of a

similar group to the one being proposed. Do you think...was it fruitful, in bringing about better coordination, having all the interests, as it were, kind of represented? And did that ultimately...so that's the first question. And did it ultimately lead to any, you know, substantively beneficial type of solutions? [LB85]

LYNNE ANDERSON: Yes, we did come up with some recommendations and, in fact, we just had a...our last meeting was within the past month. The recommendations from that, I did not bring a copy of them. Sorry, I didn't realize that I might be the member from the group here speaking. But, yes, we did come up with some recommendations and it was not...although the recommendations that we came up with, one should be doable. And we did not have great objection to any of them. In other words, we all, as a group, voted and had no "no" votes. We had obvious concerns that had been expressed about each of those recommendations, so it was a consensus, but not wholehearted everyone saying, gee, this is...this is perfect. But we all agreed, because we knew that this is a difficult situation and needs...Nebraska needs to try and approach this problem of the uninsured, and so we need to get on with it. [LB85]

SENATOR PIRSCH: Well, do you...were there any specific proposals that you can remember just briefly? [LB85]

LYNNE ANDERSON: One that I specifically recall because it did have some, oh, what's the proper term, in other words, we knew that there was some opposition to it, not necessarily from within the commission itself, which was Nebraska does not utilize the SCHIP program. That's the state...it's a national program, provides funding for children to have health insurance, but it's not children who qualify for Medicaid, because they are not that poor, which includes a lot of the people that we found through all of these studies who are amongst the uninsured. The uninsured in Nebraska, 65 percent have full-time jobs. We also have a huge number of small businesses in Nebraska, many of which cannot afford health insurance. And many of those, even if they do offer health insurance, only can insure the person who is employed there; does not include family or spouse. So one of our proposals was to try and get more SCHIP money, which should be available. In other words, we can kind of change the rules here and get waivers so that we can insure more of the children who would then qualify under the low income, even though have working parents. There was concern, and many of you are, I'm sure, aware that the funding, because the budget in Congress and Washington has not been passed and is in arrears so that monies are very short for that right now, so there was concern if we're saying let's bring in more of those monies so we can help the uninsured because we can help by insuring the children of these low-income people, the money is just not there. But people are pushing through Congress trying to increase that. So that was one of the recommendations, make SCHIP money more available through the state of Nebraska so we can insure more of our low-income families through that method. Then their health insurance, we also came up with some recommendations for having the private insurers have some sort of a package plan that they could offer and then

potentially, if that was not a possibility, that people could...kind of a fall back, could buy into Medicaid insurance, with it being kind of a separate program with less of the benefits provided and have people pay to belong to that program. So those were things that we were exploring. Perhaps the state coming up with some monies to help the low-income people in these small businesses purchase their own insurance, those were the types of things we were looking at. [LB85]

SENATOR PIRSCH: Well, thank you. I think that gives that good...fleshes it out. [LB85]

LYNNE ANDERSON: Sorry. I have a six-inch file over here and... [LB85]

SENATOR PIRSCH: No, I appreciate...no, I think that gives us... [LB85]

LYNNE ANDERSON: ...it's hard to know... [LB85]

SENATOR PIRSCH: (Laugh) Yeah. [LB85]

LYNNE ANDERSON: Any other? [LB85]

SENATOR PAHLS: Senator Langemeier. [LB85]

SENATOR LANGEMEIER: Chairman Pahls. And I'm going to put this out kind of as a question, but yet I don't really want you to respond. I want you to go home... [LB85]

LYNNE ANDERSON: Oh, okay. [LB85]

SENATOR LANGEMEIER: ...I want everybody to go home and think about this. Typically, I've been an opponent of these kind of groups because usually 99 percent of them run amuck. Without a real designated leader they don't go anywhere. And the other thing I always see with these kind of groups, when they run amuck, is it's a "let's feel good about this topic" so let's bring a player from all the industries. We throw them in a room to make them feel good that we are addressing this issue, which really we don't care what they come up with a result. They give us a binder, which I get 30 of them a day. They go on my shelf. I'm not...I don't pretend to read all those. How can we make a group like this, number one, that anybody really cares what they put out at the end? And number two, how do we keep them from running it amuck? And I don't really want you to respond to that right now, but I want everybody to think about that. And that's why I can give you examples of others that are out there that without some new guidance and new leadership they're just running amuck. [LB85]

LYNNE ANDERSON: Uh-huh. [LB85]

SENATOR LANGEMEIER: And as a taxpayer, why do I want to spend...well, it depends

on which one of these fiscal notes you read. Why do I want to spend $80,000 or $16,000 a year to have a feel good group that runs amuck? [LB85]

LYNNE ANDERSON: Uh-huh. [LB85]

SENATOR LANGEMEIER: That's...thank you for your testimony. You've done great, and thanks for sitting here all day. [LB85]

LYNNE ANDERSON: And I totally agree with you with that, because... [LB85]

SENATOR PAHLS: Lynne, did your group that you were involved with, did they run amuck? [LB85]

LYNNE ANDERSON: There were some times that there was a little muck about. (Laughter) [LB85]

SENATOR PAHLS: Well, when you have a group of 21, there's a good possibility of... [LB85]

LYNNE ANDERSON: Okay. [LB85]

SENATOR PAHLS: ...somebody carrying you off to the edge. [LB85]

LYNNE ANDERSON: I think...I think this group proceeded forward because of Dave Palm, and I probably should not say this in a political entity, but he kind of stuck his neck out and carried some issues forward that we knew there were behind the scenes people that really didn't want to hear some of these things. So I agree with you, it can become very political and there are all these outside interests. It takes a group that really feels committed and does not just sit on the sidelines. And with this group, every time we came to a point where we said, okay, this is what we recommend, people would say, okay, then what are we going to do about it? And we had people like that, what are we going to do about it? I agree with you. [LB85]

SENATOR PAHLS: Okay. [LB85]

SENATOR LANGEMEIER: Thank you. [LB85]

SENATOR PAHLS: Thank you. Thank you. Seeing no more questions, thank you, Lynne, for your testimony. We have two more proponents? [LB85]

CARLY RUNESTAD: (Exhibit 3) Senator Pahls and members of the committee, again, my name is Carly Runestad, it's C-a-r-l-y R-u-n-e-s-t-a-d. I'm here on behalf of the Nebraska Hospital Association in support of LB85. Although I was not a member of the

original coalition, the NHA was part of the original coalition and certainly look forward to continued participation with this group. I don't have a lot to add, what hasn't...what hasn't already been brought up here. I do have, if it is helpful for you, I do have a couple of examples of some of the strategies that were brought up by the Nebraska Health Insurance Policy Coalition. The other thing that I would offer is that the report from the group, it's about a 48-page report, and it's available on the Internet. I could certainly either give you the web site or, if it's easier, I can e-mail you the PDF and a summary of the report, if that would be helpful. [LB85]

SENATOR PAHLS: Why don't you give us a couple of the strategies? [LB85]

CARLY RUNESTAD: Okay. My understanding is that a few of the strategies they came up with were issues such as provide education and training to consumers and small employers about the benefits of health insurance coverage, and the advantages and disadvantages of various policies; supporting a disease management program for Medicaid patients and using the savings to expand Medicaid benefits; joining a multistate purchasing pool to negotiate lower prescription drug prices to expand Medicaid benefits; creating public and private partnerships between small employers and Medicaid. Some states have expanded coverage by creating a premium assistance program and in these public-private partnership programs, the state, the employer and usually the employee share the costs of the premium. Expanding the use of drug discount programs, etcetera, those are just some examples of some of the strategies that they came up with. [LB85]

SENATOR PAHLS: Okay. So they didn't totally run amuck. [LB85]

CARLY RUNESTAD: Didn't totally run amuck (laugh)... [LB85]

SENATOR PAHLS: No, I'm just having...it's late in the day. [LB85]

CARLY RUNESTAD: ...as far as I know. So I...on behalf of the hospitals of Nebraska, I would ask you to support and advance LB85. I think that efforts to address the expansion of healthcare coverage are critical, not only to the ongoing health of employed individuals and children throughout the state, but just on a fiscal aspect as well. [LB85]

SENATOR PAHLS: Any questions? Seeing none, thank you, Carly. [LB85]

CARLY RUNESTAD: Okay. [LB85]

DAVE McBRIDE: Senator and committee members, again, my name is Dave McBride with Nebraska Association of Insurance and Financial Advisors, M-c-B-r-i-d-e. We are here in support of the bill. Also, the intent of this in lines 19 and 20, when you look at

this it says, "remedies to address the expansion of health care coverage to employed individuals and children in the state," and that really is what our members across the state are involved in every day, working with individuals and businesses, trying to solve their...the needs of their employees and children. And so if this entity is to go forward with this kind of a charge, we would certainly pledge the support and the resources of our organization to assist however we can. It's obviously a challenge or a directive that is...deserves some attention and we would encourage you to support it. And that's all I have. [LB85]

SENATOR PAHLS: Any questions? Senator Langemeier. [LB85]

SENATOR LANGEMEIER: Thank you for your testimony, by the way. As I've talked to who...who should this group report to? Should they report to Health and Human Services? Should they report to the Governor? We obviously, with the floor debate today, we don't want them reporting to HHS. Who would you suggest they report to? [LB85]

DAVE McBRIDE: It would seem to me that if they're appointed by the Governor that it would be as logical as anything to have them report to the Governor's office. But, I mean, your question earlier or your point is very well taken. For the state to spend its resources and for the individuals on this coalition to spend their time and energy, you certainly want something tangible and productive coming out of it. So, I mean, if the committee feels that reporting to the Governor's office would be a way to assure that, that would seem to me to be the logical approach. [LB85]

SENATOR LANGEMEIER: Okay. Thank you. [LB85]

SENATOR PAHLS: Seeing no more...oh, Senator Pirsch. [LB85]

SENATOR PIRSCH: No, I'll tell you what, I think I can do it informally, so no questions. [LB85]

SENATOR PAHLS: Okay. Saved you, Dave. [LB85]

DAVE McBRIDE: Okay. [LB85]

SENATOR PAHLS: Thank you. [LB85]

SENATOR PIRSCH: Yeah. [LB85]

SENATOR PAHLS: Okay, that's...opponents? Neutral? [LB85]

JOHN O'NEAL: Thank you, Senator Pahls, and this will be very brief. My name is John

O'Neal, J-o-h-n O-'-N-e-a-l. I'm chair of the government affairs committee of the National Multiple Sclerosis Society's Nebraska Chapter. We're, I guess, one of two organizations that kind of objected to the makeup of this committee. I don't know who the other organization even was that went to Senator Howard. We do welcome her amendment, but we still feel like there's not enough representation on this coalition for consumers. There are a lot of different kinds of people who don't have insurance, and sometimes their interests are very much different and they have a lot of different things to say. You have the people who are legally disabled. They have a very big story to tell and they may not even be able to get insurance, so they may not even be affected by this bill. You have people with chronic illnesses of various kinds. Some may have MS like me and you would never know it if I never told you. But obviously we have some huge insurance problems, and we have a story to tell, and I think we need to be at the table, somebody from our group needs to be at the table to tell that story. You have the general run-of-the-mill employer, employee of a small business. He's got an entirely different story to tell. And I think employees should be at the table. The uninsured, for a wide variety of reasons can be in that situation, and I think they should be at the table. So, you know, we have no objection to the people that are...any of the groups that are part of this coalition now, but we just think that consumers need more representation. And again, I think putting one consumer advocate on this...well, actually there is one. There's a child advocate and that's fine. They should be there. But adding just one consumer advocate as the proposed amendment would do, we think is inadequate and we think there should be more. We think there needs to be more balance on this coalition. And with that, I'll ask for questions. [LB85]

SENATOR PAHLS: Okay. I do think that you have a point there. And to be honest, if this would get on the floor Senator Chambers would have an issue with certain economic, you know, people not being represented. [LB85]

JOHN O'NEAL: Uh-huh. [LB85]

SENATOR PAHLS: How many...how many people do you think should be on a committee? [LB85]

JOHN O'NEAL: Well, this is the first I've read of it until when I read this bill this year. Twenty-one does seem pretty big, but I serve on the board of trustees of our MS Society and I think we've got 24 so...of course, they don't all show up at the meetings, but (laugh) that's a pretty big committee. [LB85]

SENATOR PAHLS: Yeah. Okay. [LB85]

JOHN O'NEAL: But it gives you a variety of viewpoints, too. [LB85]

SENATOR PAHLS: Okay. [LB85]

JOHN O'NEAL: So I don't know. [LB85]

SENATOR PAHLS: Okay. I think the senator is listening to some of your suggestions. You know, as we talk about it we could...Senator Langemeier. [LB85]

SENATOR LANGEMEIER: Chairman Pahls, thank you. And thank you for sitting around today for your testimony. And if we expand this out to add more consumers, which I don't have a problem with at all in any way, if it's going to go forward, but currently there are literally hundreds of boards and commissions in this state that go unfilled because nobody steps forward that wants to be on these. How do we find the general consumer out there that doesn't have just an ax to grind that wants to sit on these committees and offer an objective position and show up? You know, it doesn't do any good to have 24 if you only get 3 show up every time. How do we find those people? [LB85]

JOHN O'NEAL: Well, that's a good question. I think to some extent you're going to...and people who are politically active these days are going to have some ax to grind. It may not be the ax to grind of their organization, but... [LB85]

SENATOR LANGEMEIER: Limited ax to grind, let's put it that way. [LB85]

JOHN O'NEAL: Right. Yeah. And I think, frankly, you know, anybody who is on the committee now probably has some axes to grind, too, so I think that's just being part of...being a human. I think everybody has got kind of an ax to grind on this subject. [LB85]

SENATOR LANGEMEIER: But how do we find even those people? If we expand to add another four people, five people, where do you find them? [LB85]

JOHN O'NEAL: Oh, I think that's pretty easy. You had a number of advocates, for instance this afternoon, on the parity issue. I'm not saying that they necessarily need to be on this coalition, but they're examples of people who... [LB85]

SENATOR LANGEMEIER: But if you wanted five different ones? Yeah, we could have got five people today, but if we five, to take your suggestion to have that small business, to have all the things you mentioned, how do you go out and find those people? [LB85]

JOHN O'NEAL: Okay. Well, you can contact various organizations. I mean there's a lot of different diseases out there. You can just start calling all the different disease groups if you want to. Call us, call Alzheimer's, call...and I don't mean...I'm not picking and choosing here. [LB85]

SENATOR LANGEMEIER: Yeah. [LB85]

JOHN O'NEAL: I'm just throwing out popular names, diabetes, kidney disease, heart disease, cancer, just start calling those organizations. They have got people and they can...just ask them, say you're looking for people. [LB85]

SENATOR LANGEMEIER: Thank you. [LB85]

SENATOR PAHLS: Any more questions for John? Thank you, John. Appreciate your testimony and your time. [LB85]

JOHN O'NEAL: Thank you. [LB85]

SENATOR PAHLS: Senator Howard. [LB85]

SENATOR HOWARD: Thank you. I'll just do a brief closing for you, and I thank Senator Langemeier and my LA for pointing out the reason for the two differences here. One was done by our Fiscal Office; one was done by Health and Human Services. I didn't realize they had come in with a late entry, and so there is quite a contradiction. I would also point out that while I am totally supportive and sympathetic to all consumers having a part of this, there are groups on this coalition who represent consumer groups, and I would point Appleseed as one of those groups that, in my opinion, does an excellent job of representing individuals with...in need and that can't be here to represent themselves. I think they do the job. Health insurance coverage continues to be a growing fiscal challenge for the systems providing care, for government, employers, and individual consumers. As the number of uninsured persons increases, we all share the impact. The challenges we face as a community can best be met through collaborative efforts. It is time for Nebraska to move forward, finding solutions for increasing the number of insured persons that don't place an unfair portion of the fiscal responsibility on any one player in the system. The peace of mind that comes from knowing that our basic healthcare needs will be met should be a part of what makes living in Nebraska a good life for us all. And I am perfectly amenable to working with consumer groups, I'd add that, but let's keep the...let's keep the figure reasonable on this coalition so it's not out of hand. And I would like to add something that Senator Langemeier said. I certainly appreciate your comment about committees running amuck. The other concern I've had about committees, and studies, and that sort of arrangement is that sometimes they are set up to get a specific answer, to produce a specific focus on information or slant that some, let's say, entity wants to have come out of that. And so that's...I agree with you. Always something to look at. [LB85]

SENATOR PAHLS: Senator, I do have a question on the fiscal note, though. I understand that they add an FTE, you know, which I just can't see the need of. [LB85]

SENATOR HOWARD: Well, and we were just discussing that. Again, I agree with you.

Currently, that's an employee within the department of social services (sic) that's already budgeted in, that is there, that works on this. And that amount, in regard to what is budgeted in, is not his entirely salary. So clearly, even now, he's not devoting his entire time to this particular issue. He's got other duties as assigned, if you will. [LB85]

SENATOR PAHLS: Uh-huh. So I do think you picked up on some of our concerns so... [LB85]

SENATOR HOWARD: Oh absolutely. [LB85]

SENATOR PAHLS: Okay. Okay. [LB85]

SENATOR HOWARD: Absolutely. [LB85]

SENATOR PAHLS: Appreciate it. Any other questions for the senator? Thank you, Senator. [LB85]

SENATOR HOWARD: Thank you. [LB85]

SENATOR PAHLS: Have a good evening. [LB85]

SENATOR HOWARD: Thank you. [LB85]

SENATOR PAHLS: That closes LB85. [LB85]

Disposition of Bills:

LB85 - Indefinitely postponed.
LB134 - Advanced to General File, as amended.
LB647 - Held in committee.

Chairperson

Committee Clerk