[LB825 LB969 LB980]

The Committee on Banking, Commerce and Insurance met at 1:30 p.m. on Monday, February 11, 2008, in Room 1507 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB825, LB969, and LB980. 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 hearing. My name is Rich Pahls. I'm from Omaha. I represent District 31, what I call the Millard of Omaha. I serve as Chairman of this committee. The committee will take up bills in the order posted: (LB)825, (LB)969, and (LB)980. Our hearing today is your public part of the legislative process. This is your opportunity to express your position on the proposed legislation before us today. Now to better facilitate our meeting today, I'm going to have you take a look at the chart over here. We're asking you to turn off your cell phone. Now I know it's going to be a little bit more difficult today to move to the first two rows because they're already pretty well filled, but we do like to have the person move to what we call the "on-deck chair" where Senator Schimek is holding up her hand. Now this is how...because I know we probably have a number of new people with us today, this is how the procedure is: the senator will introduce the bill; then we will ask for the proponents of the bill; and then we will ask for the opponents; and then we'll ask for those people who are in the neutral; and then the senator, if she chooses to close on the bill, she will do that; and then we will close the testimony on that bill. And then we start the next bill in the same process. Again, what I will do is occasionally I'm going to ask you to hold up your hand if you're a proponent just so I have some feel of how many people will be testifying for that particular bill. Like, say, the first bill would be (LB)825, Senator Schimek's. Now when you come, there's a sheet that you will need to sign in, and we're going to ask you do is very important that you spell your name because we need that for the record because this is being recorded and it's very important that we do have your correct spelling. We're asking you to be concise because we probably will have a number of people speaking. Now if you have information that we need to share with the committee members, we will need at least ten copies and we can make those copies for you. Do we have anybody right now that says, hey, I need ten copies? Okay. Just so you understand who we are sitting around this circle up here: our committee counsel if Bill Marienau; this is committee clerk Jan Foster, and then I'm going to have the senators starting all the way over here to introduce themselves to you. []

TOM CARLSON: Tom Carlson, District 38, Holdrege. []

SENATOR PIRSCH: I'm state Senator Pete Pirsch, representing the 4th District in Douglas County Omaha, home of Burke High School, where the state track and field

meet is held every year. []

SENATOR LANGEMEIER: Senator Chris Langemeier, District 23, Schuyler. []

SENATOR PANKONIN: Senator Dave Pankonin, District 2. []

SENATOR GAY: Senator Tim Gay, District 14, Papillion/La Vista. []

SENATOR HANSEN: I'm Tom Hansen, District 42, North Platte, where the confluence of the North and South Platte come together, and we all wonder why we buy flood insurance. (Laughter). []

SENATOR PAHLS: All right. And Ryan Behrns is our page from Louisville, Nebraska. Now again, I want to...just because I know we have a number of new people, if you see a senator get up and leave it's because one of us has to go to another meeting because we have a bill that we're presenting to another committee. So that's one of the reasons why we get up. Senator Schimek. [LB825]

SENATOR SCHIMEK: Thank you, Mr. Chairman and members of the Banking, Commerce and Insurance Company (sic: Committee). It's my pleasure to be with you today. For the record, my name is DiAnna Schimek and I represent the 27 Legislative District here in Lincoln, the Historic District. I'm here to introduce LB825, which requires insurance companies doing business in the state of Nebraska to provide coverage for single and bilateral cochlear implants. Legislation regulating insurance coverage for cochlear implants has been passed in the states of Oregon, Kentucky, Wisconsin, and South Dakota, and introduced in Rhode Island and Massachusetts so far as we know right now. The intent of this legislation is to make cochlear implants coverage uniform throughout the state of Nebraska, and eliminate the denials of coverage for those cochlear implant candidates who choose to take advantage of this miraculous technology. According to the FDA, 90 percent of all commercial health plans provide coverage for cochlear implants. In addition, Medicare first approved coverage for adults in 1996 and children in 1992. However, there is still a percentage of companies not providing coverage for single implants, and many more denying coverage for bilateral implants. It is time to make all insurance companies provide this coverage uniformly and consistently throughout the state of Nebraska. The impact of cochlear implants on society will far outweigh the cost to insurance companies in providing this surgery. Two studies completed by Johns Hopkins University in the years 1999 and 2000, reported significant cost benefits for children with cochlear implants. The 1999 study placed the cost savings of educating a child receiving such an implant at age three at $30,000 to $100,000 over the course of primary and secondary school education. And the 2000 study measured the cost utility of cochlear implants and found that in addition to lesser education costs and increased income potential, a pediatric implant user could have an expected lifetime savings of at last $53,198. The written and verbal testimony that you

will receive today will talk about the science and benefits of cochlear implants, and the very specific requirements for candidacy. Through this I believe it will become apparent to you that cochlear implant surgeries do not dramatically increase, and insurance companies cost will not significantly rise as a result of this legislation. Any cost associated with this legislation will be far outweighed by the increase in quality of life and potential educational results for those who choose to utilize this life altering technology. With that, Mr. Chairman, I'd be happy to try to answer any questions. [LB825]

SENATOR PAHLS: Do I see any questions for the senator? Senator Langemeier. [LB825]

SENATOR LANGEMEIER: Chairman Pahls, and thank you, Senator Schimek. You briefly touched on it a little bit there, but I didn't catch it. I have a cold so this is very good timing. [LB825]

SENATOR SCHIMEK: I understand. [LB825]

SENATOR LANGEMEIER: I can't hear anything myself. What percent of the insurance coverage out there already covers this? [LB825]

SENATOR SCHIMEK: Well, according to the information that I was given, and I actually wanted to check on this before appearing before you today, but somehow my question got lost in the shuffle, apparently 90 percent of all commercial health insurers. But the problem that is most apparent is they're not as likely to cover the bilateral for, you know, for both ears and that's quite necessary, I understand, to get a true hearing capability. [LB825]

SENATOR LANGEMEIER: So you think the 90 percent is just to the single and not the bilateral? [LB825]

SENATOR SCHIMEK: That's what I understand from the information I was given, but you may wish to ask somebody who follows. [LB825]

SENATOR LANGEMEIER: I'm sure it will be addressed in the following. Thank you very much. [LB825]

SENATOR SCHIMEK: Okay. You're welcome. [LB825]

SENATOR PAHLS: Any other questions for the senator? I'm assuming you'll be here for closing? [LB825]

SENATOR SCHIMEK: I will see. I am going to sit and listen for awhile at least. [LB825]

SENATOR PAHLS: Okay, okay. Thank you, Senator. Just for those individuals...now remember, we take one bill at a time and we're working on LB825. Now, what I'm going to do is I'm going to have the page pass around...if you want to sign on, even though you may not speak up here, if you want to make sure that you register your support or you oppose this bill, what I would encourage you to do is to sign your name and you either check support or you oppose the legislation in front of you. But we will only do this right now for this bill. The next bill we will pass around also. Okay? And just...it is my understanding that we do...if you see that you don't have some of your friends here, we do have room 1023 we're using for overflow. I'll have you...again, that's for your choice, and that will become part of the record. Okay? Now, the next group will be our proponents. And I'm just...on this particular bill, I'd just like to see a show of hands, how many proponents? Okay. As you take a look, we have a number, and I'm asking you just for the time, try to make is as concise and new information would be great. Okay, we are ready for our first proponents and, again, I'm asking you to be sure you spell your name and turn in your form. Okay? Senator Christensen just joined us. And the page will hand out any information that you do have. Okay, you may begin when you're ready. [LB825]

CLIFF CARLSON: Thank you, Senator Pahls. My name is Cliff Carlson, C-l-i-f-f C-a-r-l-s-o-n. My name is Cliff Carlson. My wife, Amy, and I are the proud parents of a three-year-old boy who was born with a severe to profound hearing loss. When he was 18-months-old, he received his first cochlear implant. When he was 33-months-old, he received his second implant. We're here today in support of LB825 for many reasons. First, because we want all those who choose to utilize this technology to have access to it. Everyday we get to see the miracle that exists inside our son as he learns to hear and talk, and want others to experience that same exciting moment. Second, we want the struggles of gaining insurance coverage to not take over the lives of other parents and adults who struggle and fight against unreasonable denials and delays in coverage for this life-altering surgery. After our son was initially considered a candidate for a cochlear implant, he was denied insurance coverage twice. Only after countless phone calls and an appeal from our surgeon and the professionals at Boys Town National Research Hospital did we obtain coverage. Meanwhile, we were forced to take our child out of daycare to keep him healthy in the event we actually got the approval. In addition, he was not able to hear and was missing out on months of valuable language an speech development. Third, we'd like to educate you and the insurance companies about cochlear implants, and force those companies who are not providing coverage for either single or bilateral cochlear implants to conform to the policies of those who are. We no longer want insurance companies to look at this surgery as experimental or cosmetic. Rather, this is a life-altering cost-effective surgery that should be covered by insurance companies like just any other medical procedure. We brought this issue to the attention of Senator Schimek because of our experience with obtaining coverage for our son's first implant. And because we know the others, adults and parents, who are having the

same experiences or worse, they're being denied altogether, and they are forced to pay out-of-pocket or simply go without. At this time, I'd like to share with you an e-mail we received from the parents of a young boy named Grayson (phonetic) in Grand Island. In the spring of 2005, we began to notice that our son, Grayson (phonetic), was having some difficulty hearing and is asking us to look at him when he was speaking. In watching him, we began to realize he's already reading lips. That summer we took him to Boys Town to have his hearing checked and they said he had some hearing loss. At that point, he was four-years-old and we purchased hearing aids for each ear. In the summer of 2006, we took him back for his annual check and they deemed that his hearing loss had gotten worse and now was considered profound loss in both ears. At that time, we began the process to see if he'd qualify for a cochlear implant. In December of 2006, he was implanted in his right ear at the age of five. This implant was covered by Midwest Security Insurance Company. He excelled the rest of the year in kindergarten and was having a great start to his first grade year. In late summer of 2007, he bumped his implant site and received a bruise. The issue never went away and after several trips back to Boys Town, we found out that he had a staph infection on that spot. In October of 2007, Grayson's (phonetic) single cochlear implant was removed and the infection was cleaned out. He is fully recovered and is eligible again for the implant. During that time, Blue Cross/Blue Shield of Nebraska approved Grayson (phonetic) for a bilateral cochlear implant that he did not receive. Our employer changed insurance companies to Coventry Insurance and they do not cover cochlear implants. Grayson (phonetic) is showing signs that the hearing issues are catching up to him in school and he'd like to have his implant back. He was doing awesome with his implant and we really want to get him another. We obviously look to other options should the insurance not cover it, but LB825 would be a huge help to us. Thank you. Grayson's (phonetic) parents are the reasons Amy and I feel so passionately about this legislation. That's not right. That little boy is suffering consequences from one insurance company's uninformed and unreasonable policy. Throughout the testimony today you will hear we hope that we will answer the questions to the cochlear implants that you might have. In addition, we hope to become clear that the benefits and outcomes of this surgery far outweigh the minimal cost to insurance companies. Thank you for your time and consideration. I'd also like to thank Senator Schimek and her staff for introducing this legislation and for giving us the opportunity to present this issue to you today. Thank you for your time. I'm willing to take any questions you might have. [LB825]

SENATOR PAHLS: Okay. Do I see questions for Cliff? Senator Gay. [LB825]

SENATOR GAY: Thanks, Cliff. Do you know...and you don't have to answer this, will there be other testifiers? You talked about the approval process. I've heard that twice now that you have to go through certain steps to be approved. [LB825]

CLIFF CARLSON: Correct. [LB825]

SENATOR GAY: Do you want to go through those or will someone else following you? [LB825]

CLIFF CARLSON: Dr. Rodney Lusk, who's a surgeon, will address that. [LB825]

SENATOR GAY: Okay. I'll wait. [LB825]

CLIFF CARLSON: But there is a very clear path to become a candidate for a cochlear implant. [LB825]

SENATOR GAY: I'll wait, and I'd like to hear that. Okay. Thank you. [LB825]

CLIFF CARLSON: You bet. [LB825]

SENATOR PAHLS: Senator Carlson. [LB825]

SENATOR CARLSON: Senator Pahls. Cliff, if these figures are correct at 90 percent of the company's cover, if the other 10 percent were mandated to cover, from what you said, I still don't think that...that doesn't solve all of the problem. A major problem is getting those that say they cover to actually approve and pay. So mandating the other 10 percent, other than on this change of plan by employer, that would be the benefit of that, wouldn't it? [LB825]

CLIFF CARLSON: It would. It would rectify situations like Grayson's (phonetic) parents got into. But to your greater point, which is one I agree with, that a lot of times they say it's covered, but the process to go through is daunting. My wife and I are lucky enough that we don't take no as a first answer and we pushed hard. I think that this mandate could also send a message to the insurance companies that there are people who are bearing the burden of this cost because they are simply taking no as their first answer and not fighting for their coverage. The message that will be sent by unifying it will hopefully force them to take a look at their process and improve and work more for their insureds best interest in covering it. I think the mandate could force them to look at their process a lot harder. Quicker coverage means better service, means lower in costs. Besides the fact that we're trying to drag the other 10 percent, so to speak, into the light and look at 90 percent coverage. Medicare has been covering it since 1986, not '96. They've been covering it for pediatrics since 1992. It's 2008. Medicare has been covering it and why is private insurance not allowed to cover it? [LB825]

SENATOR CARLSON: Thank you. [LB825]

SENATOR PAHLS: Senator Langemeier. [LB825]

SENATOR LANGEMEIER: One quick question. Thank you for your testimony, Cliff. You

seem very educated on this. What percent, if we just took a random sample of an insurance group of 1,000 people, what percent in the U.S. would have this need? I'm looking how big the insurance risk is. [LB825]

CLIFF CARLSON: Right. [LB825]

SENATOR LANGEMEIER: I'm sure they're going to testify saying it's going to drive costs up, that it's going to do all this stuff. What percent need cochlear implants? [LB825]

CLIFF CARLSON: Senator, Lusk can talk to the candidacy of it. At last survey, which I saw a number in 2005, at the end of 2005, toward 2006, there was roughly 100,000 cochlear implants in the United States-wide. There was maybe at best guess less than 10,000 pediatric bilateral cochlear implants, little kids like my son. So we're not talking about a large population. Not to mention the candidacy severe to profound or profound hearing loss, it's written into the legislation that's proposed today is very specific. There's a small group of people who fall into that candidacy pool. It won't show a noticeable spike in the number of insureds who have to have this surgery. Did I answer your question? [LB825]

SENATOR LANGEMEIER: Thank you. No, you did, you did. The numbers helped. [LB825]

CLIFF CARLSON: Okay. And like I said, I'm not an expert in the numbers. Other people will address that I hope. [LB825]

SENATOR LANGEMEIER: Sometimes for other people you'll find the last questions now. Somebody else will be thinking and they're have the answer later on. So it's kind of a prompt, too. So you did great. [LB825]

CLIFF CARLSON: Certainly. Thank you. [LB825]

SENATOR PAHLS: Yeah. Senator Carlson. [LB825]

SENATOR CARLSON: Senator Pahls. I'll ask one other question and maybe you have the answer, again, maybe somebody else later on does. But if we look at a given procedure, and have a cost factor, and it costs so many thousand dollars, and then we have some kind of an idea...we're talking about Nebraska now really, so statewide how many of those procedures could we expect. That puts a price tag on it. And if we had some comparison with that procedure versus something that's already covered that it, in general, doesn't cause delay and reasons not to okay the coverage, how would those two amounts compare? And I don't know if you have anything like that, but if not, if somebody behind has some comparisons, that could be helpful. [LB825]

CLIFF CARLSON: Sure. I do know this because I have a great friend who's an orthopedic surgeon and I asked him the question about some comparable surgeries in the state of Nebraska. And I'm trying to think if the Nebraska Hospital Association keeps track on when you check out of the hospital what surgery you're there for. Those records date back to 2005. There was 3,800 total knee replacements done in the state of Nebraska last year and they were covered by insurance. The Medicaid reimbursement was about $25,000 to $35,000 to those hospitals. That's about the same amount of Medicaid reimbursement that goes to the hospital at Boys Town when they do a cochlear implant that's covered by Medicaid. Keep in mind we're speaking only from Medicaid dollars, not private insurance dollars. But that's the...the current data shows there's a similar cost paid out from Medicaid to the hospital as it would be for on a knee replacement, and there was roughly 3,800 knee replacements done in 2005 and about 1,200 or so total hip replacements. [LB825]

SENATOR CARLSON: Okay. Thank you. [LB825]

SENATOR PAHLS: Thank you, Cliff, appreciate your testimony. [LB825]

CLIFF CARLSON: Any other questions? [LB825]

SENATOR PAHLS: And what I liked about Cliff he just said there would be probably other people following with some of the answers. Our point is for clarifications, not trying to trap anybody for information, just to get more information for us to digest. I appreciate it, Cliff. [LB825]

CLIFF CARLSON: Thank you. [LB825]

SENATOR PAHLS: Next proponent. [LB825]

RODNEY LUSK: (Exhibits 1&2) Dr. Rodney Lusk, L-u-s-k. Mr. Chairman and members of the Banking, Commerce and Insurance Committee, my name is Dr. Rodney Lusk, and I serve as director of the cochlear implant program at Boys Town National Research Hospital. I'm here today to offer expert testimony on behalf of Legislative Bill 825, which requires the insurance coverage for cochlear implants. I'm a board certified otolaryngologist and am on the national board for otolaryngology-head and neck surgery. I started the pediatric cochlear implant program at St. Louis Children's Hospital. Today, we perform both unilateral and bilateral cochlear implants at Boys Town National Research Hospital. We have a team of 12 healthcare providers and educators who evaluate candidates and follow them at regular intervals after implantation. We are deeply committed to research. Few surgeons in the state of Nebraska perform this complex surgery and few hospitals are equipped with the necessary high-tech operating rooms for the procedure. In your packet you will find excellent scientific studies and

resources which prove the efficacy of unilateral and bilateral cochlear implants. I urge you to read the written testimony of Dr. Michelle Hughes, coordinator of the cochlear implant program. A cochlear implant is not a hearing aid. The device provides electrical stimulation to neurons that cannot respond to sound. There are two components of the cochlear implant. The internal device houses the receiver and stimulator in an array that goes into the cochlea. The external portion consists of a microphone, a speech processor, and a transmitting coil. The internal receiver delivers a signal to the cochlea. The electrodes send a tiny electrical charge that goes directly into the auditory nerve. This process occurs so rapidly that the listener will hear speech and environmental sounds without noticeable delay. The enactment of mandatory universal newborn hearing screening in the state of Nebraska allows us to identify children who could benefit from cochlear implantation as early as possible. The children can receive cochlear implants by the age of 12 months. Studies indicate that children with bilateral implants can be implanted at an even earlier age and have the best possible chance of developing language skills that will help them reach their full academic potential. Adults who have lost their hearing and receive implants have remarkable improvement in their quality of life. Gentlemen, there is nothing you can do that is more important to the deaf children and their families than to ensure that they have access to this technology. If you will take the time to read the information which we have provided, you will find that society will actually save money in the long run with bilateral cochlear implantation. I would like to thank Dr. (sic: Senator) Schimek, in closing, for introducing LB825 and I would like to thank the committee for the opportunity to provide this testimony today. Questions? [LB825]

SENATOR PAHLS: I'll start over here with Senator Hansen. [LB825]

SENATOR HANSEN: Thank you. Dr. Lusk, could you explain to the committee if an adult that did hear something as a child and into a young adult age, and then got a cochlear implant what that sound might be like? [LB825]

RODNEY LUSK: Adult patients that hear, they get implanted later on and they have to have a bilateral profound to severe hearing loss. Liken the sound of a cochlear implant to be tinny. Some of them say it kind of sounds like Mickey Mouse or Donald Duck. The important thing is that it gives context, and I have children with bilateral cochlear implants who you couldn't tell were deaf. And the really crucial part in the pediatric population is to get the implant in as early as possible and to do bilateral implants, and these kids can go through education without any support. I mean, they really do miraculously well. [LB825]

SENATOR HANSEN: Is there...so explain to the committee what the difference between that child's hearing would be with one as compared with two and why is that important? [LB825]

RODNEY LUSK: We're just starting to really be able to get a handle on the importance of bilateral versus unilateral cochlear implantation. At Boys Town, we're finding out that the ease of learning over hearing, most of our kids, as you know from your own children, they pick up language just by being exposed to talking. And kids with unilateral implants have to work very hard, and the biggest problem is that they can't follow conversations. They can't pick up where the sound is coming from. Somebody will talk to them, the first thing they do is start looking around to try to figure out where the voice is. And in a classroom, noisy environment, they have to be able to track, have to be able to track their peers and have to be able to track teachers. And the work of learning and listening is just remarkably better with bilateral cochlear implants. [LB825]

SENATOR HANSEN: Okay. One last question I guess. If a child can be fitted for one of these at 12 months of age, how many cochlear implants do you think they would need during the course of their life? [LB825]

RODNEY LUSK: That's a great question. The device has no working parts, has no battery. They're designed to last for 70 years. We know nothing will last that long. The failure rate overall for an internal device is about 1 to 2 percent. So it's a device that really does quite well. [LB825]

SENATOR HANSEN: Great. Thank you. [LB825]

SENATOR PAHLS: Senator Christensen. [LB825]

SENATOR CHRISTENSEN: Thank you. I've had the privilege of going through...my father got one in November. Is it correct that you can wait too long and then they can't reverse it by using one? [LB825]

RODNEY LUSK: Absolutely. That's particularly true for the pediatric population. Adults who progressively lose their hearing and become cochlear implant candidates have speech and language development. So those pathways are already laid down. In the pediatric population, they don't get laid down without stimulation, and that's why early identification and newborn screening program is absolutely crucial. We can identify them. If we didn't have that program, we wouldn't identify them until they were three or four, and that's almost...I wouldn't want to say over the hill, but they will use the implant not as well as if they got implanted at 12 months of age. We're now finding in a number of studies that are being done in other parts of the country that children that are implanted at six to nine months of age, particularly with bilateral implants, do much, much better. So they need that bilateral implant stimulation very early on. [LB825]

SENATOR CHRISTENSEN: But can it be too late in adults? They seem to think it was too late in my dad. He's 83, but they only put one in and they took his best ear to do that. The other one he don't hear in. [LB825]

RODNEY LUSK: Depends on how long...the longer a person is deaf, the less well the device will work. We know that, and I tell parents it's likened to using a muscle. If you don't use a muscle, it atrophies. If you don't stimulate the nerve, it atrophies. [LB825]

SENATOR CHRISTENSEN: Okay. Thank you. [LB825]

SENATOR PAHLS: Senator Pirsch. [LB825]

SENATOR PIRSCH: Thanks so much, and I guess that I just have some questions as far as background as well. How much does a typical operation such as this cost with the device? [LB825]

RODNEY LUSK: I'm a physician. I don't get involved in the billing and I'm not really trying to dodge your question. One of the things that my experience has taught me is what is charged isn't anywhere close to what's actually paid. It really depends on the contract that the insurance companies have with the institution. The really sad part of the situation, I think that we're in, is that technology is being withheld from kids that could really be able to meet their full academic potential. And the costs for the insurance companies that provide the coverage don't seem to be that much of an issue. [LB825]

SENATOR PIRSCH: And of the individuals who require this type of cochlear implant...and I don't know if you know this or not, but is the typical...I think some of the previous testifier...maybe I misheard this, that about ten...would constitution...this pediatric need would constitute about 10 percent of that category. Is that correct or did I misunderstand? [LB825]

RODNEY LUSK: No, no. The number of patients that deal with the pediatric population that would qualify for cochlear implants are...they have to be bilaterally sever to profound hearing loss, and that's actually a fairly small number of children. Somewhere probably in the range of 1 to 15,000. Those are the candidates. If they have a normal hearing ear and no hearing in the opposite ear, they're not a candidate. And if they have mild to moderate loss, they're not a candidate. We're talking a very select small group of patients that take a lot of educational resources if they're not implanted. [LB825]

SENATOR PIRSCH: And of the insurance that currently exists, I think the...I guess net was testified to a little bit that there's a gap in so far as coverage with that cochlear implants. And I think the language of the bill talks about single or bilateral cochlear implants. Is the...and perhaps you can...I'm not sure if you, again, are the appropriate testifier to that, but I guess I'll state it in case somebody after you can also address that. But is the typical gap such that...is the insurance not providing typically for the bilateral or is the insurance not typically even providing for where there is a gap or a single? [LB825]

RODNEY LUSK: The situation that we're currently in is approximately I would say 90 is probably a good number. It's between 80 and 90 percent will cover unilateral implants. The state of the art is rapidly becoming bilateral implants, and the reason it's becoming that way is because the kids just do so much better, don't require the support in school. And that is one of the issues. We've actually been quite successful at getting bilateral cochlear implants approved, but it takes multiple appeals and at times even getting lawyers involved with the insurance companies on behalf of the parents. I don't do that, but the parents do. [LB825]

SENATOR PIRSCH: Yeah. Thank you. I think you've answered all my questions. [LB825]

SENATOR PAHLS: Senator Carlson. [LB825]

SENATOR CARLSON: Senator Pahls. Dr. Lusk, I didn't quite catch one of the answers you gave Senator Pirsch. In the number or the percentage of pediatric cases that would qualify, did you say 1 to 15 per thousand or 1 to 15,000? [LB825]

RODNEY LUSK: One in 15,000. [LB825]

SENATOR CARLSON: Oh, okay. I'm glad I asked you. [LB825]

RODNEY LUSK: Small number. [LB825]

SENATOR CARLSON: Okay. [LB825]

RODNEY LUSK: Very small number. [LB825]

SENATOR PAHLS: Senator Langemeier. [LB825]

SENATOR LANGEMEIER: One very...thank you, Dr. Lusk. You're going to go down in the record as being a proponent for where you're testifying. [LB825]

RODNEY LUSK: Yes. [LB825]

SENATOR LANGEMEIER: But you testimony says neutral testimony. Just so I have my notes correct, can I scribble out neutral and put... [LB825]

RODNEY LUSK: You may. [LB825]

SENATOR LANGEMEIER: Okay. Thank you. [LB825]

SENATOR PAHLS: Senator Gay. [LB825]

SENATOR GAY: Thank you, Rich. Doctor, I'm going to read from Michelle's...it would be Dr. Hughes' letter today and it goes into the candidacy guidelines are severe to profound hearing loss in both ears, limited benefit with the appropriately fit hearing aids, realistic expectations and no anatomical or other conditions. So you can do it I guess on three. What is realistic expectations? What does that mean? [LB825]

RODNEY LUSK: We can't predict with assurity (phonetic) how well a patient is going to do with an implant. And parents come in sometimes with the expectation that their child is going to have normal hearing, and we tell them that this is a device that helps assist them in speech/language development. The parents have to work very hard at working with the child. The educational system has to work hard. We need to make sure that they understand that their child is still deaf. You take the implant off, they're deaf. Okay? And depending upon how old the child is, we have to work with their expectations. If they were congenitally deaf, and they're 10 or 11 years old, they're not going to use it nearly as well as if they got implanted at 12 months of age. So we really...it's an educational process. I can think of one time when we elected not to implant because the expectations of the parents were unrealistic. Actually, that one was the expectations of the patient was unrealistic and she was a young adult. [LB825]

SENATOR GAY: Thank you. [LB825]

SENATOR PAHLS: Senator Pankonin. [LB825]

SENATOR PANKONIN: Thank you, Senator Pahls. Doctor, your comment just made me think. If you implant at 12 months when a person is that young, as their body grows, is there...as they change, do you have to re-implant? [LB825]

RODNEY LUSK: That's a great question. That was a very big concern early on, and it turns out that the implant doesn't move. The bone just kind of grows around it, it stays in one position, and we don't have to take it out for that reason. [LB825]

SENATOR PANKONIN: So you've had experience where put in at one year that that person is now maybe...I don't know how long this technology has been going...but it's ten years later... [LB825]

RODNEY LUSK: Oh yeah. Yeah, that's not an issue and by the time they're ten, that's an adult-sized head. [LB825]

SENATOR PANKONIN: Okay. [LB825]

RODNEY LUSK: And no, there's not a problem. [LB825]

SENATOR PANKONIN: Thank you. [LB825]

SENATOR PAHLS: Seeing no more questions, thank you, Doctor. [LB825]

RODNEY LUSK: Thank you, Senator Pahls. [LB825]

SENATOR PAHLS: (Exhibit 3) Just...I'm hoping this is being passed around. I did receive one sheet. It is still? Again, you can write your name down whether you support or oppose because I know a number of you do not plan to speak. And I'm asking you again, we will send around for the other bills. I'm trying not to get the confusion if at all possible. Thank you. [LB825]

DAVE RUTLEDGE: Hello. I'm Dave Rutledge, R-u-t-l-e-d-g-e, and I'm 100 percent deaf. I'm six very small batteries away from being deaf as I speak. They go out and my hearing goes out. I'm a retired elementary principal from Lincoln, and I'm currently a real estate sales person. So I might stick around to hear your testimony in the third session today as well. I'd like to put a face on someone who has a CI. Someone that was very much like each of you around the table, and that is you had good hearing. I had good hearing up until I was 52 years of age and I'm currently 60. So I had a single side or unilateral implant on my right ear, and then about a year and a half ago had my second implant, so I now am a bilateral, which just means I've got two of the devices hanging from my ears. I became deaf in my left ear better than 20 years ago. I was functioning quite nicely and like eyes, when you have two of something it's not so bad when one goes, and most of my friends I didn't go around saying, oh, I'm deaf in this ear, I'm deaf in this ear. Kids in my school discovered it because they would call my name and I would do a pirouette to see where the sound was coming from. But as fate would have it, I was at a meeting one day where we were receiving a child from a deaf unit in a different elementary school. He had a cochlear implant and about ten of the people that were working with him came to the meeting along with ten people from our building, and we sat down and kind of hashed out how we're we going to serve a child who needs a more mainstreamed experience. At the end of that meeting, it took about two and a half hours, I stood up and felt a little bit dizzy. And I went onto the lunchroom and that would be enough to make anyone dizzy (laugh). But in the later afternoon, I thought gee, I ought to take my temperature, and I had a good fever and decided it would be a good plan to head on home and so I did. Went to bed that night, woke up the next morning and I was 100 percent deaf. Just ka-boom. I had no skills whatsoever that I admire so greatly in the rest of the deaf community. I rate in the bottom 1 percent of anybody in terms of lip reading, and I don't sign at all. That happened in November. By February, because I had a severe and profound hearing loss, I qualified for a cochlear implant and was implanted in February of the following year. In April, they turned on the external parts after some limited swelling went down in my head. My results were miraculous and I harken back to a kindergartener who came in and was very sympathetic. My kids

really helped me while I was deaf. But I'll tell you, I was not a very effective principal. About 98 percent of my job is communication, and when you're shut off from the communication...I had a hearing aid that I affectionately called "Big Bertha" that would just about blow me away. It had 95 decibels, which would be about like standing next to a jackhammer and I was lucky my teeth weren't falling out. I thought that I was understanding more than I did, but it was only me looking at the world through rose-colored glasses. A kindergarten student came up to me and she gave me a full-page ad for a miracle ear, and she thought that that might be my solution. Well, my solution was a miracle, but it didn't happen to be the miracle ear that you stick into your ear and that helps you mechanically to be able to hear. My miracle was the cochlear implant. You asked what did it sound like. When I was first hooked up I heard what sounded like standing in a casino when every slot machine is going off at the same time. Now I've never done that, but that's what it sounded like, except it was so random, the beep, beep, beep, beep, beep, sounds that it meant nothing to me. And it so happened my doctor, who is Dr. Thedinger was there at my hookup and I could see his lips moving, but all I heard was "deedily, deedily, deedily, deedily," like that. Ten seconds later I started hearing words with these dingy sounds around the edges, if you will, of the words. Within two minutes, there were seven people in the room and I could understand each and every one of them. Was it perfect? No. Did people sound like Mickey Mouse? Yes. Did they sound like they talked from the bottom of a barrel? Yes. But...and I would listen to the radio and I would ask my wife, is that a man or a woman. And the other thing I experienced was every environmental sound that I ever knew sounded different, so I felt like I was a three-month-old. But interestingly, if I could label it, the first time after I got activated, I heard an ice mixer and my wife said, do you want to know what that is? And I said, yeah, what is it? We were in a restaurant and she said well, they're blending something in a blender, and as soon as she said that, I could recognize it as that sound. And so basically I went through the reorienting to environmental sounds. Through speech, it works fabulously well. And the longer that I was implanted, the better I become at understanding people talking, environmental sounds, somewhat with music. But music is not a particularly aesthetic experience for me. But what it was designed for, and that is to be able to understand people, it helped immensely. Let me share for just a second, when I was deaf it really took me right out of the social scene period. It took me out of my family. They would write me notes and then I would make some astute comment about what they were talking about, and my kids would look at me like I was an idiot because that conversation had gone on down the stream about five minutes and I'm making a reaction to it. My son was in seminary. Someone paid for the seminarians to go on a ski trip. He had two nickels to rub together. I gave him my credit card. He was home and they were talking and, just like your Auntie Griselda, I'm sitting there smiling and nodding and so on. I don't understand anything that's going on. And my wife then later asked me, she said, did you ever wonder what we were talking about? I said, no, not really. Well, your son, the seminarian that took your credit card, had his skis stollen when he was up on the mountain, and he had to debit your card for $300 dollars to pay for the skis. And I go,

what (laughter). There's some humorous sides, but most of it is not humorous at all. It's very depressing and I wouldn't recommend it. I could not have functioned as a principal. Currently I am, as I mentioned, a real estate salesman. My number one tool is this and I use it well. Think for a moment, even if I were singly implanted, what you would think of me as your realtor as I'm showing around and dancing to keep my right side towards you at all times. You would think I was probably pretty flaky or you would look for another realtor. I have my market share for a one-year real estate salesperson and I'm still working on it. But the fact of the matter is I pay taxes as opposed to receive support from the state of Nebraska and I plan on continuing to do that. I'm not as good an investment as some of the good looking youngsters you're going to see here who are going to return a great deal more. But it allows me to perform professional kinds of duties and it allows me to do what I choose to do as opposed to what I'm forced to do because I can't function in the job roles that I currently have as a completely deaf person. I think insurance is for catastrophic kinds of things. It's great if they pay part of my doctor bill for my annual physical, but if it's a catastrophic kind of thing that costs money, that's what I take insurance for. And the poor people that are that 10 percent that we're talking about who believe they have insurance that's going to cover their young family or their child of six months to find out that they would not cover it because of some interesting pieces of it, like you had to have been injured by a sharp object or that you, in surgery, had had your hearing dismantled, to me just does not cut it. That there should not be someone pretending to be an insurance company who does not in fact cover things that are catastrophic that could effect you, your kids, their kids, and so on. So that's why I'm here. I'd like to answer three questions if time would allow or you could re-ask them. What does it sound like? Yup, it sounds like Donald Duck, bottom of the barrel. It only gets better. The brain is extremely plastic. It takes very, very little information and makes a mountain out it. It's just fabulous. When they first invented these things, they thought the top of the mountain would be for some kid with his back to his parents could recognize his name. All of my information comes right through that. I do not lip read you period, so everything has to come through. My lateral, super. Is it as big an improvement from going completely deaf to one ear? No. But it allows me to identify where sound is coming from. It allows me to work in noisy environments without positioning my body in awkward ways and to dance around and so on as I'm working with people. And it just gives more depth or texture to my whole hearing experience. The cost, in the year 2000, this right implant cost approximately $49,000. In 2006, this side cost more than $100,000. I didn't quit being a principal because I didn't love it, and I didn't quit being a principal because my hearing was not perfect or that if I took them off, it would be quiet. In fact, that was a job plus, particularly in the lunchroom. I could just switch it off and everybody thinks that I'm listening carefully to the sound, but I could get away with it. The fact is it's much cheaper than a heart surgery and that's what took me out. I had heart surgery and my doctor said, would you like to live to see all your grandkids? And I said, yeah, that sounds like a good plan. He said, then you probably better hand it up and so I did. I might add that that catastrophic insurance is administered to people irregardless of whether you were smoking and doing things to

your body like...I didn't smoke, but not exercising enough and all those kinds of things. And most insurances pay that without flinching and for aged people, and to me it's incredibly dumb not to cover a small kid and say you are destined for a life as a deaf person because your parents had the unfortunate position of having to work for someone that bought insurance that doesn't cover much of anything that they can wiggle out of. So that's my four minutes and I appreciate your listening. [LB825]

SENATOR PAHLS: Senator Gay. [LB825]

SENATOR GAY: Thank you for your testimony. I've got a question. You said in November you found out you're deaf, and then in February you had the implant? [LB825]

DAVE RUTLEDGE: Yes. [LB825]

SENATOR GAY: That's pretty quick and then I'm hearing others stories saying, well, we had to fight the insurance company. How did you get that done so quickly? [LB825]

DAVE RUTLEDGE: I got it done so quickly because I was identified as being just about as deaf as you can get. "Big Bertha" was blaring and I couldn't function, and with the testing, I qualified under FDA regulations that governed it. And in 2000, if I'm not mistaken, it was tougher to get it because they were trying to weigh benefits versus cost, I think. And so they were not going to risk someone's poor hearing to get an implant because once you go into the ear, you probably have ruled out the possibility of having actual hearing in that ear. So they implanted the ear that had most recently had hearing. Back in November it was hearing fine. So that nerve...the nerves there had been working. Interestingly, this ear that had been dead for all practical purposes for 20 years, when I was implanted, worked just fine. And again, because I was not a deaf person until I was 52, all my language and so on was intact and so on. And so it was each case was a different case. Had I been deaf up until 52 and received it, I would have expected my outcome would not have been as miraculous as what it was. [LB825]

SENATOR GAY: Okay. Thank you. [LB825]

SENATOR PAHLS: Senator Pirsch. [LB825]

SENATOR PIRSCH: I just want to say thanks for coming down and testifying. I was part of a community internship this past year. I also have seen Dr. Thedinger perform these operations, and so I appreciate your coming down. But with respect to the insurance coverage, were you denied then coverage on... [LB825]

DAVE RUTLEDGE: I was not and I'm very pleased that I had a insurance company that did exactly what I expected them to do, and that is if I have a catastrophic event, I would

like to think I'm covered. And as a professional, I could cover other kinds of costs. But a cost of over $100,000, particularly when I was retired, would have been a difficult position to have been placed in. [LB825]

SENATOR PIRSCH: But was that on both cochlear implants that you were covered or just one? [LB825]

DAVE RUTLEDGE: Both. [LB825]

SENATOR PAHLS: Thank you, Dave. Appreciate your testimony. Next proponent. [LB825]

KATHRYN FOSTER: Hello. My name is Kathryn Foster. I'm an educational audiologist with Lincoln Public Schools and with Southeast Nebraska Regional Program for students who are deaf and hard of hearing. I come here in support of LB825 as it has extreme impact on the educational advantage for our children who can receive cochlear implants. I work with children who are from birth to 21, and have worked with many kids who have received implants at different stages, starting at age 2, then 18 months, and now most recently at 12 months of age. We have 21 students in Lincoln Public Schools who have cochlear implants. We have 120 students who are identified for special education services in the area of hearing impaired. So you can see that of our hearing impaired students, it's about 10 percent of our population that have severe to profound hearing loss that have cochlear implant support. Not all of our children with severe to profound hearing loss have cochlear implants. But that has been, at least to my understanding, at the parents request rather than being an insurance issue. There have been insurance issues, obviously, especially for the second implant, and we've had families that have had to have fund raisers, etcetera, in order to try and get the second implant, and there are those that are waiting in the wings. I think it is important that the committee understand that 95 percent of our children are born to hearing parents. These are parents who have no suspicion that they're going to have a deaf child in their family, and so they come with verbal language as being the language of the home, which is the first educational environment. In past times prior to cochlear implants, these profound hearing children would wear boomer or the body shaking hearing aids in order to get some access to sound. A profound or severe to profound hearing loss of 90 dB is comparable to a normal hearing child being able to hear a pin drop at a level that they can hear a gas-powered lawn mower. I hope to put some of this in perspective for you. We have extreme benefits that have already been spoken of that in being able to access verbal language and being able to develop literacy in English, and provides further opportunities for these kids in the area of job opportunities and further education. The chief predictor of outcomes for our little ones is early identification. We have, since LB950 has been in place, we have 100 percent of our birth hospitals that are doing newborn hearing screening, and our attempt is to identify hearing loss prior to three months of age with intervention in place prior to six months of age. There is a critical

stage in the brain of a baby at around six months of age where the neural pathways are being formed and that window is open, or the plasticity of the brain for an infant, is open where we can provide initial or primary language up until about age two. And after that, they operate as English as a second language kind of a student. At this point in time, on the National Institute of (on) Deafness and (Other) Communication Disorders, they talked about the cost at one point in time of sending our little ones to a residential program for the deaf and the cost is on the order of $1,020,000, as compared to $60,000 to $100,000 for an implant. Are there any questions? [LB825]

SENATOR PAHLS: Kathryn, just one, I may have missed it. Will you spell your name for the record for us? [LB825]

KATHRYN FOSTER: Kathryn, K-a-t-h-r-y-n, Foster, F-o-s-t-e-r. [LB825]

SENATOR PAHLS: Okay. Thank you. Senator Pirsch. [LB825]

SENATOR PIRSCH: Again, could you just state your title then? [LB825]

KATHRYN FOSTER: I'm an educational audiologist. I work with the educational needs of our kids for Lincoln Public Schools and Southeast Nebraska Regional Program for students who are deaf and hard of hearing. In the state of Nebraska, as you may already be aware, with the closing of Nebraska School for the Deaf, we divided into regional programs and I'm an audiologist for the southeast region. [LB825]

SENATOR PIRSCH: Very good. Then you would have certain types of training with respect to medical audiology then. Is there an age, which I think others have kind of alluded to that there's more...that at a younger age it's an imperative that at some point in time there's a diminishing return. Is this a settled area as far as studying when that age is or is it...you know, at some point and age, I think it was alluded to 10 or 11 that...and not having had the ability to discern sound that it was probably not an easy thing to recover from, but that at a young age, 6 months, 12 months, that there seemed to be a lot more...is that an established kind of...is there studies in the field? [LB825]

KATHRYN FOSTER: There are...yes. Primary by cochlear implant audiologists, but there are basically three tracks for our proposed...or not proposed...I'm sorry, I'm also older and nervous and so I can't come up with a name or the word... [LB825]

SENATOR PIRSCH: Don't worry about it. [LB825]

KATHRYN FOSTER: ...but for our outcomes. What we can have in anticipation of what benefit. The youngest aged children develop speech and language. They develop prosody very similar to normal hearing. [LB825]

SENATOR PIRSCH: When you say youngest age, I have a hard time knowing if you mean 6 months or 6 years or 16. [LB825]

KATHRYN FOSTER: Okay. And I'm talking about our two-year-olds and younger. Actually the age of cutoff is the 2-year-olds and younger, then 5-year-olds and younger, and then about 13. There seems to be for the binaural or the second implant a critical age as well, with eight years between the initial implant and the second implant as being a critical timeframe for how much benefit can be derived as far as directionality, being able to tell localized where the sound is coming from, and the benefits that they receive from being able to understand in background noise. That's dependent on being able to tell where sound is coming from. That allows us to pay attention here and not pay attention over here. Okay? [LB825]

SENATOR PIRSCH: Great. Thank you very much. [LB825]

KATHRYN FOSTER: It also helps with our ease of communication. Dave talked about with how well he can, you know, kind of operate in a listening environment. [LB825]

SENATOR PIRSCH: Thank you very much. [LB825]

SENATOR PAHLS: Thank you, Kathryn. Appreciate your testimony. [LB825]

KATHRYN FOSTER: Okay. [LB825]

SENATOR PAHLS: Just by a show of hands, how many more proponents? Just gives me a feel. One, two, three, four, five, six, seven. Okay. [LB825]

JENNIFER CHRISTO: Good afternoon, Mr. Chairman and members of the committee. My name is Jennifer Christo, C-h-r-i-s-t-o. I've been an audiologist for nine years. My primary clinical focus has been in educational audiology as well working with deaf and hard of hearing children. My current position is with the Omaha Hearing School for Children, and auditory/oral school whose primary mission is to educate deaf and hard of hearing children and their families by teaching those children to listen and talk. For those of us who have the privilege to be parents, we know that the sweetest sounds a parent will ever hear is that of "I love you" spoken by your child. To many of us, the fact that our children will develop spoken speech and language is taken for granted. However, for the parents of thousands of babies born every year with profound hearing loss, those sweet words may not ever be uttered without proper medical and educational intervention. Since the early 1990s, significant medical breakthroughs have abound in the hearing healthcare field. One of the most impressive is that of cochlear implant technology. Cochlear implants, as stated by several previous testifiers, is an electronic implantable device that stimulates the hearing nerve and provides the user access to the sounds of parents, peers, and the environment. They're most appropriate

for those individuals who do not benefit from traditional hearing aids. Through the implementation of newborn hearing screening, parents are obtaining a diagnosis of their child's hearing loss at a few weeks or months rather than years. As pointed out by Dr. Lusk, these children can now be implanted as young as one year of age per FDA guidelines. The research and literature in the audiology profession is consistently showing that with early cochlear implantation and early appropriate intervention, these children are able to develop speech and language on par with their normal hearing peers. There's no doubt that we live in a hearing and talking world. Prior to even just 15 years ago, the options for profoundly deaf individuals was much more limiting. Hearing aid technology could only provide so much amplification and often it was not enough for a young child to hear and understand all the sounds in their environment. In this current day and age, we are all alarmed at the rising costs of healthcare and insurance. However, for those of us in the educational, medical, or government professions, we are increasingly being held accountable for outcome measures and results. When you stop to think that by giving a deaf child the ability to hear through cochlear implants, coupled with early intense intervention, over $420,000 can be saved in special education costs and over $1 million over the lifetime of an individual can be realized, you see the true value in providing such medically and educationally relevant care. Is it appropriate to ask parents to bear the cost of cochlear implant surgery because insurance will not when society will bear the true cost if a hearing impaired individual is not given the chance to succeed in his/her mainstream environment. Helen Keller once famously said, being blind cut me off from the world of things, but being deaf cut me off from the world of people. As an audiologist at Omaha Hearing School, I have the benefit everyday of seeing what impact cochlear implant technology has made for deaf students. As a casual observer, you may not even be aware the child is deaf. I invite you to visit the Omaha Hearing School for Children to see what cochlear implants and oral deaf education have done for children of our state. Any questions? [LB825]

SENATOR PAHLS: Any questions? Senator Gay. [LB825]

SENATOR GAY: Thank you. Senator Pirsch, I think, was asking too and I kind of...what's the best age to get this done? I mean, is five and under, five to ten... [LB825]

JENNIFER CHRISTO: I think the literature is definitely strongly supporting the younger the better. Twelve months of age is what's FDA guidelines at this point, improved down to 12 months of age. I've been to conferences where in Europe, they're implanting as young as four to six months of age bilaterally and showing wonderful outcomes for those children. There is a window where it does start to close. Is that what you're referring to? [LB825]

SENATOR GAY: Yes. So I guess if you're a parent, you're finding out fairly... [LB825]

JENNIFER CHRISTO: Um-hum, at a fairly young age. Yeah, a few weeks. [LB825]

SENATOR GAY: ...my child is not picking up on...is not hearing me and you start getting concerns. The audiologist then finds out early, and if you're doing any screenings, oh, by the way...so as early as two, if they have an implant, that could stay with them for the rest of their life then? [LB825]

JENNIFER CHRISTO: Absolutely. [LB825]

SENATOR GAY: ...is what Senator Pankonin referred to. [LB825]

JENNIFER CHRISTO: Yeah. The literature is showing that the younger, the better. There certainly is a window where if a child has not benefited from hearing aids, by the age of 12 decides they want a cochlear implant, they may not benefit as well because, like Dr. Lusk pointed out, it's like a muscle, it atrophies, the hearing nerve if it hasn't been consistently stimulated. If you don't use it, you lose it. [LB825]

SENATOR GAY: Don't use it, you lose it. Okay. Thank you. [LB825]

JENNIFER CHRISTO: Right. [LB825]

SENATOR PAHLS: Senator Langemeier. [LB825]

SENATOR LANGEMEIER: Thank you, Chairman Pahls, and thank you for your testimony. We've heard a lot today about pediatrics involved in this, and in the bill it says in here we're mandating coverage for single or bilateral. [LB825]

JENNIFER CHRISTO: Bilateralm, um-hum. [LB825]

SENATOR LANGEMEIER: My questions is is what determines that "or"? And then a follow up to that is is at some point, at some age from zero to two should it not be or should it be mandatory bilateral? [LB825]

JENNIFER CHRISTO: Well, I think, again, going back to what outcome studies are showing in Europe, certainly what trials are going on in the United States, bilateral is definitely showing much better outcomes. I mean, our brains are designed to receive input from both sides, and stimulation from both sides is better than one side. As Katie pointed out and Dr. Lusk pointed out, it's much more fatiguing to only be able to listen and hear with only one ear versus two. Children that have unilateral hearing loss certainly are more at risk for...just having normal hearing in one ear and unilateral hearing loss in the other ear, are twice as likely to repeat a grade as somebody that has two functioning normal hearing ears. And I think that bears out for bilateral implants as well. [LB825]

SENATOR LANGEMEIER: Okay. I guess my curiosity is is if we're going to give them the option to go single or bilateral as an option in this bill, as speech development starts to progress in those young ages up to, I think, up to three... [LB825]

JENNIFER CHRISTO: Um-hum. [LB825]

SENATOR LANGEMEIER: ...would it be not to say we must have bilateral from zero to three and then single beyond or... [LB825]

JENNIFER CHRISTO: I think those of us... [LB825]

SENATOR LANGEMEIER: I'm getting a lot of head shaking behind us. [LB825]

JENNIFER CHRISTO: Yeah, I think most people would agree that bilateral would always be the preferred means of intervention. [LB825]

SENATOR LANGEMEIER: Okay. Thank you very much. [LB825]

SENATOR PAHLS: Senator Carlson. [LB825]

SENATOR CARLSON: Senator Pahls. You mentioned potential savings of $1 million over a lifetime and one of the other testifiers also did. Expand on that a little bit. What are the things that make up that $1 million? [LB825]

JENNIFER CHRISTO: Well, the costs of...for somebody that's not able to participate in mainstream schooling, they would require the services of an interpreter. As they get older, they may need to participate in vocational rehab programs. Different public assistance, and that means to help people with education needs and training to qualify for positions. [LB825]

SENATOR CARLSON: Okay. Thank you. [LB825]

SENATOR PAHLS: Senator Hansen. [LB825]

SENATOR HANSEN: Thank you, Senator Pahls. The evaluation process that these children go through once they're identified as being deaf, certainly there are other health problems that go along with some of these children for various reasons. What are some of those reasons why they couldn't be fitted for a cochlear implant because of other health reasons? What are some of those reasons? [LB825]

JENNIFER CHRISTO: There are sometimes if the shape of the cochlea, the organ that it's implanted in, there's a malformation where it's not...they're not able to get as good of a electrode insertion. You know, Dr. Lusk may be able to speak better to some of those

core morbid conditions that... [LB825]

SENATOR HANSEN: Is it a function of age and the evaluation process together that says this child is not a candidate for the cochlear implant? [LB825]

JENNIFER CHRISTO: I don't think age necessarily always precludes somebody from being a candidate. Really it goes back to realistic expectations on the part of the recipient and the family, what kind of a benefit they receive from amplification through hearing aids, if there's been any benefit at all or if they're not benefiting. Certainly the age of individual. Were they born deafened? We're they deafened later on due to illness or accident? [LB825]

SENATOR HANSEN: Okay. Thank you. [LB825]

SENATOR PAHLS: Seeing no more questions, thank you, Jennifer. Next proponent. [LB825]

JILL McGRANE: Hi. My name is Jill McGrane. It's M-c-G-r-a-n-e, and I guess I'll just tell a little bit about our story. We found out Abigail had hearing loss at around 12 months. It was a severe loss at that time. She wore hearing aids for about a year and with very little progress. So at two years old, a normal child might have upwards of 1,000 words in their receptive language, and she had maybe 20 words. So she wore hearing aids for just a little over a year before we got our first implant. So she was implanted when she was just over two in her right ear and that one was...we are one of the 10 percent. We were not covered under insurance. She fit all of the criteria. You know, they just denied our claim, you know, our claim three times saying that it was just not a covered benefit. It was another time they had said that it was a cosmetic surgery. And then a year later we decided to implant her left ear, and that one was covered by insurance, which we had since switched to the other insurance company. So we did pay out of pocket for the first one, $40,000, and that was just...I mean we knew that she had to have it and it was not going to be covered. We knew it wasn't an option of if she could get it, she was going to and, you know, we found a way to, you know, take out a loan and pay for it. She...one versus two. I just wanted to touch on that a little bit. So she had her first one at two and a half and her second one at about three and a half. And before she had...when she just had the first one, she couldn't localize like...she had amazing language and, you know, she could understand everything, but she could not figure out where the sound was coming from. So you know, I might talk to her and I'd be, you know, just behind her to the right and, you know, I'd say something and she would look just scanning the room for me because she just couldn't find me. And then she got the second one and immediately if I said some things, she'd look directly in my direction, which is just vital for the classroom because, I mean, the teacher moves around and, you know, you don't always know where they are, and so that's why we decided to do the two versus the one. I guess I could have came up here and gone on and on about

the benefit of them and the need for it. It's not an option for us. It's a need. But I just wanted to bring Abigail because I think I'm just going to let her talk for a little bit and I just want...I mean, it's amazing and I guess there's just no...it's a need and it's just ridiculous that...you know, we are responsible enough to have the insurance and pay for them and it just, you know...for them to say it's cosmetic or just not a covered service, but...first, I'm just going to take...Abigail, I'm going to take your magnets off and then I'm going to see if you can hear. Okay? I just want to show you that she's completely deaf. Abigail. Abbey, can you hear? [LB825]

ABIGAIL McGRANE: I can't hear you. [LB825]

JILL McGRANE: There's completely...profoundly deaf. Okay. Now can you hear me? Okay. Can you tell everybody...can you tell them what you want to be when you grow up? [LB825]

ABIGAIL McGRANE: A farmer and the veterinarian. [LB825]

JILL McGRANE: A veterinarian? What's your favorite kind of animals? What are you going to take care of? [LB825]

ABIGAIL McGRANE: Horses. [LB825]

JILL McGRANE: Horses? That's cool. What is your favorite thing to play? What's your favorite thing to play at home or wherever? [LB825]

ABIGAIL McGRANE: My new horse from Christmas. [LB825]

JILL McGRANE: Your new horse from Christmas? What's your new horse's name? [LB825]

ABIGAIL McGRANE: Butterscotch. [LB825]

JILL McGRANE: Butterscotch. So just...you just can't imagine what it's like to be a parent and be told that your child needs something and go through the process. It's not like a doctor just says, oh, you know, I think you should get this. It is a process. You have to fit the criteria of being deaf, for one. You get no benefit...you have tried hearing aids and get no benefit from them. As a parent, you have to have high motivation and realistic expectations. We have to...the cochlear implant is not a cure. It is a tool. It is...you know, you turn it on and you have to work, work to get...I mean, she understands. She is going into a mainstream situation with no services. She will require no services besides wearing her implants. We don't do any sign language. I don't even know how to spell my name in sign language and neither does she. She can lip read pretty well, like in the bath and stuff, but doesn't rely on it. And so I guess that's pretty

much all. I mean, I just...if you have any questions... [LB825]

SENATOR PAHLS: Okay. I don't see...thank you, Jill and Abigail. Oh, Senator Hansen. [LB825]

SENATOR HANSEN: Sorry I didn't wave. Abigail? Abigail? You have beautiful hair. Thank you for coming today. [LB825]

JILL McGRANE: I just wanted to...I just brought a picture of the day that we got her implant and two weeks later is when they, it's called activation, when they turn it on. And I just have a picture of Abigail and I would be more than happy to pass it around. You can just see her eyes light up and, I mean, she's hearing sound for the first time. And it's just amazing. And then just along with the...I think it's unfortunate that we do have to have a mandated, you know, law to say this has to be provided because most insurance companies probably will provide it. But there just are some that won't and I think that's what this is for. [LB825]

SENATOR PAHLS: Okay. Well, we thank you for your testimony. Abigail, take care of mom. Next proponent. [LB825]

KRISTI CURREN: Hi. My name is Kristi Curren, it's K-r-i-s-t-I C-u-r-r-e-n, and you're going to meet my son. He will be testifying next. He's 13. He has bilateral implants and the main reason for us to help get this bill sponsored was we had the first implant. We were implanted, no problem. He was implanted at six years of age. So there we went to go bilateral this last year. In August our surgery was scheduled for...we had it in writing for six weeks from two different departments from our healthcare. We had it from pre-certification and from the approval for the overnight stay if needed. Six weeks in writing and the day before surgery somebody at our healthcare coverage called our hospital and said we decided not to cover this. That was at 2:00 on a Friday. Our surgery was scheduled for 6:00 Monday morning. Like Cliff and Amy, I'm not one of these parents that take no very well, but if I had been, I would have given up. A lot of parents, once they hear that denial, they don't know how to fight or how to get it done. Luckily, we've been implanted the first one for six years, so I kind of know how the system works. But it took our surgeon calling, which was Dr. Lusk. It took me sending a 45-page fax 3 different times showing the benefits of bilateral and it took me calling them twice a day, everyday for 3 weeks. I called them every morning and I called them every night. Do we have a decision? Do we have a decision? And I'm not sure if they approved me because they got tired of hearing from me or if they approved me because of the stuff that we sent in to prove that it was beneficial. Dillon was 6 when he was implanted the first time and he was 13 the second time. So some of the questions that you've answered about, is there an age that there's a cutoff. It's so much individually based on the child and what hearing they've had before, what benefit they've had from hearing aids, if their nerve has been stimulated. So there's not a magical number of,

yes, if they're not implanted by five, they're not going to benefit from that. Some of the other things that you're heard on the cost of that, I want to make sure that the billed amount and the paid amount or so different. Our surgery in September, our insurance company was billed at $92,000, however, we both know that the contracted amount for that is going to be, if at all, half of that amount. So why the initial number seems high at $92,000, it's actually probably going to be somewhere in the $45,000 to $50,000 range. A lot of emotional testimony today. You don't need me to come up here and say how wonderful it is because you'll hear my son tell you. But some of the things that I thought of is what happens if he runs out in the street and that car goes to honk at him and he's not going to hear it? What happens if he's an adult and he's at home by himself and that tornado siren goes off? He's not going to hear that. He did not benefit from hearing aids. So his world was silent. What is he going to be able to be when he grows up? You know, what jobs are going to be offered to him? There's a lot of literature out there that says the average deaf person that goes through high school without the hearing aid or without the implant graduates with a fifth or sixth grade level after high school. That doesn't leave very many opportunities for him. I wanted him to have every opportunity to be whatever he wants to be. Now, granted with his implant, there's certain things he can't do. He can't...he doesn't have the right to serve in the armed forces. You know, he could never be a policeman, but everything else to him is open. He can do whatever he wants to do and that was my goal. But the realistic expectations for me, I want him to be a taxpaying citizen. That was my only goal. I want him to be able to have a job, hold a job, and live on his own, and now with his implants, he's able to do that. Any questions? [LB825]

SENATOR PAHLS: Senator Carlson. [LB825]

SENATOR CARLSON: Senator Pahls. Kristi, when you got that telephone call on Friday saying that it wouldn't be covered, what was the reason? [LB825]

KRISTI CURREN: I didn't actually get the phone call. They called the hospital and made the hospital call me. At that time they thought that it would not be beneficial. It was still experimental. And when I called the insurance company to talk to them about it, their answer to me was we'll talk to your physician about this, this doesn't involve you. I tried telling them that since I pay the premiums every month that I'm kind of their customer. And the one lady said, well, he has one, why does he need two? My comment to her was, you have pair of glasses, you have two lenses. You don't have one. You're eyes work better in groups and so does your hearing. But no, they didn't call me. They called the hospital directly. [LB825]

SENATOR CARLSON: Thanks. [LB825]

SENATOR PAHLS: Seeing no more questions, thank you. [LB825]

KRISTI CURREN: Thank you. [LB825]

DILLON CURREN: My name is Dillon Curren, D-i-l-l-o-n. My name is Dillon Curren and I'm 13. I'm a seventh grader at Millard Central Middle School. I am currently the only hearing impaired person in my school. I was on the honor roll last year and I'm the honor roll this year, too. Cochlear implants are a big part of my life and very vital. When I was born, I was born premature and diagnosed with auditory neuropathy. This kind of hearing loss was uncommon in those days. I was the first kid in the state to have auditory neuropathy. The first six years I could hear very little. Imagine the loudest sound, but are very small for me. In April 2001, I received my first cochlear implant. I was nervous prior to the surgery. After the surgery, the recovery was hard and I did not like it, but I knew it would help me. Hearing new sounds was a very big deal for me. I'd hear the dog barking or people talking. It's amazing how technology works. I can hear everything I couldn't hear before. My first day of hearing, I heard the cat meow and my mom says it scared me because it was so much clearer. Now I can hear my family. They say that they love me. I can hear my friends talking and teachers in my classroom. Unfortunately I can now also hear my mom, take out the trash and clean my room (laughter). Music is my favorite thing to listen to. With the help of my implants, I am able to listen to my favorite music like rock and heavy metal. Then in 2007, I had my second implant. My mom did research on bilateral implants and I agreed to have a second one. It was originally scheduled for August, but due to conflicts it was postponed to September 9. Once again, I was nervous and not sure how it would be different. Now in school I am very successful. Part of that success is because of my cochlear implants. Without my implants, I probably wouldn't be this successful. I have been also able to learn three languages: English, sign language and French. I mastered English and sign language. I am still learning French, but our teacher said I'm doing a great job and I have an "A" in French. All of this is due to my hard work and my cochlear implant. I've been able to communicate with other people and listen to them and understand them. Without my implants, it was very confusing to me. I understand that some of the deaf may want to stay deaf and that's fine with me. I have a group of friends that are. For those who need an implant, they need it. For those who want them, their school and communication can be improved. I'm in sports. I participate in football, basketball, and right now, wrestling. With basketball I'm able to hear my teammates that help me when I'm stuck in a position. And I can learn moves in wrestling by listening and communication. Finally, implants made my life so far successful. I have mastered two languages and I'm able to play sports. I know that I can be whatever I want to be with the help of the implants. I can be a doctor, a lawyer, or even a senator. I think I might be a teacher for hearing kids can too have the best of both worlds. I can teach them sign as well as hear them. I've met people and befriended them with the same disability. All I'm saying is the implants that are a big piece of my life. I've been a deaf individual and now hearing. If I had to choose again, I would pick my implants. [LB825]

SENATOR PAHLS: Duncan (sic: Dillon), I think you'd be a good teacher. Senator

Hansen. [LB825]

SENATOR HANSEN: What was your first name? [LB825]

DILLON CURREN: Dillon. [LB825]

SENATOR HANSEN: Thank you for coming today. That's one question I had about how the sports would work, if you could wear a football helmet or if you could...when you wash your hair, do you have any problem or when you shower after sports, no problem there? [LB825]

DILLON CURREN: No. Well, when I wrestle I take off both my cochlear implants to wear my helmet because if I put it on it will smush the cochlear implants and I can't really hear well. So it's no different between on and off. [LB825]

SENATOR HANSEN: Okay. Thank you. Thank you for coming. [LB825]

SENATOR PAHLS: Thank you for your testimony. Next proponent. [LB825]

CARLY RUNESTAD: (Exhibits 4 and 5) Good afternoon, Senator Pahls, members of the committee. My name is Carly Runestad, it's C-a-r-l-y, my last name is R-u-n-e-s-t-a-d, and I'm the director of health policy for the Nebraska Hospital Association. And on behalf or our 85-member hospitals around the state, I'm here today to support LB825. I will be very brief. You've had a great deal of expert testimony today, some really amazing testimony. I'm pleased that I was able to be here to hear it today. I will submit my letter of testimony for the record. I was also asked by Children's Hospital, they had hoped to be here today to support the legislation, but were unable to make it, and so they asked that I submit their letter of support as well. So that is coming around. The only thing that I would just highlight today is that collectively Nebraska's hospitals employ a great deal of people. We have over 39,000 full-time employees and part-time employees, and that's just within the hospitals themselves. That doesn't take into account all the employees that we have in the assisted living facilities, and the nursing homes, and the clinics, and so forth. And so for hospitals it's critical for us to really examine all of the costs and the outcomes that are associated with insurance mandates, and of course, this is to guard against potential increase in our healthcare costs. But our members also believe that it's vital to support legislation that improves and enhances the quality of life for all Nebraskans and we believe that this bill, LB825, does just that. It's positive outcomes greatly outweigh the costs that are associated with it. For many individuals who have profound to severe hearing loss, cochlear implants may be their only opportunity to alleviate their hearing loss. And so on behalf of the hospitals, I would ask that you support and advance LB825 and thank you for your time today. [LB825]

SENATOR PAHLS: Any questions? Seeing none, thank you. Next proponent. Let's see that's...just one more time, that's the end of the proponents? Okay. Now we hear from the opponents. [LB825]

MICHAELA VALENTIN: (Exhibit 6) Good afternoon, Senator Pahls and members of the Banking, Commerce and Insurance Committee. I am Michaela Valentin, M-i-c-h-a-e-l-a V-a-l-e-n-t-i-n, and I am a registered lobbyist appearing on behalf of Blue Cross/Blue Shield of Nebraska. Blue Cross/Blue Shield of Nebraska provides or administers group health insurance and individual health coverage for more than 717,000 Nebraskans, including 2,500 companies and government entities. We ensure roughly one in every three Nebraskans. On behalf of our customers, we oppose LB825 because mandates, in general, increase total healthcare costs. While mandates guarantee more health coverage, they do not necessarily ensure better health coverage. Mandates can increase premium costs, reduce health coverage for some individuals, or force others to become uninsured. Any state mandate that becomes law does not reach the entire insurance pool in Nebraska. Insurance plans that are covered by the Employee Retirement Income Security Act of 1974, otherwise known as ERISA, are exempt from state mandates. ERISA is a body of federal law that preempts the application of state imposed mandates to employer-sponsored benefit plans that are self-insured. ERISA does not cover federal, state, and local government employers and certain religious organizations. Any state mandate that is passed would apply to those entities. What this means for Nebraska is that most large employers who are able to self-insure will avoid the mandate. In Nebraska, self-insured employer-sponsored benefit plans account for approximately 64 percent of the market. Mid-size and small employers will have to absorb the cost impact of the proposed mandate. The mandate does not apply to the individual market. Because Blue Cross/Blue Shield of Nebraska is always working to make healthcare coverage more affordable and accessible, we must oppose the imposition of a state mandate that is counterproductive to our goal of ensuring access and affordability for all. We specifically tailor our plans to meet the needs of our customers. For example, we do not offer maternity coverage in some plans that were designed for people who do not require that type of coverage and the plan price is substantially reduced because that component of coverage is eliminated. Employers like to have these types of choices when making cost effective decisions to provide healthcare to their employees. Imposing a mandate effectively strips the employer from having a choice or worse, it eliminates the opportunity to provide coverage to their employees all together. Blue Cross and Blue Shield of Nebraska strive each day to contain costs for our customers while still offering comprehensive healthcare coverage. The reality is, everyday employers are struggling to maintain healthcare coverage and any mandate imposed upon that coverage will lead to an increased number of people who become uninsured because they can no longer afford the premium increase that is passed on to them from insurance carriers. Although Blue Cross and Blue Shield of Nebraska currently provides coverage for cochlear implants, both singular and bilateral, we are able to do so because historically Nebraska has not been a state that imposes

numerous mandates and that keeps our costs down. If this mandate passes and technology advances in the area of cochlear implants, premiums will most likely increase and will be passed on to the customer. For every mandate that is imposed, more Nebraskans cancel their insurance because they cannot afford the premium cost increase associated with the mandated coverage. This year, insurance premiums will increase anywhere from 0 to 40 percent. In a nation that is striving to adopt major healthcare reform of which access and affordability are two key pieces, consider that implementing a state mandate is diametrically opposed to the goal of providing healthcare for everyone. Thank you. I'll take any questions. [LB825]

SENATOR PAHLS: Senator Carlson. [LB825]

SENATOR CARLSON: Senator Pahls. Would you explain Blue Cross/Blue Shield's approach to this cochlear implant? Do you have plans that do cover them and then plans that don't? Plans that cover one and are there plans that cover two? [LB825]

MICHAELA VALENTIN: Well, we will cover. When it is put in for singular, we will cover that and we cover bilateral if you meet the criteria that has been explained in the previous testimony. The plans that are with us that self-insure, however, they can choose not to provide that at this time. So if they don't, we won't cover that. [LB825]

SENATOR CARLSON: And did you say that 64 percent...you mentioned something about 64 percent. [LB825]

MICHAELA VALENTIN: Yes. Of employer benefit plans in Nebraska are self-insured, meaning the mandate would not apply to them. So if you were to pass the mandate in here those people would not have to follow that mandate. [LB825]

SENATOR CARLSON: Okay. Thank you. [LB825]

SENATOR PAHLS: Senator Hansen. [LB825]

SENATOR HANSEN: Thank you, Senator Pahls. I'm covered by Blue Cross/Blue Shield. I didn't plan on having a bad back. Some people that have kids don't plan on having deaf children either. So what is the criteria that after a couple has a child within a year...within six months to a year that they find out this child is deaf and cochlear implants will work? How does that evaluation process come about? [LB825]

MICHAELA VALENTIN: I can't speak to the specifics of the evaluation process at this time, but I can get you that information. [LB825]

SENATOR HANSEN: Okay. Thank you. [LB825]

SENATOR PAHLS: Senator Pankonin. [LB825]

SENATOR PANKONIN: Thank you, Senator Pahls. Michaela, out of that 64 percent that are in these ERISA plans, do you have any idea...for example, that could be for the NSEA, the teachers...a lot of teachers would be in those type of plans, right? [LB825]

MICHAELA VALENTIN: Um-hum. [LB825]

SENATOR PANKONIN: And we already had a principal up here that was covered. Whether he was on that plan, he didn't state. But do you have any idea what percentage those plans would cover these procedures? [LB825]

MICHAELA VALENTIN: No, not without looking at the specific exclusion and limitations of those plans. [LB825]

SENATOR PANKONIN: So even though this mandate wouldn't necessarily apply to them, there may be a lot of those plans or potentially a lot of those plans that cover this already? [LB825]

MICHAELA VALENTIN: Potentially, yes. It all depends on what the plan wants to cover. Some of them are very benefit-rich. [LB825]

SENATOR PANKONIN: Okay. Thank you. [LB825]

MICHAELA VALENTIN: Any other questions? [LB825]

SENATOR PAHLS: I see no more questions. Thank you, Michaela. [LB825]

MICHAELA VALENTIN: Thank you. [LB825]

SENATOR PAHLS: Next opponent. [LB825]

JAMES WATSON: Good afternoon, Mr. Chairman. My name is James Watson. I'm vice president of state affairs for United Healthcare, also testifying in opposition to LB825. In terms of building upon the testimony that my colleague from Blue Cross gave you, approximately 70 percent of our plans or self-insured. Another component to consider in that regard, is in the remaining 30 percent you're going to find mainly small businesses. And that's the additional component that you have to consider when you talk about imposing mandated benefits. In 1965, there were only eight mandated benefits across the country. Currently there's over 1,900. The Council for Affordable Health Insurance estimates it's a cost of basic coverage increases by somewhere between 20 and 50 percent due to mandates, depending on the state and the type of the mandate and whether perhaps it's covered under the plan in any event that it's not an additional cost.

But those are the rough numbers. And yet every mandate has core supporters and advocates for sure. But each mandate has to be looked at in its cumulative effect that it has on the insurance industry, at least that's how we look at it, to determine the impact on premium. And mandates on private insurance impact the insurance market just like mandates on any other commodity. So if you took, for example, a mandate on cars and how they're constructed, you'd say, well, you have a choice now, here's your Cadillac. But if you can't afford a Cadillac, you have to walk. That's how mandates will keep people out of the market by pricing it, and we do know that more and more Nebraskans are not able to afford the coverage. So I think it's important to keep in mind the total circumstances of the insurance industry as you move forward and not focus on a single mandate in a single situation because almost always the considerations will move you as the considerations would move you today. If you have any questions, I'd be happy to answer them. [LB825]

SENATOR PAHLS: Any questions for James? Senator Gay. [LB825]

SENATOR GAY: I've got a question. When you're doing a plan design, I guess...I'm a human resources manager and I'm doing a plan design deciding how I can save money or buy a plan. I don't have a plan, let's say. [LB825]

JAMES WATSON: Um-hum. [LB825]

SENATOR GAY: Let's use this scenario. I don't have a plan but I want to...I have like a lot of young employees and I want this in there. How do they go about this menu and decide? Because most...a lot of people just...you talk about small business, they're no experts in insurance, in plan design. [LB825]

JAMES WATSON: You bet. Right. [LB825]

SENATOR GAY: When you're out there selling this, you don't know, as Senator Hansen mentioned, until after you find out. Hey, I've got a real problem here and a real expensive problem. They love their kids and they want to take care of it. But how do you set that up that you educate the consumer then? []

JAMES WATSON: In terms of what's covered and what's not or... [LB825]

SENATOR GAY: Yeah, basically. If this isn't covered by some people, smaller employers, how do you educate them? I mean, that you should buy this or that or the other thing? [LB825]

JAMES WATSON: Well, we start out in a small business market with a whole series of plans in variations for employers to pick from. Generally in the small business market, you don't see those employers becoming self-funded. So each small business plan,

because it's most likely fully-insured, is going to contain the applicable mandates of any particular state. In terms of educating employers as to what's available and what's not available, there are tremendous on-line tools that employers will use to find out if something is covered under a particular United benefit plan or not. We also have sales and marketing individuals that educate benefit managers, and brokers certainly represent United to benefit managers in telling them what's covered and not covered, what's included and what's not included. The market changes all the time and we all try and improve what we have to offer and what we have to bring to the market. So in any given year, there will be additional changes. So usually around the January timeframe, and I guess probably earlier than that in October and November, we start to tell people what the new plans are going to look like for this year and that year. Right now we are very much in favor of the consumer directed health plans where you have a health savings account that can pick up items that hit the high deductible to go along with those plans, and some uncovered expenses as well. So I mean, the industry is changing, the industry is evolving, and I guess part of my message to you is that we should let the industry evolve and we should have the industry do the things that the marketplace is asking for them to do. [LB825]

SENATOR GAY: Is there...well, a follow-up question then. [LB825]

JAMES WATSON: Sure. [LB825]

SENATOR GAY: You don't know what this is until after you need it, let's say. [LB825]

JAMES WATSON: Um-hum. [LB825]

SENATOR GAY: But is there any clauses in any insurance policies if...a general clause, let's say, that says, well, this would be a tremendous benefit a small...we will pay up to $25,000 for a whatever it is, next thing on the list is a prosthetic or something like that... [LB825]

JAMES WATSON: Um-hum. [LB825]

SENATOR GAY: ...that it would enhance a life and will pay up to a certain portion, like an open ended...you don't have any of those obviously... [LB825]

JAMES WATSON: No, we really don't have open ended things. [LB825]

SENATOR GAY: And that's kind of I think what people want with...when they talk about catastrophic health insurance. I don't know the problem until after I have it. [LB825]

JAMES WATSON: Right. [LB825]

SENATOR GAY: Here it seems like a simple thing that if I could have it, it would be tremendous benefits to everybody down the road. I mean, I understand both sides of the story. I'm just saying there maybe some way your industry should look and say, how can we fix this. [LB825]

JAMES WATSON: Well, we do look, you know, every year at what the marketplace is asking for and we have broker counsels to get feedback from them. The list actually...I mean you'd have to say it's limitless in terms of the list of things that's almost impossible to predict what anybody is going to need in a particular group setting. I think if we have some people in the brokerage industry or perhaps benefit managers that will testify later, they may be able to tell you what the considerations are with their employees. But we do try to take that feedback and make it into something that people can use as a benefit. I mean, that's really what the goal is is that the employer is trying to provide a benefit to the employees. [LB825]

SENATOR PAHLS: Senator Pirsch. [LB825]

SENATOR PIRSCH: Thanks for coming down to testify. I think it was Dr. Lusk who earlier testified that there were about, in Nebraska, 3,800 ear replacements per year. Is that...I don't know if you're aware of this kind of statistical information or not. [LB825]

JAMES WATSON: To be honest, I wouldn't disagree with the doctor. But I really don't...I'm not an actuary or... [LB825]

SENATOR PIRSCH: I was trying to...oh, sure. You bet. I guess I was trying to get a sense of whether this type of operation or procedure is typically performed on younger people or on adults, so to speak. Do we know or have you seen any kind of... [LB825]

JAMES WATSON: No, I have not seen any statistics about it at all. I'm sorry. [LB825]

SENATOR PIRSCH: Okay. No. That's quite okay. I'll address that to some other testifier. With respect to political subdivisions...right now it wouldn't have a fiscal impact on the state because they currently provide those coverage. But with respect to political subdivisions, do you know, is that type of coverage typically covered as well? Is it similar to the state or does it vary from subdivision to subdivision, if you know? You may not be the right... [LB825]

JAMES WATSON: I do not know with the political subdivisions. [LB825]

SENATOR PIRSCH: Okay. Well, very good. I appreciate and... [LB825]

SENATOR LANGEMEIER: Other questions? I do have one more, Mr. Watson. Thank you. United Healthcare, what percent of your policies cover this, if any? [LB825]

JAMES WATSON: All the policies...well, I can't speak to the self-funded, it's the employer's choice, but in the remaining 30 percent, all the policies will cover the first, the unilateral. I checked before I came down here today to find out about the situation with the bilateral and our information that I could locate was about a year old. And at that point, we still maintained that it was unproven in the medical literature for the bilateral, but we always update that every year and review it every year. So I would say that there's a good chance, based upon what I've heard today, that that situation may actually change. [LB825]

SENATOR LANGEMEIER: Okay. Thank you. Are there any other questions? Senator Gay. [LB825]

SENATOR GAY: Back to preventive...we're also into a preventive healthcare, too. [LB825]

JAMES WATSON: Sure. [LB825]

SENATOR GAY: But on some of these...you heard testimony earlier, on a younger child, let's say, where it has tremendous economic benefit...I see where you're coming from, too, on your side, but let's say it had a tremendous benefit at five or under. How does that...and you're no actuary, but if you do a piece of it versus mandating it for everybody, but say it's a cutoff at a certain age, does that skew the pricing formula somewhat or...? [LB825]

JAMES WATSON: Only if that would mean that fewer would be done. [LB825]

SENATOR GAY: Well, it obviously would because you'd have a shorter age, where if you catch it early, fix it, we got a lot of benefits. [LB825]

JAMES WATSON: Well, I mean, like you look at it though in terms of at a certain age range, say one to five, there are going to be X numbers of these in a particular population. And then if there are additional needs above age five and they wouldn't be covered, you'd have to have a lot of additional need to have cost savings from that. As I understand from what the previous testimony was is that these things are not something that occurs in a population with great frequency. So it's very difficult to say whether additional procedures would be necessary between 5 and, say, 20. I think the cutoff would be very tough to determine. [LB825]

SENATOR GAY: I see what you're saying. Thank you. [LB825]

SENATOR LANGEMEIER: Any other questions? Thank you, Mr. Watson. [LB825]

JAMES WATSON: Thank you very much. [LB825]

SENATOR LANGEMEIER: Next opponent. [LB825]

TONY SORRENTINO: Good afternoon. My name is Tony Sorrentino, S-o-r-r-e-n-t-i-n-o. Today I'm representing the Nebraska Chamber of Commerce and Industry as a member of their health insurance committee regarding our opposition to LB825. The limitations on everyday life that many of us take for granted are without a doubt serious and substantial, and worthy of consideration for coverage by insurance policies in the state of Nebraska. And I certainly do not question the applicability and the efficacy of the medical treatments that we've heard testimony on earlier. I am not a doctor. Instead, our opposition to this bill is based on the concerns that we have for the consumer that we represent and the access to employer-provided health benefits that are typically provided to the citizens of the state of Nebraska through the employee/employer relationship. Already many employers are finding it difficult to continue to offer coverage to their employees who are forced to pass along most of the nearly 10 percent average increase through this decade. Most of those employers do not have the financial means and ways to bear the brunt of this and are indeed considering whether or not they can continue to offer those programs. As employee benefits consultant in Omaha, I and my fellow partners represent over 900 employers, and everyone of them is feeling the stress, of course, of the increased medical cost that we bring to them through the carrier partners that help to insure their plans. Last year, 46 or our plans terminated because they could no longer afford to offer coverage, which is nearly 5 percent. As stated earlier, approximately 65 to 70 percent of all groups in the state of Nebraska are ERISA plans, meaning they are self-funded and they can pick and choose as whether or not they cover this benefit and many do, many of ours do. We are fortunate enough to represent most of those, and many of them do cover it, but some do not. But that does leave the remainder of these costs to be picked up by the remaining 30 percent, which typically, frankly are the employers who can least afford it. They are smaller types of employers who are struggling financially in a lot of areas. Earlier testimony indicated that certain federal Medicare programs and state Medicaid programs pay for this procedure, and I understand that to be true. With all due respect to these very worthy programs, they have the luxury of reimbursing providers at a level far below what private carriers reimburse, which are all represented here and I won't speak for them. But these unfunded reimbursements have to be paid for somewhere, and the trickle down effect is that these costs are passed down to the fully-insured providers of small group health insurance. So on behalf of those small group health insurers and our clients who protect many citizens at the state of Nebraska, we are opposed to this measure and I would be happy to take any questions. [LB825]

SENATOR LANGEMEIER: Are there any questions for Mr. Sorrentino? Seeing no questions, thank you very much for your testimony. [LB825]

TONY SORRENTINO: Thank you. [LB825]

SENATOR LANGEMEIER: Further opponents? [LB825]

ROBERT HALLSTROM: (Exhibit 7) Mr. Chairman, members of the committee, my name is Robert J. Hallstrom, H-a-l-l-s-t-r-o-m. I appear before you today registered lobbyist for both the National Federation of Independent Business and the Nebraska Bankers Association to express our opposition to LB825. I'm handing around some testimony that covers both LB825 and LB969, but will naturally hope to be here as well to register for (LB)969. Mr. Sorrentino has covered most of the materials that I have in my testimony that's being circulated to the committee. Our small business owner members are stressed and strapped with regard to their ability, they certainly have a desire, but to their ability to provide health insurance coverage to their employees. Small businesses represent probably the largest sector of the economy that does not, as much as they would like to, have full insurance coverage. We've seen many plans. Mr. Sorrentino reflected the number of plans that had terminated within his scope of employment. But we see many plans that maybe don't terminate, but they're raising co-pays and deductibles and doing things that make it more difficult on the employee. We think that these types of issues, while they may be worthy individually, the culmulative effect of them make it extremely difficult for small employers to continue to provide health insurance coverage or to provide it all in the first instance. For those reasons, we are opposed to LB825. I'd be happy to address any questions of the committee. [LB825]

SENATOR LANGEMEIER: Are there any questions for Mr. Hallstrom? Seeing none, thank you for your testimony. [LB825]

ROBERT HALLSTROM: Thank you. [LB825]

SENATOR LANGEMEIER: Further opponents? [LB825]

JAN McKENZIE: Senator Langemeier, members of the Banking, Commerce and Insurance Committee, for the record, my name is Jan McKenzie, spelled M-c-K-e-n-z-i-e. I'm executive director and registered lobbyist for the Nebraska Insurance Federation here today in opposition to LB825. I want to take a little different perspective on it from what both the proponents and the opponents have maybe talked about, and put it in a purely kind of philosophical manner regarding what insurance is and why we have it and how it works. I heard a number of proponents talk about the actual cost to insurance companies will not increase. First of all, insurance companies aren't the people who pay for the policies. The policies are paid for either by individuals who purchase it, like me, or purchase it through a group, or they are paid for by employers who purchase insurance for their employees as a benefit to part of their wages. So I think sometimes people who have had insurance provided to them all their

lives by an employer don't understand that that's a benefit to them and that somebody pays for it. Their company pays for it out of their profits. Where if I pay for it myself, as an example, I pay $800 a month for my husband and I in our 50s...that always hurts. They increase your premiums, Senator Hansen, you know that, too, when you turn 50. And we have a $3,000 deductible per person. So it is catastrophic insurance and that's what I can afford. And I know there are a lot of other people in Nebraska who are like that, who pay for their own insurance, and likewise, small employers who pay for insurance. In the last 20 sessions, we have had 60 mandated benefit bills introduced in the Legislature. And every single one of those were very important issues, very expensive in many cases. And we've argued in the past that while every single one of them is a valid, legitimate health need that should be covered, what happens is a number of things, potential effects. When we wanted mandated contraceptives a few years ago we talked about how that could take place, but what would happen is your copay would go from $10 to $20 because that's what will happen. Somewhere it adjusts to cover for the expense of an additional coverage. So every time people think someone else is paying for something, in reality we all pay for it by the goods we pay...the price we pay for goods when we purchase from a company that provides insurance to its employees. They charge in order to provide that coverage as a benefit to their employees. The second thing I think happens, especially in health insurance, is because it's been provided to us in many cases we don't look at it like we do house insurance or our car insurance. When I look at my policies and shop around or I see, you know, Geico or Progressive or Allstate or State Farm or any of the companies that want my business for my car and my home, when I sit down with an agent, they go through, here's what you can get. You can get replacement coverage on your home or you can get appraised market value depreciated value on your home. Likewise, when I buy insurance on my car, I can increase my liability coverage beyond what the state requires or not. I can have a higher deductible against my collision so that I can make it more affordable. In health insurance, because we are given a plan by our employer, we don't always remember that somebody picked out what was in that plan. And that's what people were talking about before in saying self-insured versus fully-insured. I've done this for almost ten years now and I tell you, every time we get into these issues, I have to go back and refresh for myself the different between an ERISA plan, self-insured, and a fully-insured plan. Right now in Nebraska, 64 percent of all private insurance provided out there is not ever covered by a mandate, unless it's a federal mandate. We can pass this bill and we can pass the next bill and those 64 percent are not going to get the mandate unless it's a federal mandate, or the company or the employer chooses to put it in the policy they provide. So thinking that we're going to give it to everyone is not a reality. And I know that people think that will happen, but that is not the reality. And likewise, it may get covered, but suddenly you go from a $500 deductible to $1,000 deductible instead because that is the way the market works and it is a market. The third thing I want to say is that sometimes we have unintended consequences, much like the contraceptive coverage. When you look at contraceptive coverage may increase your copay. What also might happen, and you all understand this where I know a lot of

the constituents here today won't, you know that we had a bill last year that looked at what was happening with our CHIP program, which is how we help people who cannot get insurance, anywhere else get insurance. It's very expensive, but it's their last resort. You know that that fund is funded. The CHIP program is funded by premium taxes paid by the companies who do business in this state. Every time we put more pressure on the private market in any way, we put pressure either into uninsurance, we put people into uninsurance or we put people into ERISA. And every time we push more people into ERISA, into self-insured plans, more companies into that, those plans do not pay premium tax. So what we begin to do is try to solve one problem and create another. As we push more plans into ERISA, we create more potential harm for how we fund our CHIP program, which is how we help the people least able to afford insurance in this state. So I'm going to stop with that. Those were a few points I didn't think the committee had had a chance to consider today in light of all the good reasons that you've heard to consider a mandate. But these are the realities of what you, as lawmakers and policy makers, have to consider in how this really works, whose really affected, and how the overall policy of a mandate would effect Nebraska's ability to do the other things it does in this regard. I'd answer any questions. [LB825]

SENATOR LANGEMEIER: Thank you, Ms. McKenzie. Are there questions? We'll start on the end, Senator Hansen. [LB825]

SENATOR HANSEN: Thank you. Jan, you brought up the term "catastrophic health insurance" and I know who pays for health insurance, especially those who pay for their own because I do that, too. But let's talk about a different group of people than you and I. Let's talk about the people that are younger, in the childbearing ages. Okay? If the mother hears and the father hears and the life insurance agent says, you know, it's just a very small chance that you'll ever need a cochlear implant in your children because you both hear. Okay? Well, that doesn't always happen. What about childhood leukemia? What about childhood deafness? These are things that don't effect very many people, but can't the insurance business tell the people that, you know, here is a class of insurance because you're of childbearing age that you can get catastrophic health insurance for X amount and cover some of those catastrophic events. And I think the cochlear implant would be one of those catastrophic events because the difference between $100,000 and $1 million worth of education for that child throughout the system until they finish high school, to the big picture, to the state is a huge difference. [LB825]

JAN McKENZIE: I agree with that and I think you heard from the players in the companies that are members of the Nebraska Federation and who are here do cover them, do cover them. And I think...I mean, in the past there were mandates to do colorectal screening. Well, 15 years ago that was like, no, that was experimental, we don't need to do that. Well, over time what happens is, and you see all the time, that certain procedures and certain things become covered because it makes sense and it's

no longer experimental and it's out there, it's proven, and it is a good thing to cover and it should be covered. The other thing is I will tell you, in any case as an individual, I can go out and shop a policy if I had a child born with a particular illness and I didn't get it covered in my policy. There's nothing that precludes me as an individual from going out and buying a policy individually (laughter) with preexisting conditions. Well, and I know what they're saying and that I'm not talking specifically about their instance, but you don't have to always take what you're given and you can, but it's impossible to afford it. If I did not have insurance and I was diagnosed with multiple myeloma, I know I would be on Cobra or something that the state provided or on Medicaid. Same thing or lost my job and had to go out and find something. I know what you're saying is that somehow there ought to be a way for insurance to predict or provide for part of that when something shows up that we hadn't planned on in the original list of things we covered. But that's difficult to do because you know insurance is priced on a history of risk. And so when you don't know what the risk is, to say well, we'll cover up to this much of something we didn't know would exist is something that would make actuaries go crazy because they are the people who determine what you pay. That's the reality of it. [LB825]

SENATOR HANSEN Thank you. [LB825]

SENATOR LANGEMEIER: Senator Pankonin. [LB825]

SENATOR PANKONIN: Thank you, Senator Langemeier. Jan, real quick, you talked about 60 mandated bills over the years. How many of those passed? [LB825]

JAN McKENZIE: I just got that list put together a little earlier. I'll go back and...probably... [LB825]

SENATOR PANKONIN: Half? Third? [LB825]

JAN McKENZIE: Oh, no, no. The only thing that I can recall off the top of my head, and I will have to double-check, was colorectal screening... [LB825]

SENATOR PANKONIN: Someone in back held up the good list. [LB825]

JAN McKENZIE: I would say in those 20 years, maybe some of them, like colorectal screening that we did a couple of years ago...but no one opposed that anymore because it is standard practice now. [LB825]

SENATOR PANKONIN: Okay. Well, we've got a lot a testimony. [LB825]

JAN McKENZIE: I'll find out. I'll find out and you've got a lot more to do today. [LB825]

SENATOR LANGEMEIER: Senator Gay. [LB825]

SENATOR GAY: Just real quick, Jan. I mean, what you're saying, you can't get this after you find out your child is deaf. [LB825]

JAN McKENZIE: Right. [LB825]

SENATOR GAY: But is there something...as we're trying to be better consumers is what a lot of us are trying to do here, but you just don't think of these things. But are there riders out there on some of these policies that you can go buy the rider and it will cover cochlear or something? Let's say I got a young workforce and I know that haven't...like Senator Hansen mentioned, here's who I'm trying to cover. I look at my insured pool and I say, you know, I've got a lot of young employees, they'd probably appreciate this. And I put five or ten things in a rider that maybe increases my insurance a little bit, but you lay that risk off. Is there any riders out there now or why doesn't the industry have something like that? [LB825]

JAN McKENZIE: You know, I don't know because I know, especially in the individual market, there are a lot of new kinds of things being provided through some of the companies if you...again like last week, we talked to go on Internet and shop around a little and see what you can get. I think, much like home insurance, where you can get a marine rider on certain things. I don't know preventive medicine, well baby visits... [LB825]

SENATOR GAY: Well, yeah. I guess I'm just saying somewhere down the road. You know, you mentioned 60 different bills that were introduced. There's a need out there for somebody. But you could pick up...let's say, pick your pool of ten most common things and, yeah, you're going to pay more for it because there's a risk there that we may have to put in a $100,000 cochlear implant or whatever. But there's nothing out there now where you can kind of a la carte pick these things that are a concern? [LB825]

JAN McKENZIE: Not that I'm aware of. [LB825]

SENATOR GAY: Okay. All right. Thanks. [LB825]

JANIS McKENZIE: But I don't know. I mean, some people used to have that in cafeteria plans when they were offered where they could pick and choose or.... [LB825]

SENATOR GAY: Yeah. That kind of thing. They don't do that much anymore. [LB825]

JANIS McKENZIE: Actually what a lot of people doing now and the closest thing to that would be the idea of a health savings account where what you do is you increase your deductible to $3,000 or $4,000 or $5,000 and you're able to put that much aside in a

savings account that you can carry over... [LB825]

SENATOR GAY: Yeah. [LB825]

JAN McKENZIE: ...from year to year and earn interest. So you have that to protect against things you might not be... [LB825]

SENATOR GAY: But I still want to be covered under something that I wasn't looking for. [LB825]

JAN McKENZIE: Right. No. [LB825]

SENATOR GAY: That's all I'm saying. [LB825]

JANIS McKENZIE: Right. [LB825]

SENATOR GAY: Thanks. [LB825]

JANIS McKENZIE: Okay. [LB825]

SENATOR LANGEMEIER: Seeing no other questions, thank you for your testimony. [LB825]

JAN McKENZIE: All right. Thank you. [LB825]

SENATOR LANGEMEIER: It's back to you, Chairman. [LB825]

SENATOR PAHLS: Thank you, appreciate it, Senator Langemeier. Good afternoon. [LB825]

BILL PETERS: Mr. Chairman, members of the committee, my name is Bill Peters, P-e-t-e-r-s, Bill, B-i-l-l. I'm here appearing on behalf of Golden Rule Health Insurance in opposition to (LB)825. I have nothing significant to add to what has already been presented except to point out that we sell individual insurance. That's all we sell. That's the insurance you buy when your employer no longer provides or when you're self-insured or self-employed. And with that, mandates make it more expensive and more difficult for one to acquire insurance. And the effect of mandates, as Jan just mentioned, is to ultimately increase the price because you wouldn't have a mandate if you weren't trying to pass on some cost. And when you pass on the cost, the price goes up and you get to join the uninsured pool or you pay more premium. And that's our general opposition to mandates. [LB825]

SENATOR PAHLS: Senator Langemeier. [LB825]

SENATOR LANGEMEIER: Bill, thank you for you testimony. The thing I'm struggling with here is that this is a minor...the risk is so low, if the numbers we've been given here are accurate across the country. We talk about how this is going raise premium, I think taking a benefit that has such a minor chance or risk that it's going to happen, how can it effect premiums so drastically? [LB825]

BILL PETERS: But when it happens, it's costly, and when you're in the individual market, you don't have the buying power of big group policies. And we talk about what is billed and what is paid. The one is going to pay probably the higher percentage is those that are coming under an individual policy. And that risk, plus every other risk, has some cost. It's not saying that...you know, for instance Golden Rule covers single transplants. They do a lot on medical necessity, but the mandates that cause the increases when the numbers ultimately go up and most insurance costs aren't that much. You know? A doctor's bill and then, you know, you proceed up. But when they do hit and when you talk about on individual policies, when you get into five to six figures, that smarts. [LB825]

SENATOR LANGEMEIER: One more follow up question. In this language in the mandate, no where in here does it say what percent of coverage. Has Golden Rule looked at that? [LB825]

BILL PETERS: Not that I'm aware of. [LB825]

SENATOR LANGEMEIER: It doesn't say whether it's going to pay 10 percent of this, 2 percent, 50, 100. I mean, we could mandate this piece of legislation and the insurance industry could come back and say, great, we'll add it to you policy, we'll cover 10 percent. [LB825]

BILL PETERS: I'm not aware that we have any kind of a provision like that once you covered your deductible and your copay. [LB825]

SENATOR LANGEMEIER: Okay. Thank you. [Okay]

SENATOR PAHLS: Senator Carlson. [LB825]

SENATOR CARLSON: Senator Pahls. Bill, on individual policies and underwriting, Golden Rule or any other company that writes has the option of saying no. [LB825]

BILL PETERS: That's true. [LB825]

SENATOR CARLSON: So if you currently cover one implant but not two, and a family applied for coverage with Golden Rule and divulged on there that they have a child who

needs an implant, you're not going to take them. [LB825]

BILL PETERS: I don't think so, but I'm not absolutely certain. It would seem to me the underwriting would probably exclude them. Insurance isn't for already known problems. It's for the unanticipated. [LB825]

SENATOR CARLSON: Yeah. I understand. Thank you. [LB825]

SENATOR PAHLS: Seeing no more questions, Bill, thank you for your testimony. I'm just...by a way of hands, how many more opponents? Okay. Thank you. [LB825]

PAT HOEFENER: I'm between you and a break. (Laugh) I'll make it quick. My name is Pat Hoefener, H-o-e-f-e-n-e-r. I'm here representing the Nebraska Association of Health Underwriters, as well as NAIFA-Nebraska. The Nebraska Association of Health Underwriters, that represents about 400 health insurance agents throughout the state of Nebraska, the agents that are actually dealing with the businesses that are purchasing insurance, as well as the individuals that are purchasing insurance. NAIFA-Nebraska, they comprise of about 1,200 licensed life and health agents, work in a whole spectrum of products out there. We're here to oppose bill (LB)825, and as you've heard in the past, our concern is more the affordability of it. And you've had the insurance companies that have been up here and said that it will have an impact on pricing. It always reminds me of a stat that was thrown out there that every 1 percent of insurance premium increase, there's 600,000 people in the United States that lose coverage. So with that, that's our concern is our members are hearing of escalating prices everyday. And as it was mentioned before, there are businesses that aren't offering insurance that were a year ago, and two years ago, and three years ago. And so that's what our concern is. [LB825]

SENATOR PAHLS: Okay. Any questions for Pat? Senator Christensen. [LB825]

SENATOR CHRISTENSEN: Thank you, Chairman Pahls. Has anybody done any actuarial numbers on this so we would know what it would cost? [LB825]

PAT HOEFENER: Not to my knowledge, no. [LB825]

SENATOR CHRISTENSEN: Thank you. [LB825]

SENATOR PAHLS: Anymore questions? Thank you. That's the end of the proponents (sic: opponents). Anybody speaking in a neutral? I see nobody in the neutral. Senator Schimek did waive...I don't see her around, she did waive closing. Okay. That will close the hearing on LB825. I'll wait just a second before we start the next hearing. [LB825]

BREAK []

SENATOR PAHLS: Good afternoon. We are ready to start on LB969. Again, we will pass this around for those of you who want to make sure your name gets recorded in the record. I'm assuming because you're not testifying, but you do at least want us to know that you are here in support of this bill. Senator Pankonin. [LB969]

SENATOR PANKONIN: Thank you, Chairman Pahls and members of the committee. I am Dave Pankonin and I represent the 2nd Legislative District. I am here to introduce LB969 on behalf of the Amputee Coalition of Nebraska. I'm going to take a minute from my prepared remarks to say as an employer, I'm one of that 30 percent or 36 percent that pays for health insurance for my small business. And when these folks came and talked to me, I knew that this program could potentially raise those costs. I know how the system works on that, and we're going to have some cost numbers for you today. And even after knowing that and hearing their story, that's why I decided to carry this bill. LB969 would require that the most appropriate prosthetic be medically necessary by a treating physician be covered by insurance plans in the state of Nebraska at a minimum equal to coverage provided in the federal Medicare program. Medicare establishes a cost for each type of prosthesis. Medicare then pays 80 percent of the cost and the patient pays 20 percent. LB969 would not prevent application of deductibles or copayment provisions contained in the insurance plan or require coverage to be extended to any other procedures. Copayments would not be allowed to exceed those imposed under part B of the Medicare fee for service program. For purposes of this bill, prosthetics are defined as artificial legs and arms, and associated components. The lifetime for these artificial limbs depends on many factors, including the individuals age, activity level, and overall health status. For example, adults can typically use a prosthetic limb for three to five years, but growing children may require a new device more often. The cost for prosthetic limbs vary greatly and no one would suggest that they are inexpensive. However, appropriate coverage for prosthetic care would ultimately result in a cost savings for Nebraska. Individuals who receive proper care can be productive citizens and avoid the need to depend on assistance from the state Medicaid program. The Medicare and Medicaid programs, and federal employees health insurance plans all cover prosthetic devices without caps or other restricts. The Veterans Administration and the National Guard plans both provide prosthetic coverage without caps or limitations if the limb was lost during active service. Currently, insurance companies doing business in Nebraska have various forms of caps. Although it seems that the trend in the past year has been to modify policies to include caps for prosthetic coverage. Private citizens in Nebraska who pay health insurance premiums should be afforded prosthetic coverage that has at least equal to the coverage provided in the federal Medicare program. Seven states have already passed legislation that is similar to LB969, and 25 additional states are currently developing legislation. With the introduction of LB969, Nebraska can be added to the later group and with support from this committee and the full Legislature, Nebraska would require insurance coverage deemed necessary by treating physician for individuals who need to have prosthetic

limbs. I would be happy to answer questions, and representatives from the Amputee Coalition of Nebraska and other experts on this subject are here to provide more information about the provisions of LB969. Thank you. [LB969]

SENATOR PAHLS: Any questions for the senator? Seeing none, we'll...I know your office provided it, about half of dozen people at least will... [LB969]

SENATOR PANKONIN: I think we have...yeah, we'll try to keep it moving. [LB969]

SENATOR PAHLS: Okay. I just want to go over that because we do have a lot of people, new people. Again, we will have the proponents, then I'll call the opponents, and then I'll call the neutral, and then we'll have the closing of the bill or the hearing. Here's a question. Just by a show of hands so I get a feel, how many proponents do we have probably speaking? Okay. I'm just saying we have probably about a dozen, so keep that in mind. Try to make sure you get your information clear to us. Again, I'm going to ask you to spell your name. You may begin. [LB969]

JOHN RUSH: (Exhibit 1) Good afternoon, Mr. Chairman, members of the committee. Thank you very much. My name is Dr. John Rush, R-u-s-h. I'm the chief medical officer for Hanger Orthopedic Group based in Bethesda, Maryland. We're the largest providers of orthodics and prosthetics patient care in the United States with 620 patient care centers in 46 states, nine here in Nebraska. Hanger is proud to support the Amputee Coalition of America and its state chapters in this advocacy of this important legislation. Before I came to Hanger as its chief medical officer, I was a senior vice president for medical management at Cigna Healthcare, and then at PacifiCare prior to the United Healthcare acquisition. Currently, there are more than 1.8 million Americans living with limb loss. Every year, more than 130,000 Americans undergo amputation, and that number does not include our brave men and women who are returning from service to this country from oversees. Those suffering from limb loss can and do regain their lives, but only with proper prosthetic care. Unfortunately, private health insurance companies have begun to cap or limit prosthetic devices at unrealistic levels. Some have imposed caps at $1,000 per year, $2,000 per year, $7,000 per lifetime. These are very unreasonable. Others have sold policies that cover...that a covered person has only access to one prosthetic limb per lifetime. People that are amputees are amputees for life. Their limbs are not going to grow back. Imagine if you were five years old and were told you had to wear the same pair of shoes the rest of your life. These kinds of caps are absurd. I brought additional examples from Nebraska, as well as other states, of coverage restrictions from various insurance companies and I can have that passed around to the committee. Everybody knows about the increasing healthcare costs in this country, but of the monthly premiums less than 12 cents is spent on prosthetic care. Analysis from state mandate conditions, and these are not our studies or the studies of the Amputee Coalition, but of legislatures from states that have passed these bills, have all shown the same things: it's the right thing to do; it's the proper role of insurance; and

it saves the state money. Insurance companies and their lobbyists are hoodwinking you. They are cost shifting to the state. They are taking premiums from your constituents and then capping these services. Prior to 2000, they all covered prosthetics without caps or restrictions. Currently, Medicare, Medicaid, the VA, and in Nebraska, the Nebraska employees health insurance, all cover prosthetics without caps or restrictions. Your constituents deserve that same coverage. I know you're going to consider other mandates. Somebody said there was 60, even though you may have only passed ten. The reason you are considering so many is because the marketplace is not working and there is need for these services. While you consider other mandates, most mandates increase everybody's costs because more people have access to that mandated benefit. Not so with prosthetic mandating. No one is going to cut off their arm or leg to access this benefit. Currently, eight states, I have to correct the senator, it's not seven any more, it's eight, Colorado, Maine, New Hampshire, Rhode Island, Massachusetts, California, Oregon, and New Jersey have all passed prosthetic parody bills. Additionally, there are 30 states now working on it; 7 have already introduced this bill. I've already testified this year in Vermont, Maryland, and Virginia. We believe that of those 30, 20 states will introduce this bill. In signing the California...very interestingly, of the eight states that have passed, five were signed by Republican governors and in signing the California bill, Governor Schwarzenegger said: I'm signing AB2012. Currently, when health plans insurers offer orthodic and prosthetic coverage, they may offer coverage that in reality provides only a small portion of the total cost of a prosthetic limb. For instance, a health plan may cover only $2,000 of the cost of a prosthetic arm, leaving the patient to pay the remaining cost, which could be $10,000 or higher. While I am very concerned about the rising costs of healthcare coverage and have vetoed many bills mandating coverage for certain services, I believe that when someone chooses to purchase additional coverage, that coverage must not be illusory. I would have loved to have hear him say that. Right? (In Schwarzenegger voice) Illusory: I will be back. In addition to these state-by-state efforts, there was talk about ERISA. Representative Rob Andrews, who chairs the education and labor health subcommittee will introduce a national bill. This is a national prosthetic parody bill that I will pass around so that ERISA will be covered as well, those other 60 percent. Just so you know nationally, and it may vary so I'm not disputing the insurance lobbyists, 45 percent of Americans are covered under health insurance policies that are regulated by their state, 55 percent are under ERISA. So it is an issue and it may be a little bit different here in Nebraska, but when the national bill is introduced later this month or early in March, we hope to rectify that. In short, your constituents deserve healthcare coverage for catastrophic illness. That's the very reason they buy it, to protect themselves and their loved ones against stroke, heart attack, cancer. The loss of an arm or a leg is a catastrophe and should be covered. As a physician, I have to ask why would the state allow such a discriminatory practice? Why allow amputees to be treated differently than someone who has a hip or a knee replacement? The only distinction between the two is one is an internal device, one is an external device. They're both prescribed for the same medical reason: to return a patient to their highest functional level possible. Can you imagine someone of

your loved ones who needs an artificial hip or knee having to be forced to have fundraisers to obtain 50 percent of the costs? What happens if the insurance companies decide to apply these arbitrary distinctions to other devices? What's next? We'll have only one cardiac stint? Sorry you had three blockages there. In truth, these people here today should not be here to ask for a mandated benefit, but health insurers have left no other choice. The only other way they're going to provide the needed benefit is if they're forced to. Why allow health insurers to continue to cost shift to the state? Every amputee in this room wants one thing: to be a productive member of society, to be able to work and provide for their family. I think it was Senator Gay remarked that employers and the insurance lobbyist want choice, and that choice is also illusory. I think insurance companies come to employers and say, you know, your premium costs are going up 20 percent. They say, well, I can't afford that. The insurance company then says, well, here's some ways to mitigate that cost. We'll go to generic only prescriptions, increase your hospital deduction. Oh, here's this DME column. What's that? Durable medical equipment, we'll cap that at $2,000. The employer, who again is not an expert in insurance, doesn't understand that prosthetics are covered under that. When we have denials from insurance companies and call the employer, they have no clue that that was capped or restricted. In summary, the people of Nebraska deserve healthcare coverage for catastrophic illness or injury. Medicare, Medicaid, the VA, and Nebraska state employees health insurance all cover prosthetics without caps or restrictions. Analysis from the various state mandates show that this legislation would cost no more than 12 to 38 cents in monthly premiums. So $1.50 to $4 per year. You cannot...everybody that gets in a car, that mows their grass, that works on a farm is a potential amputee and it should be covered. All of the states that have passed this needed legislation have found that their state Medicaid programs have saved money. This bill will undoubtedly save the great state of Nebraska money as well. Other healthcare mandates increase healthcare costs to the entire healthcare system because more people have access to that benefit, but this will not be the case with LB969 as it will neither increase the frequency nor the occurrence of amputations. The only other thing that I would like to say before I close is that some of the insurance lobbyists say that they would not be able to do utilization review if this bill passed. I have also have a one-pager that I can pass along with the state studies on Medicare. It limits what type of prosthetic device can be provided to people based on their functional ability or level. There are four levels and a prosthetic device is...no one is going to get the microprocessor knees if they're a 94-year-old bed bound who loses their leg from diabetes. Thank you very much. I'll take any questions. [LB969]

SENATOR PAHLS: Do we have any questions for Dr. Rush? Senator Carlson. [LB969]

SENATOR CARLSON: Senator Pahls. Dr. Rush, you've referred to 12 cents 2 different times. Earlier I missed what you said and then I almost got what you said the second time (laugh). [LB969]

JOHN RUSH: I'm sorry. I'm from Washington. I've got to talk fast. Twelve cents PMPM, per member per month. Twelve cents to 38 cents. That's what's found in the mandate commissions from the various state legislatures. The JLARC report from Virginia, the joint legislative accounting commission (Joint Legislative Audit and Review Committee), found that 80 percent of all amputees returned to the workforce, and that's also not included in the analysis of those bills. If you do not give somebody a prosthetic device, they tend to sit in a wheelchair. They have problems with obesity, depression, flection contractures; not to mention home care...nursing home care that would be born by the state. We've seen patients that have lost their leg in a car accident. Their health insurance pays for the amputation, pays for rehab, and then by that time, they've used their benefits. They can't afford the prosthetic device. They lose their job. They go onto Medicare or Medicaid just to get the prosthetic device to go back to work and pay health insurance premiums to the very company that curtailed the coverage in the first place. [LB969]

SENATOR PAHLS: Doctor, I have a...just by looking at...it looks like your organization is a pretty large organization: 620 patient care centers? [LB969]

JOHN RUSH: In 46 states, yes. We are publicly traded. [LB969]

SENATOR PAHLS: Okay. Thank you. Any other questions for the Doctor? Thank you for your testimony. [LB969]

JOHN RUSH: Thank you. [LB969]

SENATOR PAHLS: Next proponent. [LB969]

STEVE HUGGENBERGER: (Exhibit 2) Good afternoon, Mr. Chairman, senators. My name is Steve Huggenberger, that's H-u-g-g-e-n-b-e-r-g-e-r. I'm the chair of the Amputee Coalition of Nebraska. And the coalition came together to try and ensure that amputees would have adequate insurance coverage for their prosthetic benefits. This coalition is made up of amputees, of limbless people, of the families of amputees and limbless people, of healthcare providers, doctors, prosthetic providers. I've been an amputee since a 1971 farm accident on my farm, on my fathers' farm. I'm currently an assistant city attorney with the city of Lincoln, and I couldn't have come to the place where I'm at today without the prosthetic care that I've had in the past. In the early years of my being an amputee, our family had no insurance to cover the prosthetics that I needed. At that time, we depended upon others. We depended upon the March of Dimes. We depended upon state assistance. And the amputee care or the prosthetic care at that time was not very good, but it was all that there was and I didn't know any different and I tried to make the best of it. Those were very difficult days. After becoming employed and having group insurance plans, all of those group insurance plans included prosthetic coverage and I was able to see what a difference good prosthetic

care could make, and that was a difference between night and day. Three years ago, 2003, my prosthetic coverage in my group health insurance plan was reduced. The coverage for prosthetics was reduced to $2,500, and I've included in my handouts copies of my prosthetic benefits from my city of Lincoln health insurance plan from 2003, 2006, and 2007. Initially, I had a $2,500 cap placed on prosthetic benefits with United Healthcare. This is the city of Lincoln plan, but it was managed by United Healthcare. When the city then contracted with Coventry to provide the management of that plan, that $2,500 cap also became part of Coventry's proposal. My last prosthesis in 2002 cost me a little over $21,000. It was at that time, when I'm looking at these caps and I know what my experience has been in the past. I realize I have a real dilemma in front of me in terms of paying for these things. I, as well as others, were very concerned with the coverages and the changes in coverages that many of us were seeing in our group insurance plans. I've included examples in my handout materials of other patients' explanation of benefit plans just to show you that this is not limited to the city of Lincoln. Example: The coverages for prosthetic benefits were being capped in a multitude of different ways, and that was something that had not occurred before. We were seeing caps that were anywhere from $2,500 a year, $3,500 a year, $5,000 a year. Sometimes we'd see a lifetime cap, $50,000 lifetime cap. Sometimes we'd see a cap or a limitation that will pay for the first prosthesis; we won't pay for anything after that. We, who are in this coalition, realize as we see these things that most of us are not going be able to afford the prosthetic care that we've benefited from in the past, and that's prosthetic care that we need for the future. The prosthetic care, as has been said by Dr. Rush, that prosthetic care for Medicare patients is not capped in that way. Veterans benefits are not capped in that way. We've sent information to all of your offices about what prosthetic care costs in today's world. A below the knee prosthetic leg can cost easily up to $25,000, and above the knee or up to the hip prosthetic can go much higher than that. An arm prosthetic is very expensive as well, almost as much as the above knee prosthesis. The information that we've provided you was given to you in terms of ranges and averages. We all know examples from our group of individuals that go above those averages, higher than $25,000 for a below the knee, higher than $50,000 for an above the knee prosthesis. Some of the members of our group are double amputees, so the hit to them is twice the amount that it is for most of us. Prosthetic devices are really like every other piece of equipment. Every piece of equipment wears out depending on how much you use it, and depending on how old it is. That's one thing that's a certainty. Another thing that's a certainty is the stump of every amputee, the residual limb. That changes over time. Every single amputee stump changes. When you encounter a piece of equipment that's worn out or you have a piece of equipment that no longer fits properly, you have to make changes, you don't have a choice. Many of us in this group have had a prosthesis for a long time. And we know what it's like to stay with a poor-fitting prosthesis too long or to use equipment that needs to be replaced. And we also know what it's like to benefit from the technology that we have today. And I can't impress on you enough how better it is today with the technology that we have today, and what a tremendous difference that can make to a

person's life. I've included pictures in my materials of the various prosthetics that we're talking about just so you'd have some idea of what it is we're talking about. Dr. Rush had indicated, and I think the senator indicated as well, Senator Pankonin, that we're estimating that a prosthetic would need to be replaced every three to five years for an adult, and sometimes twice a year for a growing child. With a $2,500 cap on their prosthetic benefits, most families couldn't take that kind of a financial hit every year or every three years. They will either deplete whatever assets they have or they will resort to state assistance. Some in our group have suggested they'll simply go back to crutches. Some have suggested they'll just go back to wheelchairs. Some have suggested they just won't wear prosthesis at all, and that's really a terrible decision to have to make. The more sedentary that a person gets, the more other health issues and healthcare costs arise. And if an amputee is prevented from accessing prosthetic care, those complications will increase: knee problems, shoulder problems, back problems, skin break down, osteoporosis, muscle loss, depression, whatever other costs associated with nursing home care, with home care. You know, that subsequent cost far exceeds the cost of the initial prosthesis. The majority of amputations in the United States are due to vascular or circulatory diseases, diabetes. And those diseases are on the rise. You know, this is truly an issue of need for these people. Nobody chooses to be an amputee. A person becomes limbless because of an accident or a disease or a birth defect. No one that we know of in this group misuses the benefits that we're talking about, and yet we have caps in Nebraska. We have examples in the materials that I've passed out of caps with Coventry insurance, United Healthcare insurance, Mutual of Omaha, Blue Cross/Blue Shield. There have been a number of questions about what kind of impact are we talking about here in Nebraska and that's a hard question to answer with precision. Just trying to figure out how many amputees and limbless people there are in Nebraska is difficult and I think that's a HIPAA related issue. But if you look at the national estimates, we have estimates nationally that there are 400,000, a low of 400,000 to a high of 3 million amputees in the United States. If you take those numbers and you do a prorate a calculation for Nebraska, that comes out to a low of 2,300 amputees or a high of 17,000 amputees. We have polled about half of the prosthetic offices in Nebraska to try and figure out how many patients that we're talking about. We've come up with numbers between 1,100 and 1,200 patients. For that reason, we think that 2,300 number is probably pretty close to correct for Nebraska. Now, most people don't have any idea what the prosthetic coverage is in their health insurance policy and they couldn't tell you the difference between an AK or a BK, an above the knee prosthesis or a below the knee prosthesis. And they sure wouldn't have any clue about what these things cost, however, the public expects to be covered when they lose a limb due to accident or due to a trauma. We have widespread support from individuals and organizations throughout Nebraska for this effort. We have support from the American Cancer Society, the Nebraska Chapter of the American Physical Therapy Association, the Nebraska Medical Association, the AARP, and dozens and dozens of veterans. In return for premiums paid, consumers expect to be covered for catastrophic illness and catastrophic injuries, and they expect that their monthly premiums will

provide them with the most basic of care and that's what prosthetic coverage is. It's basic care for these kinds of issues and it's being pushed out of reach by the caps that we're seeing. The general public expects basic care to be covered in their insurance. Prosthetic bills, like LB969, ensure that prosthetic care will be treated as basic care. Replacing a knee is covered, replacing a hip is covered, a prosthetic limb should be covered as well. You would not tell someone that they can only have one heart attack per lifetime or that they can only have $2,500 worth of stroke care. And legislation like LB969 requires that prosthetics be treated the same as every other basic essential care in private insurance plans. We've already spoken about the other states that have adopted this type of legislation. We urge you to pass this legislation this year. Every year that we wait is another year that people will begin to cut back on needed prosthetic care. If the estimates that we make are correct, several thousand amputees in Nebraska, and we think that is a correct number, there could be hundreds of amputees up here testifying. We haven't suggested hundreds of amputees will come up here and testify, but we have asked for a sampling of various experiences as part of the coalition presentation to come up and talk to you. Thank you for your attention. If I can answer questions... [LB969]

SENATOR PAHLS: Do we have any questions for Steve? I see none, thank you, Steve. [LB969]

STEVE HUGGENBERGER: Thank you. [LB969]

SENATOR PAHLS: Next proponent. Good afternoon. Is this something you want to send out? Okay, thank you. [LB969]

MELISSA McCABE: (Exhibit 3) Yes, sorry. My name is Melissa McCabe, M-c-C-a-b-e, and I was born and raised in Fremont, Nebraska, and I'm an amputee. My lower right leg was amputated almost 14 years ago, and at the age of 11, I was diagnosed with cancer and required the amputation. Some people say I only have one leg. I actually have two. One is just slightly a little different. I am here to talk about the leg that is a little different. After my amputation, I was fitted with a prosthesis. During the first year, as my stump physically changed, which is common with all amputees, I had to be fitted with several new legs. And as a very active teenager, I was known to break a prosthesis or two. Because of my slightly different leg, I was able to ride a bike, play softball, basketball, march in the band, roller blade, and my favorite, do dance lessons. I was a normal teenager enjoying what normal teenagers do. I was covered under my mother's insurance and after the normal deductible, the insurance paid the balance of many prosthetic legs that I went through. It wasn't until a few years ago while I was in college that the insurance companies started talking about a yearly cap. When the insurance companies said that they are only going to pay $2,500, we talked to the insurance company and they said that the prosthesis was under the wrong insurance code. They did pay for the leg after the deductible and the copay. I was thrilled when I got my first

job after graduating from college in 2004. I had insurance in my own name. I no longer was a dependent of my mother's insurance. After visiting my orthopedic doctor for a biweekly checkup, he felt it was time for a new prosthesis. I would say that I'd torn the leg to pieces. As with all the prosthetic devices, the doctor wrote a prescription and I went to my provider for a new leg. While we were in the process of making the new prosthesis, my provider called Coventry Health Care to check whether a preapproval was necessary. We learned that there might be a $2,500 cap. We completed the leg and submitted the necessary insurance forms and learned, in fact, that there was a cap. The prosthesis cost over $15,000 and that doesn't even include the skin covering because the insurance company rejected it because it was cosmetic. Coventry paid $2,500. Along with rent, utilities, a car payment, groceries, a student loan, and also now a payment for my prosthetic provider, my mom is helping me make the payments of the remainder of the bill. I still enjoy playing coed softball, but now I need to make a decision whether I want to risk playing and break my prosthesis. If it breaks, I won't be able to afford the additional bills that will fix it. If I would fall playing softball and break my left leg, the insurance company would pay for the surgeries, casts, physical therapy that I would need. I worry that I won't have the last prosthesis paid off before I need a new one. I'm working hard to be a good productive citizen of Nebraska. I graduated from University of Nebraska at Kearney, and I have stayed in Nebraska to live, to work, and to someday raise a family. I say that the lack of insurance coverage on a prescribed item by my doctor worries me a lot. Fourteen years ago on February 14, I lost my leg. Please help for me to have a productive life and stop this insurance injustice here in Nebraska. Please support LB969. Thank you very much. [LB969]

SENATOR PAHLS: Any questions for Melissa? We appreciate your testimony. Thank you, Melissa. [LB969]

MELISSA McCABE: Thank you. [LB969]

SENATOR PAHLS: Next proponent. Good afternoon. [LB969]

STEVE MOUNTAIN: (Exhibit 4) Good afternoon, Mr. Chairman and committee members. My name is Steve Mountain, it's M-o-u-n-t-a-i-n. I'm 50 years old and I'm a resident of Lincoln, Nebraska. I was brought up in a military family, an Air Force family, and when my dad retired, we come back to Lincoln where it all started. At 18 years old, I got a job on the Burlington Northern Railroad, knowing that one day I would have good insurance and a good retirement. And after 27 years on the job, I never really ever needed my medical benefit. At the age of 46, after 10 years of practice, of study, and heartache, I earned my Formula One Race pilot's license. On May 29, 2005, Memorial Day in Yukon, Oklahoma City, Oklahoma, I was racing in a sanctioned Formula One Air Race, and during the second flap of the second day race, my engine came apart at over 250 mile an hour. They do not stop the race because of a May Day. There were seven other aircraft on the race course at the time and I could not jeopardize or risk any of my

fellow pilots. I tried to hold it off as long as I could until they cleared the runway, but I stalled and went in at over 100 mile an hour. At that point I was out of it, unconscious. After cutting me out of the wreckage and putting me an a med flight helicopter, I died en route to Oklahoma City. Once I got to the trauma center there at Oklahoma City, I died again. Both times. Both times I was in the light. Both times a man told me I was going back. After 36 days and 28 surgeries in an induced coma, I woke up, less two legs. I also had a lot of titanium inside my body, which I never had. You know, it's hard to look at oneself when there's only part of you left. How do I start over now? But I was lucky, I was lucky I was alive. I was lucky I had good insurance to cover my medical bills and a set of new prosthetic legs. During recovery, I had my ups and downs. Once the legs...things started changing with my legs once I got on them. I had two more surgeries and three more sets of sockets, plus leg components before it started working for me. Through rehab at Madonna and my own determination, I do my own driving now. I do my own daily chores. I scoop the sidewalks. I scoop the driveway. I do everything I got to do myself. I try to do it myself, and it's because I got legs that I'm able to do this. I had to quit my job and go on a disability retirement, and with that went my insurance. I'm now on Medicare. I pray that one day I'll be able to go back to what I started, back to the railroad and retire, back to flying airplanes upsidedown and going fast. But it scares me when I think that the insurance companies want to treat mine and other people's needs as an uncoverable or durable good items when it means more of a real life to all of us, more of a normal life. I shake in fear at people like myself have little or no coverage when it comes to prosthetics. I worry that people in this situation become dependent upon the state's offices, agencies, and programs. We buy insurance for the unexpected. If insurance companies don't want to cover prosthetics and many other items, why do we need insurance? Go to the state? No. No. Being stuck in a wheelchair? Thank God, not me. Put legs under me and watch out, watch me go. Everyone who carries insurance coverage should have the backing, help, tools to be on their way to recovery. We should be supported with the care, the prosthetics, tools, and encouragement we need to the road to recovery and success. That is why we carry insurance coverage, not to be left in the dark, left in the dust to find our own ways out. It should not be the state's responsibility to take care of what we have insurance for. If you have any questions, I'll try do my best to answer them. [LB969]

SENATOR PAHLS: Do we have any questions for Steve? Senator Hansen. [LB969]

SENATOR HANSEN: Thank you. Steve, I read along with your testimony. You are one tough son of a gun. [LB969]

STEVE MOUNTAIN: I appreciate... [LB969]

SENATOR HANSEN: Appreciate your coming today. Appreciate you doing what you do for yourself and for the state. Don't fly the planes upsidedown (laughter). [LB969]

STEVE MOUNTAIN: Upsidedown is a lot more fun, but going fast low to the ground, that can get real dangerous. [LB969]

SENATOR HANSEN: Thank you. [LB969]

SENATOR PAHLS: Yeah. Thank you, Steve, appreciate your testimony. Next proponent. Good afternoon. [LB969]

GIGI JENSEN: (Exhibit 5) Good afternoon, senators. My name is Gigi Jensen, that's G-i-g-i J-e-n-s-e-n. I'm here today as the mother of a six-year-old amputee. My daughter Kaylin was born three month premature and weighed under two pounds. Due to a blood clot at ten days old, she underwent a right knee disarticulation, which is an amputation above the knee. Today, Kaylin is a sweet, smart, energetic kindergartner, but although she lives with a limb deficiency, she doesn't let that slow her down at all. Kaylin learned to walk on a prosthetic leg and was walking independently at 19 months old. She has had a lot of battles to fight in her young life. I am hoping today to help you understand why our state needs to pass legislation that will provide prosthetic care for Kaylin and all other amputees in Nebraska with reasonable copays and deductible allowances. Our insurance company is Blue Cross/Blue Shield and they cap their durable medical equipment, their DME coverage, at $5,000 per calendar year. Just one of Kaylin's street legs cost over $10,000. As a child, her legs are fairly simple. The knees are not computerized. They're just mechanical. As she reaches adult size, the technology becomes increasingly more sophisticated and costs upwards of $30,000. The increased technology benefits the amputee by providing a more stable, safer, and more real limb. Because Kaylin is a growing child, she needs to have her street leg replaced every 9 to 12 months. If insurance would provide for adequate street legs, it would help allow for us to provide her with a shower/swim legs and, at some point, an activity leg, a sports leg. Unfortunately, when you have an above the knee amputation, you don't just change your shoes when you go from one activity to another, you have to change your whole leg. Aside from the purchase of a leg, you have maintenance. Kid's feet continue to grow and so the prosthetic foot needs to be replaced. Kaylin has needed to have knees replaced because she was out playing around being a kid, crawling around in the dirt and the sand and she has locked the knee up more than once. Her first legs came from the Shrine Hospital in Minneapolis. They are an amazing organization that does so much for children, however, their proximity to Omaha makes it very difficult and once the child reaches 18 or 21 as a full-time college student, they're no longer eligible to receive their care. The trip is about 400 miles, about a six and a half hour trip each way. When Kaylin was a toddler with really no working parts to her leg, it worked all right. We made our three trips up to Minneapolis each year and just tried to make little mini family vacations out of it. You go every four to six months and at one of those checkups, Kaylin would get casts for a new socket. Two weeks later, you make another trip up and you cross your fingers that that socket fit well. We developed a rapport with a local prosthetist, Russ, when Kaylin was having some fitting issues with a leg that we had

received from the Shrine. It ended up that Russ had to make her a new leg. When Russ makes a new leg for Kaylin, she has about three or four fittings before the final leg is even started. There are probably five to seven visits before the leg is complete and then Kaylin walks out of the office with her leg fitting perfectly. As Kaylin continued to grow, we found we were having more and more times that we needed immediate attention. It just isn't an option for your child to have to go without her leg. As the parent of an amputee child, it is so important to be working with someone that you have an ongoing relationship with, and someone that your child gets to know and feel comfortable with. When you're six plus hours away from that person, it's difficult to create that bond. I can call Russ's office and everyone in the office knows us and if there's a problem, he will get us in immediately to get it fixed. When Kaylin was about 18 months old, I had her up on her changing table changing her diaper and she was fidgeting around. She knocked her leg off, it fell, hit the ground and cracked down one whole side of the socket. We needed a new socket as soon as possible. That is the kind of immediate care and comfort level that you need when your child's mobility is at stake. We are a middle class, one income family living in Elkhorn, and my husband is a small business owner in the community. Insurance premiums for a small business are astronomical as it is. It would be a serious financial hardship for us to have to pay every year the expenses over a $5,000 cap imposed by our insurance company. Kaylin and other amputees are a segment of the population that, although are labeled disabled, yet most are healthy and active and they want to be an integral and productive part of society. However, if they are not given the access to affordable prosthetic care, it will be our Nebraska Medicaid dollars that are supporting them. I'm very frightened to think of Kaylin's future. Imagine how scary it is as a parent to know that someday your child may not be able to afford to walk. Please vote in favor of LB969 and thank you for your consideration of this very important issue. [LB969]

SENATOR PAHLS: Gigi, I just have a question of myself since I am a Shriner as we discussed earlier. You know, allowing to be a Keystone Kop allows me to be crazy, and one of the reasons we do this is to help children. You can go to Minneapolis. They do...I thought they had transportation. Will they...? [LB969]

GIGI JENSEN: Yes, they will. [LB969]

SENATOR PAHLS: Okay. Curious, I know you have a relationship with Russ. [LB969]

GIGI JENSEN: Um-hum. [LB969]

SENATOR PAHLS: Is there anyway that these two, like Russ and the hospital, work together? Or is that... [LB969]

GIGI JENSEN: Well, to a certain extent. I mean, when we have gotten legs in the past at the Shrine, yes, then Russ has done some maintenance on them for us. [LB969]

SENATOR PAHLS: I'm just asking these questions from a personal thing just so...as a Shriner. Okay. Yeah. Thank you. [LB969]

GIGI JENSEN: Sure. The problem with going to the Shrine is that you can go up there and you get cast for a socket, but if that doesn't fit right, we've had to come back here and then have Russ recast her for another socket. And it's just because of the proximity. If we lived in Minneapolis, or something, you could run in, have it fixed and kind of like we do here locally. It just makes it so difficult because of the distance. [LB969]

SENATOR PAHLS: Yeah. I understand. I'm just doing some of this for my own personal...thank you. Do we have any other questions? Seeing none, appreciate your testimony. [LB969]

GIGI JENSEN: Thank you. [LB969]

SENATOR PAHLS: Next proponent. [LB969]

ALLISON ALDRICH: (Exhibit 6) My name is Allison Aldrich, A-l-d-r-i-c-h. I'm from Schuyler, Nebraska, and currently a sophomore at Nebraska Wesleyan University here in Lincoln. I lost my leg due to cancer at the age of seven. For the first few years, I went to the Brace Place in Omaha, Nebraska, to have my prosthetic legs made, and my parents health insurance helped pay for these legs. As a child, I did go through at least one leg a year and sometimes two. There were numerous times that the insurance company declined paying for different parts of my prosthesis and my parents had to foot the bill. Because of nonpayment by the insurance company and the deductibles and copays, this became a financial hardship and we applied to go to Shriners Hospital in Minneapolis. This is where I have been going for the last 12 years, since I've been 12 years old. My parents and I estimate that we have driven to Minneapolis and back approximately 40 times in the last 8 years so that I could have my prosthetic legs made at no charge. Up until a couple of years ago, my parents paid for gas and hotel rooms when we went to Shriners, however, Shriners is now reimbursing them for the hotel expenses. Shriners has been really good to me and I appreciate so much what they have done for us. However, because of the time needed to travel to Minneapolis, I will say that I don't have my prosthesis adjusted as often as I would if I had a provider here in Nebraska. Because of wearing a prosthesis that didn't fit properly, I developed a problem with my back and I've had to go through physical therapy to correct it, which the insurance paid for. My time with Shriners is growing to a close. I will not be able to continue with them after my 21st birthday. I am 20 years old now. Because I'm a full-time student, I've been able to continue going to Shriners after I turned 18. So within a year, I will need to have my prosthetic expenses covered on my parents health insurance, which is Blue Cross and Blue Shield. Their policy has changed since I was first used when I was younger. The insurance will now pay for only one prosthesis every

five years. I am very concerned that I will have to have a new one sooner than five years. That is a long time to go for any amputee, especially for me because I'm so active. My prosthesis range in price from $18,000 to $25,000. I will be out of college in a couple of years and it's scary to think of having to pay for prostheses on top of my student loans and everyday expenses of rent and groceries. I'm a member of the United States women's national paralympic sitting volleyball team. We participated in the paralympic games in Athens, Greece, in 2004 and received the bronze medal. I am planning on participating in the paralympics this fall in Beijing, China. I am proud to represent Nebraska and the United States. I am hoping that I have a prosthetic leg that will be in good shape when I travel to Beijing. Today, I'm asking you for your support of LB969. Please help us amputees with your support of this bill. Thank you. [LB969]

SENATOR PAHLS: Any questions for Allison? Thank you for your testimony and good luck in Beijing. [LB969]

ALLISON ALDRICH: Thank you. Thank you. [LB969]

SENATOR PAHLS: (Exhibit 7) I'm still on the proponents. [LB969]

CARLY RUNESTAD: (Exhibit 8) Good afternoon, Senator, members of the committee. My name is Carly Runestad. For the record, it's C-a-r-l-y, last name is R-u-n-e-s-t-a-d, and I am the director of health policy for the Nebraska Hospital Association. On behalf of our 85-member hospitals in the state, we ask that you support and advance LB969. As you've already heard today, people living with the loss or absence of a limb sometimes face discouraging obstacles when trying to obtain the necessary prosthetic devices. Without access to coverage for these necessary devices, their ability to lead independent productive lives can be severely compromised. The appropriate use of prosthetics enables people to function independently in society instead of being dependent on state and federal programs. In the interest of brevity, I will end with that and just tell you that on behalf of Nebraska hospitals, we would urge you to support and advance LB969, which will ensure that people with limb loss are given the opportunity to lead full and productive lives. Thank you. [LB969]

SENATOR PAHLS: Any questions for Carly? Seeing none, thank you. Proponents, next please. [LB969]

SHERYL HAVERMANN: (Exhibit 9) Hello. My name is Sheryl Havermann, last name is H-a-v-e-r-m-a-n-n, and I am her today as a mother to a six-year-old amputee. My daughter Brielle lost her left leg above the knee to cancer in June of 2006 at the age of four. Since her amputation, our family has been thrust into the world of prosthetic care and our eyes have been opened to the many inadequacies and obstacles for treatment. I am here today to speak about the trend with insurers to place a cap on prosthetic limbs so low that they, the insurer, is left paying approximately 5 to 10 percent of the

cost of a limb, and the recipient is left with the remaining 90 to 95 percent balance. This is exactly opposite what is the track record for other medical costs, where the insurer is paying 80 to 100 percent of the covered cost and the recipient is paying for the 0 to 20 percent balance. My goal is to see that laws are created that ensure that prostheses are covered on par with other basic medical services. I'll pass this around. We are covered under Coventry Health Care. So I pulled their vision statement for you to read. They have a sentence that says, our aim it to offer products and services that will responsibly improve the quality of life of all we serve. It was the $2,500 to $5,000 cap. I don't know how that's covered. I believe that there's lobbyist from United Healthcare and Blue Cross in the room as well. And while I don't have access to that web site, perhaps they do and they could submit those mission statements for you guys to take a look at as well. I'm employed as a pharmacist and as such, I am very familiar with healthcare, insurance restrictions, denials, prior authorizations, and payments. These are things I deal with on a regular basis at work, however, I also have experience with these issues on a personal nature. We have challenged our insurance company for payment or our coverage on many of Brielle's medical procedures over the last two years, including coverage for her first prosthetic leg. We have dealt with first level appeals, second level appeals, payment reconsiderations, prior authorizations, denials, etcetera. And this is my file of the last 18 months of challenges that we have worked with this company. Despite our history of problems, we do not have an adversarial relationship with members of this insurance company. We work very well together. We currently carry family health insurance through my husband's employer, First Data, and we are insured through Coventry Health Care of Nebraska, as I stated earlier. Our current policy does not have a cap on durable medical products, such as prosthetic legs. Prosthetics are required to have a prior authorization for payment under our plan and there are certain restrictions to coverage. However, through Coventry personnel, we have learned that our policy is clearly not the trend. Ninety to 95 percent of policies that Coventry has in place have a cap of $2,500 to $5,000 on durable medical coverage. We are in the 5 percent of policies that do not have this cap, however, we are also astute enough to realize that changes will occur within our plan in the near future to meet the trends that have been set. At some point, our minority status of not having caps on coverage will morph into the majority status, and we will be faced with limitations on prosthetic coverage just like the rest of Coventry cardholders are experiencing today. We nervously anticipate the open enrollment season each October when choices for next year's healthcare plans are made available to us through First Data. I attempt to be proactive and I am in regular contract with the human resource managers within First Data to remind them that we do utilize the durable medical portion of the insurance provided and what on cap coverage would mean to our family. I would like to say that they take this into consideration when they negotiate insurance for the coming year, but we are but one family amongst 5,000 employees. Prosthetic coverage is one of the main things we have to look at when considering insurance each year. For 2008, we were given three choices: Coventry, which had no cap on durable medical; Aetna, where Aetna's representatives were unable to comment on what their durable medical

coverage consisted of; and United Healthcare, which had a limit of one prosthetic limb every three years, which is not a feasible option with a six-year-old child that needs a new leg every six to nine months. Coventry happened to be the most expensive option to our family, but really was our only choice when looking at our needs for coverage. Coventry has covered two legs in the time since Brielle's amputation. Her original leg cost $13,000. The leg she's wearing today cost $18,000. While these costs are at the bottom end of prosthetic prices, they are too expensive for us to pay out-of-pocket for each year. If our health insurance plan was to place caps on prosthetic coverage, we would have no other choice but to seek prosthetic care out of state at Shriners Hospital in Minneapolis, Minnesota, for as long as Brielle remained eligible for their generous care. We simply could not afford to pay the $30,000 each year in out-of-pocket difference in costs. Traveling out of state for prosthetic care is not something I look forward to and is not something that is ideal for Nebraska residents. The care is not a substitute for in-town care, and the time required away from jobs and school will take its toll. For the 18 months that Brielle has been a patient at her in-town prosthetic provider, we have had 35 appointments. That is an average of roughly two appointments every month. If you consider the distance from Omaha to Minneapolis, which is 800 miles round trip. This turns into a logistical nightmare. I vividly recall times where we have rushed into our prosthetic provider because of an acute issue. Either Brielle's leg wouldn't go on that day because of swelling of her limb, she had sores at the bottom of her limb that needed urgent attention, or the fit wasn't quite right and she was an unstable walker. These are all things that cannot be managed out-of-state in a reasonable fashion. The difference of mobility and day-to-day life from when she can wear her leg and be a functional and independent child is vastly different from the days when she cannot wear her leg because of an improper fit or pain. It is critical to us and to Brielle that she be able to wear her prosthetic leg on a regular daily basis. A six-year-old child is simply not happy being confined indoors to sit-down play only as she is when her leg doesn't fit. I truly hope and pray that our current choice of seeking in-town care is not taken way from us because of our inability to cover the out-of-pocket expenses should our insurance place caps on prosthetic coverage. Since the topic of caps was introduced to us by our insurance company while Brielle was in the hospital recovering from her amputation, we have been aware of its existence. God willing, Brielle has many years and many prosthetic legs ahead of her. As her mother, I do not want to see prosthetic coverage as an obstacle to care for her. She has enough challenges already without worrying about how to pay for the leg that she needs to be a functional, ambulatory independent individual. A diagnosis of cancer is expensive in and of itself. For 2007 alone, our family has paid just over $5,400 in out-of-pocket expenses towards Brielle's medical care. We have met the $1,500 deductible for hospitalizations, which covers her surgeries. There is no cap on coverage for that portion of our insurance. We have met the $1,500 deductible for lab work, which is where her CT and MRI exams that she needs every three months to track the cancer care. That also has no cap on coverage for that aspect. We have met the $1,500 deductible in durable medical goods, which covers her prosthetic leg. Today, there is no cap on that coverage

and we have paid just over $900 in copays for physician office visits and physical therapy. That element also has no cap on coverage. I would like to see the legislature to be proactive to our situation, and put into place the necessary laws that will ensure prosthetic care is obtainable within the state and affordable to its residents. After all, we pay for insurance to ensure that we have a safety net when something goes wrong. Please ensure that that safety net is not taken away. While our family is not in critical need of this legislation today, our time is short lived. But there are so many more individuals that needed this legislation years ago. Please be a voice for the amputee and allow them the chance to be a productive, contributory citizen to this state. Any one of us in this room today could be involved in a car accident or, as in Brielle's case, undergo surgery for an unrelated incident and be diagnosed with cancer. Do you know what your prosthetic coverage is on your current insurance? Do you have an expectation that the insurance cover the surgery, the hospital stays, the rehab services, the prosthetic legs? I do. Please vote in favor of LB969. Do you have any questions? [LB969]

SENATOR PAHLS: Senator Christensen. [LB969]

SENATOR CHRISTENSEN: Thank you for coming in. I appreciate your concern. I drive form Imperial, which is 5 hours to Lincoln all the way to Minneapolis. [LB969]

SHERYL HAVERMANN: Oh, do you. [LB969]

SENATOR CHRISTENSEN: Yes, 13 hours, so I understand very much. Thank you. [LB969]

SHERYL HAVERMANN: Also understand, Senator Pahls, you made a comment earlier that...about the working relationship between Shriners and like the in-town providers. And probably the closest analogy that I can make is like orthodontic care, where you go and get your braces put on and the orthodontist bills the insurance company a set amount that covers all your office visits. You know, if you break a band chewing gum or, you know, your monthly visits, that's all covered in that initial lump sum fee. It's the same for prosthetic legs. They bill out a billing code and the payment is there. You know, so Shriners, although they don't bill, would recoup that money. The in-town prosthetic providers cannot charge for office visits, you know, unless they replace parts. So hopefully that helps a little bit. [LB969]

SENATOR PAHLS: Okay. Yeah, it does. Any other questions for Sheryl? We thank you for your testimony. [LB969]

SHERYL HAVERMANN: Okay. Thanks. [LB969]

SENATOR PAHLS: Next proponent. Good afternoon. [LB969]

GENAVIEVE ANDERSEN: Hello. I'm Genavieve Andersen, G-e-n-a-v-i-e-v-e A-n-d-e-r-s-e-n, and I am an amputee of 17 years. When I was eight months old, I was amputated up at Shriners Hospital in Minneapolis. This amputated...this procedure needed to happen because I had a condition called fibula hemimelia, which means that I do not have a fibula bone in my left leg and so my left foot was amputated. Within a few months, the Shriners fitted me with a prosthesis and I was on my way. This is my first leg. The foot had to be shaved down so it would fit me. I'm grateful that we found Shriners after a long search to find care that would help us. I grew up having to have many legs. I sometimes had to have three a year and that costs a lot to our family. And so we are very lucky to have Shriners to help cover the costs. And for me, my Shriner help ends at 21 instead of the new 18, so I'm scared for when I turn 21 and have to find a healthcare insurance that will at least pay for some of it so I don't have to either go and have fundraisers and ask for help from strangers if that's what I need to do to cover the costs or the worst case scenario, just stay inside and not be able to walk. I would like to demonstrate what it would be like to go without a prosthetic if you will allow that. [LB969]

SENATOR PAHLS: Go ahead. [LB969]

GENAVIEVE ANDERSEN: Right there with that little walk, my stump started to hurt just a little bit and if I had to do that up and down stairs all around my house, it would be an incredible pain towards the end of the day and I don't think I could handle that. So please pass bill (LB)969. Thank you. [LB969]

SENATOR PAHLS: Genavieve, may I just ask you a question? What do you...what year of school are you in now? [LB969]

GENAVIEVE ANDERSEN: I'm a junior. [LB969]

SENATOR PAHLS: Okay. It won't be long and you'll be out in college? [LB969]

GENAVIEVE ANDERSEN: Um-hum. [LB969]

SENATOR PAHLS: What's your future? What do you want to be? Have you decided yet? [LB969]

GENAVIEVE ANDERSEN: I would like to be an amputee counsellor. [LB969]

SENATOR PAHLS: Okay. With your background and your understanding? [LB969]

GENAVIEVE ANDERSEN: Um-hum. [LB969]

SENATOR PAHLS: Well, thank you. Thank you for...well, do we have any questions, I should say. Thank you. We appreciate your testimony. [LB969]

STEVE ANDERSEN: (Exhibit 10) Hello. I'm Steve Andersen from Millard, Nebraska, S-t-e-v-e A-n-d-e-r-s-e-n. Genavieve, my daughter, you just heard speak. We've had great, great care from Shriners Hospital for 17 years. I am very concerned about what will happen when she reaches the real world and has to find insurance that will cover her prosthetics. It would help tremendously if you would make prosthetic care mandatory. As you could see, with Genavieve not being able to afford a leg, she would become handicapped. She would have back problems. She would have mental problems, and it would be a greater expense to the healthcare industry. I would appreciate if you would vote for bill (LB)969. I'd like to even take that one step further. I understand the banking and insurance committees have already prioritized your bills for this short session. I would appreciate one of you senators that have not already prioritized a bill to make this your priority and get it onto the floor this year. Senators Carlson, Christensen, Gay, or Langemeier, I don't believe that you guys have already prioritized a bill. So I would appreciate it if you would grab hold of this one and run with it. Thank you. [LB969]

SENATOR PAHLS: Any questions for Mr. Andersen? Thank you, Steve. [LB969]

STEVE ANDERSEN: Thank you. [LB969]

SENATOR PAHLS: Appreciate your testimony. Appreciate your daughter's testimony more though. Hello. [LB969]

GEORGIA BEHLEN: Hello, Senator Pahls and members of the committee. My name is Georgia Behlen, B-e-h-l-e-n. I'm the mother of a son with an amputee below the knee, amputation below the knee. He is a structural welder. Needless to say, if he doesn't get new legs, he won't be welding anymore. You have heard many amazing stories today about what a difference prosthetics make in an amputee's life. I'm here to talk about priorities. I'm going to approach this from a totally different way. I want to talk about the priorities that insurance companies appear to have chosen. You already have the demographics for prosthetics costs per year, and there have been some different estimates on about how many amputees there are in Nebraska. I was told by one person in authority that it's about 1.2 amputees per 1,000 in our state. That amounts to somewhere between 1,500 and 2,000 people. Now, here come the priorities. Just to give you an idea where the insurance companies interests lie, let's look at another population in this state. This isn't a joke, so please don't laugh. Our citizens who take VIAGRA, a drug covered by most insurance companies, in Columbus where we live, a town of about 22,000 people, we checked with one pharmacy. It has 12 customers who get a prescription of VIAGRA every month. That involves eight pills at a cost of $100 per month. Take that amount times 12 customers and you get $1,200 times 12 months, and

the total becomes $14,400 in one year for VIAGRA. This amount does not include CIALIS and LEVITRA, the other two drugs on the market. There are 6 pharmacies in Columbus, so 6 times 14,400 is $86,400 just in Columbus for only one of 3 ED drugs. How much statewide do you suppose the insurance companies pay annually for ED medications? But they're not trying to put a lid on spending there. Let's think about what is more important here. ED pharmaceuticals or arms and legs for amputees? We truly feel that the insurance companies are picking on amputees because they represent such a small portion of the population of Nebraska that they think they can sneak caps through without much effort. Please do not let them get by with this. Losing an arm or a leg is traumatic enough without then losing insurance coverage to get a prosthetic. Unlike our natural arms and legs, prosthetics wear out and have to be replaced about every three to five years, depending upon usage. A lid on what insurance companies have to pay would make it virtually impossible for most amputees to replace the prosthetics. We strongly urge you to pass LB969 and guarantee that all citizens of the great state of Nebraska will be able to enjoy that good life that we talk about, not just those who are lucky enough to have both arms and legs. Thank you. [LB969]

SENATOR PAHLS: Do I see any questions? Thank you for your testimony. [LB969]

GEORGIA BEHLEN: Thank you. [LB969]

SENATOR PAHLS: Anymore proponents? Any opponents? [LB969]

MICHAELA VALENTIN: Good afternoon Senator Pahls, members of the committee. My name is Michaela Valentin, M-i-c-h-a-e-l-a V-a-l-e-n-t-i-n, and in the interest of time, I will keep this brief. Blue Cross/Blue Shield of Nebraska is opposed to the mandate on prosthetics. We do currently pay at the Medicare rate, but we are opposed to it because of the testimony I gave earlier on LB825 that mandates in general increase total healthcare costs. Are there any question? [LB969]

SENATOR PAHLS: Do I see any questions? Thank you, Michaela. Oops, sorry. I thought...Senator Carlson. [LB969]

SENATOR CARLSON: Senator Pahls. I think one of the earlier testifiers talked about Medicare and as though that that was pretty well covered there. [LB969]

MICHAELA VALENTIN: Yes, we do cover it at the Medicare cost. [LB969]

SENATOR CARLSON: At the Medicare cost? [LB969]

MICHAELA VALENTIN: Um-hum, and actually above it, 115 percent above Medicare. [LB969]

SENATOR CARLSON: Thank you. [LB969]

SENATOR PAHLS: Senator... [LB969]

SENATOR PIRSCH: Oh, I was just going to ask a question. You had testified in the prior hearing with respect to the ear... [LB969]

MICHAELA VALENTIN: Cochlear implants, right. [LB969]

SENATOR PIRSCH: ...cochlear implants. The ERISA had played some sort of role. Is that a similar factor in this or not? [LB969]

MICHAELA VALENTIN: Yeah. ERISA plays that role in all plans that are self-insured. So they are excluded from mandates. [LB969]

SENATOR PIRSCH: Would that be the same percentage then? I think you said 64 percent of plans were exempt then in Nebraska from this...you know, if the legislature were to pass it. Still two out of three plans would then would still not be required to be covered by it? [LB969]

MICHAELA VALENTIN: Right. The ones that are self-insured do not have to provide that benefit. I'm sorry? [LB969]

BILL MARIENAU: You said 64 percent of plans or covered employees? [LB969]

MICHAELA VALENTIN: The employee sponsored benefit plans that are self-insured. [LB969]

BILL MARIENAU: Or 64 percent of people who have some coverage? [LB969]

BILL MARIENAU: I'm sorry. Okay. Thank you. [LB969]

SENATOR PAHLS: Thank you for that clarification. Any other...Thank you, Michaela. [LB969]

MICHAELA VALENTIN: Sure. I've submitted my testimony, so it will be there for the record. Thank you. [LB969]

SENATOR PAHLS: Okay. Yes. Thank you. Appreciate that. Next opponent. [LB969]

JAMES WATSON: Good afternoon, Mr. Chairman. My name is James Watson. It's J-a-m-e-s W-a-t-s-o-n. I'm with UnitedHealth Group testifying in opposition to LB969. I think, you know, at this point, the other piece that goes along with the ERISA thought

process is that the remainder of the 64 percent are going to be largely Nebraska small businesses. Those are the people that buy fully-insured benefit plans. So when we talk about ERISA and non-ERISA, I think it's critical that we understand that it's not just a business, it's a small business and these businesses are struggling all the way across the board. The other thing that I'd really like to do, at this point, is sort of level set a little bit if we can about costs and things like that because I've heard ideas that it doesn't cost that much and it would only be a little bit. But when you go look at insurance...and you know, earlier, I started in 1965, I said there were only 8 mandated benefits. Well in 1965, preventive care wasn't covered at all. There weren't such things as CT scans. There were no MRIs. There was no such things as nuclear medicine, no robotic surgery, and no gamma knife surgery. Those are the things we pay for. All day, every day, those are the things we pay for. So to think that the insurance companies are making choices. You know, we are making choices. We're dealing with limited resources. People can't pay the price and we have to keep the price down. Affordability is so key, it's very important to small businesses. So I think in the whole equation, when you talk about what a mandate does, you also have to consider what the insurance company is doing with the rest of the premium, too. And the healthcare industry in and of itself has just mushroomed with things that we get to pay for, and they're no longer as cheap as they used to be either. You know, a cataract surgery in the '60s was probably a 10-day hospital surgery. Now, you're in and out, but it's very expensive. So you can...you know, it's not like we have a dynamic pie that's constantly growing. It's a limited amount of funds that people are willing to spend on insurance. And so when we are covering the big picture items, it's difficult when a state legislature imposes additional mandates on us and it does hit the bottom line and it does hit small business. I know it's late and if you have any questions, I'd be glad to answer them. [LB969]

SENATOR PAHLS: Any questions for James? Seeing none, thank you. [LB969]

JAMES WATSON: Thank you very much. [LB969]

SENATOR PAHLS: Thank you. Next opponent. Good afternoon. [LB969]

RON SEDLACEK: Good evening, Senator Pahls and members of the Banking, Commerce and Insurance Committee. For the record, my name is Ron Sedlacek, that's R-o-n S-e-d-l-a-c-e-k, and I'm here today on behalf of the Nebraska Chamber of Commerce and Industry in opposition to LB969. Every year we talked to our members, we go statewide, and we also have several written responses in response to surveys of our member businesses. We always ask what is the greatest impact on your cost of doing business in Nebraska and it can change from year to year. And generally the top three, however, are taxes, cost of healthcare, and worker's compensation. And they can vary from one year to the next as to which makes the top of the list. Last couple of years, again, it's healthcare costs. And from that respect in representing the state chamber today, we'd like to think we're really representing the consumers of the

insurance products because so many of our smaller businesses, particularly those that haven't migrated to ERISA programs are finding the group health programs to be more expensive, less affordable, in other words, and quite often it becomes less availability to the point where they may discontinue those group programs. Some of the local chambers had those programs. The state chamber, at one time, had a group health insurance program, no longer can be competitive. It's been talked about, before many employers, year-by-year, are migrating to federal ERISA programs where these mandates do not apply because they can provide an insurance program and benefit for their employees at an affordable rate. They don't have to...and still, of course, they're experiencing, as well as group plans, double digit increases from year-to-year. Many of the smaller businesses are finding that it's no longer a situation of just increasing copays or deductibles to essentially allow for...and these are many smaller businesses, too, just get off the group program. And that's what our fear is is that what we're doing essentially is as the universe is shrinking here, we're providing the opportunity for the Legislature to decide on whether there should be more mandates, which will cause both group and private insurance to increase further, which means that probably more employers will try to migrate to those programs again. So it just continues to exacerbate itself and no end to the problem in the foreseeable future. Certainly there are...I believe Tony Sorrentino, who was representing the state chamber in the previous bill, had mentioned there are many alternatives that Congress is looking at in regard to tax incentive-type programs such as health savings accounts and so forth. That in part can help to prepare oneself for a planned expense. Not all these expenses are planned. And as a matter of fact, over the years since we've been testifying on mandated benefit bills, there's not one bill that we've seen that isn't well-intentioned or has a story to tell, as certainly has affected the lives of many. And we appreciate that and understand that and are empathetic with that, but by the same token, our goal is to try to preserve a system that is disintegrating to some extent. And for those reasons, we would continue to oppose additional mandates. From what we understand, hopefully this is accurate, about 12 states currently require a mandate of this type of coverage in one form or another. At least that's my understanding. [LB969]

SENATOR PAHLS: May I ask you? Is that increasing or decreasing? You're saying currently 12 states? I mean... [LB969]

RON SEDLACEK: That's for the mandate. I assume that that's probably either an increase or the level amount at this point. I don't know what proposals are before the state legislatures and what chances they have of enactment this year. [LB969]

SENATOR PAHLS: Okay. Any questions for Ron? Seeing none, thank you. [LB969]

RON SEDLACEK: Thank you for your time, senators. [LB969]

SENATOR PAHLS: Next opponent. [LB969]

JAN McKENZIE: (Exhibit 11) Senator Pahls, members of the committee, for the record, my name is Jan McKenzie, spelled M-c-K-e-n-z-i-e. I'm executive director for the Nebraska Insurance Federation here in opposition to LB969. I do have...I don't know that I have enough copies. I did give a few members of the committee this Nebraska state facts on health insurance from the American's health insurance programs this morning. And I wanted to talk a little bit more about the small employer issue because I know a number of the proponents on this legislation this afternoon talked about the cap. And that cap does, in fact, in many cases is a part of hat's offered to small employers under different carriers' plans because they are the hardest to underwrite. If you only have 25 employees, it's hard to underwrite, it's hard to carry the risk over time on a small group. And you get a couple of people in the group who get very ill and suddenly you've added catastrophic costs to a pool. And the pool is this...and we understand how taxes work in state government where all of us put our money in one pot through our taxes, whether it's for schools or cities, roads, fire protection, police protection. Those pennies all go in the jar and then our state government, and our local government, and our school boards decide how they're spent. Well, insurance works the same way, it's just not government. The money put into the pool is through premiums, and then the employer or the person who purchases it hopes that we all have enough pennies in there to pay for everything. Well, in the first legislation today, I talked about what's starting to happen. Everybody is concerned about the thing that effects their family or their own health and everyone wants everything covered. In a perfect world, we'd have everything covered, everything, but no one could afford it. It's like if you went in to buy a vehicle and everyone had side air bags, front air bags, absolute guaranteed safety, highest safety rating, every possible backup beeper, everything. But most of us can't afford that and that's the other side of this. It's not that someone decides that we can all have those things in our insurance plans if we want to pay for it, and the problem is we can't all pay for it. So it is a shared...a way that we all share in protecting each other and ourselves against things that we can't afford by ourselves, any one of us. On this sheet you'll see percent of employers offering health insurance. Last year, we had 36 percent of our small employees providing health insurance. This year it's 31 percent. Last year, we had 11 percent uninsured. This year we have 12 percent uninsured. Nationally, we rank 41st of all 50 states in the percent of our employers who can offer health insurance. It is becoming an issue and it is nationally, it's going to be a huge issue in this presidential campaign. How do we provide health insurance coverage to people that they can afford, and how do we allow employers to continue to do it? And those are things I know you're all going to wrestle with, and I know that these are things that are difficult to consider when we're looking at real need. All of these issues today were real need. But I want you to consider the other effects of what you do when you limit the wide array of menu options that are out there for people, either employers or individuals, looking to buy insurance that fits their needs and that they can afford. With that, I'd answer any questions you might have if I can. [LB969]

SENATOR PAHLS: Any questions for Jan? Seeing none, thank you. [LB969]

JAN McKENZIE: Thank you. [LB969]

SENATOR PAHLS: Next opponent. [LB969]

BILL PETERS: Mr. Chairman, members of the committee, my name is Bill Peters, B-i-l-l P-e-t-e-r-s, appearing on behalf of Golden Rule Health Insurance company. My testimony is much similar to the past. I'd just like to make a couple of observations. I don't believe the industry is hoodwinking. We are one of the more regulated industries and we have the factors of competition. To a large extent, insurance, other than negotiating, which individuals, unless we have a real great network, don't examine cost. We determine whether it's covered and pay the cost under the proposed contract. There is certainly...any time that health insurance or any other insurance does not pay, that cost is shifted to someone. That's the principle of insurance. The pooling concept of insurance...as you shift the cost to the others and you share the cost with the others in your pool. And certainly if certain needs are not met, there's a cost to the state. But it's not that the insurance industry is shifting that cost. And I would suggest, no one has suggested if it was such a great investment that the state pay. Someone has to pay in the situation if we continue to have insurance, and our concern is, for individuals, is to oppose the mandates. Let us try to provide insurance for the most folks that we can and not lose them. And certainly when we're talking about the ERISA, which is our competition, they're the ones that set the policy; it's not the industry. With that, I would gladly revert my time to the chair. [LB969]

SENATOR PAHLS: Any questions for Mr. Peters? Seeing none, thank you. [LB969]

BILL PETERS: Thank you. [LB969]

SENATOR PAHLS: Good afternoon. [LB969]

PAT HOEFENER: Good afternoon. Thank you for giving me the opportunity to speak. My name is Pat Hoefener, H-o-e-f-e-n-e-r. I'm here on behalf of the Nebraska Association of Health Underwriters and NAIFA-Nebraska. Again, we are here in opposition of LB969. And again, I think based on prior conversations, but I think it's due to the cost. As health insurance agents, we hear the piece about rate increases and cost increases everyday. And our concern is is the higher those rate increases are, the more people will go without and thus have a bigger effect on those that do have coverage because it's going to be cost shifted. And the cost shifting occur and we're trying to hopefully eliminate that and thus, that's why we are here opposing. Earlier you guys had some questions about...can I ask you guys questions? Is that okay? You guys had questions and it seemed like I was unsure you guys were talking about how do you select a product or so forth like that. I mean do you guys all understand that process

and I guess the role the agent plays in that? [LB969]

SENATOR PAHLS: What...I'll give you a little bit of time to explain that. [LB969]

PAT HOEFENER: Okay. Well, I guess what I meant by that is you do find carriers and whether it'd be something we talked about earlier today or this subject, many carriers are going to cover it many different ways. And thus that's really what the role of the agent would be is to work with that contact person at the employer or as well, on an individual setting on one on one and based on what they feel their needs are, this plan may be more appropriate for them or this plan. And really that's where the agent comes into play and that's where their role would be. [LB969]

SENATOR PAHLS: Any additional questions here? Okay. Thank you. [LB969]

PAT HOEFENER: Thank you. [LB969]

JERRY STILMOCK: Senators, my name is Jerry Stilmock, S-t-i-l-m-o-c-k, appearing on behalf of the National Federation of Independent Business and Nebraska Bankers Association. We have previously submitted testimony in relation to (LB)825. I cannot say it any differently for the reasons previously stated, my two clients oppose this type of legislation and mandated benefits and that's the extent of my testimony, senators. [LB969]

SENATOR PAHLS: Any questions? Thank you. [LB969]

JERRY STILMOCK: Thank you. [LB969]

SENATOR PAHLS: Anymore opponents? Anybody in the neutral? I see nobody in neutral. Senator, it's yours to close. [LB969]

SENATOR PANKONIN: I know we've had a long afternoon. I'll make this quick. And as I said in my opening, I'm one of those small business people. I belong to the NFIB. I'm at part of that 30 or 36 percent that this probably hits. But I looked at our plan, just did the quick calculation, we've got 13 full-time employees on our plan at Pankonin's Incorporated, that's 26 covered people. If the 38 cents, the high side number, is a number that's in the realm of possibilities to cover folks like this, that's $10 a month. My health insurance...I just got the notice on meeting with my agent on Friday when I'm 9.4 percent. That translates to $965 over $11,000 a month that my company pays for health insurance. That would be another $10 a month. I'd rather see these folks have a chance because otherwise I'll be paying it through taxes because they're going to be on Medicare because you can't...you know, where there's other disruption in the system. I think some of these things we have to make a choice. We got people involved and I'm speaking for myself, but I think at some point...and we know that we've got problems in

this whole system, but at some point you've got to look at some of these benefits because these folks are real folks and they need help, too. I'm willing to pay the $10 a month. I think a lot of people would. One of other comment I want to make. I told the gentleman down there, I don't know if he left or not, but the other factor we haven't talked about in these insurance companies...and United Health and I'm going to dig out that article--I think I still got it at home--because I was so upset about it. This Dr. McGuire that ran United Health, that got forced out for back dating these chance to buy stock and it was just a blatant deal that he finally got out. But over the last year, the guy took about $500 million between...and to get rid of him, whatever they paid him big money, he took a lot of these stock options that he back dated and they made some kind of settlement. But I mean, this guy...you know, these companies make money, too, and this guy was egregious in how he handled his leadership of that company that's a major insurer. So you know, these folks are all telling us that we're paying and we do, ultimately. But when someone needs to make hundreds of millions of dollars in a year period of time, when you got folks that need this kind of help, is that right? I don't think so. Thank you. [LB969]

SENATOR PAHLS: Any questions for the senator? That closes the hearing on (LB)969. We will be opening up on (LB)980. We'll clear a little bit and we'll let people... [LB969]

BREAK []

SENATOR PAHLS: Hear ye, hear ye. We are ready to start LB980. Senator Carlson, the floor is yours. [LB980]

SENATOR CARLSON: Good afternoon. I'll start like Senator Wightman the other day, good evening. Chairman Pahls and fellow members of the Banking, Commerce and Insurance Committee, I'm here to introduce LB980. I'm Tom Carlson, T-o-m C-a-r-l-s-o-n. This bill was brought to me by the Nebraska Credit Union League and I'm not taking a position on the bill, but I believe it deserves a hearing. LB980 expands the account options available to real estate brokers to include federally-insured credit unions. Current law requires a real estate broker to maintain a separate insured, noninterest-bearing trust account in a bank, savings bank, building and loan association, or a savings and loan association. LB980 would not change current law, but only add credit unions to the institutions available to accept real estate trust accounts. I appreciate your consideration of LB980. I'm not prepared to answer questions about this bill, but those who follow me are able to address your concerns. Thank you. [LB980]

SENATOR PAHLS: Any questions for Senator Carlson? I think we've been told look for the proponents. Thank you, Senator. [LB980]

BRANDON LUETKENHAUS: (Exhibits 1, 2, and 3; 5 and 6) Good evening as well. Mr.

Chairman, members of the Banking, Commerce and Insurance Committee, my name is Brandon Leutkenhaus, B-r-a-n-d-o-n L-u-e-t-k-e-n-h-a-u-s, and I'm here on behalf of the Nebraska Credit Union League. Our association represents state-chartered and federally-chartered credit unions in Nebraska and their 420,000 members. And I appear before you today to offer our support for LB980. I'd like to thank Senator Carlson for introducing this important piece of legislation. LB980 changes the language in the state statute to include credit unions as a permissible depository for real estate broker trust accounts. Currently, credit unions are the only federally-insured financial institutions in Nebraska that cannot carry these accounts. Our association was contacted in late 2007 by a credit union who indicated that a real estate broker had approached them in opening up a real estate trust account. The broker informed them...or the credit union informed the broker that they couldn't do that according to current state law and they in turn asked us to amend current state law or help in amending it. So I'd like to provide this committee with some information on this particular bill regarding the operations and insurability of real estate broker trust accounts at credit unions. Following my testimony will be Mr. Bryan McGee, who is vice president at Mutual First Federal Credit Union in Omaha. Mr. McGee will be able to talk directly to how these accounts will be administered at a credit union. Under current state law, two things are required of the banking institutions, which Senator Carlson outlined for you. The account must be federally-insured and the account must be a noninterest-bearing account. Credit unions meet both these requirements, however, because of structural differences between banks and credit unions, there would be some operational differences that need to be pointed out. LB980 is in no way intended to circumvent the membership requirements at a credit union. This bill is solely for the benefit of credit unions and their members by allowing their members to keep their money in the credit union. Credit unions can only accept funds belonging to its members or those who qualify for membership. And that's an important point, that credit unions can only accept funds belonging to their members or those who qualify for membership. This piece of legislation would not change that. There are limited exceptions which permit a credit union to accept nonmember funds, such as if it serves predominantly low-income members and thereby qualifies as a low-income designated credit union. National Credit Union Administration or the NCUA, who is our federal regulator, defines a member as those persons enumerated in the credit union's field of membership. Membership in a credit union is limited to groups having a common bond of occupation or association, or to groups within a well-defined neighborhood, community, or rural district. A credit union's charter outlines its membership requirements. Because of a credit union's membership requirements, not all credit unions would likely be interested in establishing these types of accounts. However, there are those credit unions that would like to provide this service for their members and it is our belief that they should not be prohibited from doing so based on the current criterias. A real estate broker trust account in a credit union would be set up as a noninterest-bearing agent account. Section 745.3(a)(2) of the NCUA's regulations define an agent account as: funds owned by a credit union member and deposited in one or more accounts in the names of agents; in this case, a real estate broker. The

credit union member or members continue to own the funds, while the broker serves only as the custodial agent of those funds. NCUA regulations also permit a credit union to offer noninterest-bearing accounts, as outlined in NCUA's legal opinion 06-1101. Like for-profit banks, credit unions are federally-insured financial institutions that have the full faith and backing of the United States government. Credit union accounts are insured up to $100,000 by the NCUA or National Credit Union Administration, where as bank accounts are insured up to $100,000 by the FDIC. In both cases, the funds in these accounts are insured. If this bill were to pass and for whatever reason a broker would decide that they'd like to open up a real estate broker trust account in a credit union, that account would be insured. To open up the account, the person or persons whom the funds belong to must be members of the credit union or qualify for membership. Each member who has funds in that account would be insured up to $100,000. If the broker was a member, although not required by the NCUA regulations, it's our understanding from discussions with Bob LaConte in the NCUA that there would be an additional $100,000 of insurance appropriated to that account because of the membership of the broker. The primary reason for creating a trust account is to separate trust funds from other funds of the broker. Reasons for establishing and maintaining a trust account separate from the broker's own money include the following: In the event the broker should die, the money in the trust account will not become part of the broker's estate; the trust funds will not be at risk if a judgment is entered against the broker; and each client's account is insured up to $100,000 regardless of the total balance in the trust account. Allowing credit unions to act as depositories for real estate broker trust accounts is not a new concept. I have provided you with a map identifying over 30 states, the ones that are shaded, that currently allow credit unions to serve as depositories for such trust accounts. In speaking with real estate commissions from surrounding states, including Iowa, Kansas, Missouri, and Wyoming, they have indicated to me that they have not experienced any issues whatsoever with credit unions and them offering these real estate trust accounts to their members. The Nebraska Real Estate Commission had some questions about the possibility of these accounts, which primarily focused on the insurability of the funds and membership requirements. After meeting with the commission, we have researched their concerns and I believe that we can satisfy the commission's concerns. These accounts are federally-insured by the NCUA and the principals of these accounts must be members; otherwise those accounts will have to be opened in another banking institution. We know from past experiences that our competitors may attempt to cloud the issue, but we want to provide you with several facts. These accounts would be for the benefit of the credit union members by allowing them to keep their money in the credit union. Real estate broker trust accounts established at a credit union would be federally-insured by the full faith and backing of the U.S. government. Credit unions are authorized to offer noninterest-bearing accounts as required by state law. Over 30 states allow credit unions to offer these accounts, and real estate commissions in surrounding states have not experienced problems with credit unions offering these broker accounts. And also what's very important is that LB980 is not a mandate that requires brokers to open up a

real estate trust account in a credit union. It simply expands the choice of permissible institutions to include Nebraska's federally-insured credit unions. State law currently allows a real estate broker to maintain more than one trust account. We are simply asking that brokers be allowed to decide how many and where they are going to establish their trust accounts. Credit union members are engaged in real estate related activities on a regular basis. We believe they should have the choice to keep their down payments and earnest money deposits in their credit union. I ask that this committee move LB980 to General File for consideration. And I would just add, again, that these funds that go into the real estate trust accounts have to be members of the credit union. So if a broker wants to come into a credit union and open up a trust account, the people's money that he's going to deposit must qualify or be members of the credit union, and credit unions deal with that issue every day. You cannot just walk into a credit union and somehow become a member. You have to qualify for membership and there's different ways you qualify. As I talked about in my testimony, some are geographical. For instance, Mutual First Federal Credit Union, which I mentioned, that's a community-charter credit union. If you live, work, or worship in at least the Omaha area, and I think there's other surrounding areas as well that they serve, you can be a member. And so there is that issue there, but again, credit unions deal with that issue every day about making sure people are qualified for membership. And that's all I have, Mr. Chairman. I'd be happy to answer questions the committee may have. [LB980]

SENATOR PAHLS: Brandon, I have a question. [LB980]

BRANDON LUETKENHAUS: Sure. [LB980]

SENATOR PAHLS: Since we're dealing with real estate, do you have...will they be a proponent of this bill? Like the Real Estate Association, that group, will they be... [LB980]

BRANDON LUETKENHAUS: The realtors? [LB980]

SENATOR PAHLS: Realtors, yes. [LB980]

BRANDON LUETKENHAUS: We talked to them briefly about it, but I don't...they didn't say they would support or oppose it. [LB980]

SENATOR PAHLS: Okay. Any other...Senator Carlson. [LB980]

SENATOR CARLSON: Senator Pahls. On page 3 of your report here it says to open up the account, the person or persons whom the funds belong to must be members of the credit union or qualify for membership, so clarify that. It means they could qualify for it, but they don't have to. [LB980]

BRANDON LUETKENHAUS: No. What it means is many people qualify for membership of a credit union. They can...Senator Carlson, for instance, you may qualify for a credit union because you live in Holdrege. That doesn't mean you're a member of the that credit union, but if a you had broker who was going to deposit your earnest money into that credit union, they would have to confirm that you are eligible for membership, that you are qualified to be a member of that credit union. So you don't have to be a current member of the credit union to have your earnest money deposited into that trust account. You simply have to qualify for membership. You have to be qualified to be a member. So when they deposit that money, you are a member because you're qualified. You live in the Holdrege area. You live in Holdrege or live, work, or worship in Holdrege. [LB980]

SENATOR CARLSON: Okay. Thank you. [LB980]

SENATOR PAHLS: Senator Christensen. [LB980]

SENATOR CHRISTENSEN: Is there areas credit unions serve that banks don't that becomes a need? [LB980]

BRANDON LUETKENHAUS: Several. Yeah, and last time I looked, there was about 11 communities where there's a credit union but no bank in the community. Most of these are rural areas. [LB980]

SENATOR CHRISTENSEN: Okay. Thank you. [LB980]

SENATOR PAHLS: Senator Langemeier. [LB980]

SENATOR LANGEMEIER: Chairman Pahls, thank you. It's late. I'm glad to wake you up there. [LB980]

SENATOR PAHLS: I'm looking to see who you are. [LB980]

SENATOR LANGEMEIER: Brandon, thank you for your testimony. As a broker, I have 24 hours to put that money in my trust account. [LB980]

BRANDON LUETKENHAUS: Okay. [LB980]

SENATOR LANGEMEIER: How do I go through this process to figure out if you're qualified or you're a member or... [LB980]

BRANDON LUETKENHAUS: Well, I think the reality of the situation is brokers aren't just going to walk into a credit union and say I want to open up a trust account. Most of the times they're going to have relationships with their credit union. They're going to

understand the dichotomies of credit unions and you have to be members and that type of thing. But if this was the case, you had 24 hours, you'd walk into the credit union and say I'd like to open up a trust account. [LB980]

SENATOR LANGEMEIER: Let me stop you. Not to opening the account, because I have to have that account registered with the real estate commission long before I can put money in it. I'm talking about when I sign a purchase agreement at midnight on Sunday night for mom and pops little three-bedroom house and I just took $500. I got 24 hours to get that money in my trust account or the next business day, which would be Monday. How do I go find out if whoever's buying this house is a member or my seller? That's my question. [LB980]

BRANDON LUETKENHAUS: Well, senator, I guess I don't know if I can necessarily...I understand your question, I don't know if can necessarily answer that because we don't have trust accounts here in Nebraska. But I know more than 30 other states do and there's a way to do it, and may Bryan McGee can allude to how that's done. But this is occurring in more than 30 other states with no problems that I'm aware of, and so I would love to get you an answer, too, following this committee hearing. If I can, I will try to do that and get that to you right away. [LB980]

SENATOR LANGEMEIER: Thanks. [LB980]

SENATOR PAHLS: Brandon, seeing no more questions, thank you. [LB980]

BRANDON LUETKENHAUS: Thank you. [LB980]

SENATOR PAHLS: Next proponent. [LB980]

BRYAN McGEE: Mr. Chairman, members of the banking committee, I wrote my notes. I didn't memorize them, so if I'm looking at my paper...my name is Bryan McGee, B-r-y-a-n M-c-G-e-e. I'm here today on behalf of Mutual First Federal Credit Union. Our credit union is a community-based credit union or chartered-credit union that serves 12,000 members in the Omaha MSA. Mutual First Federal Credit Union is a federally-insured financial institution just like state and federal-chartered banks, savings banks, and the like. As Brandon mentioned, I'm a vice president of Mutual First Federal. I'll give you just three seconds of background. I've got a 21-year career in banking; 4 of those in a credit union, 17 of those years in banks. I'm here in support of LB980. I would share with you my reasons for appearing before you in support of this piece of legislation. Mutual First Federal has been engaged in the business lending and deposit services since February of '04. In that time, I've developed a complete suite of products for the business or commercial customer. We offer all types of lending products from working capital to asset acquisition. We offer three types of demand deposit accounts and an array of savings options for businesses. Mutual First Federal has introduced an

on-line ACH transactional suite for business customers and we, within the next 30 days, will roll out a remote capture product for business customers, if you're familiar with that product. However, we are the only federally-insured institution that can't offer escrow accounts to real estate professions. Mutual First Federal and myself would like to see this changed. In 2007, a commercial customer approached me about opening his trust account for his commercial real estate operation. I had to turn away that business. Since that time, I have been approached by two additional customers to take and hold in an escrow account their earnest money on a commercial building purchase. Once again, I've got to turn away that business. These are people that are currently doing business with us and want to continue to do business with us. These types of accounts would simply be an additional product and service we could offer to current customers that we do business with, as well as potential new business we might garner at Mutual First Federal. It is the desire of Mutual First Federal and myself to simply compete in the marketplace. Banks have been offering these accounts for years. It's a great source of deposit growth for the institution. We would like the same opportunities that the banks have enjoyed for the last number or years. Every bank I've worked at in my 21-year career has had these options and had these accounts as an option. We'd just like the same opportunity. Take any questions if you got them. [LB980]

SENATOR PAHLS: Any questions? Senator Pankonin. [LB980]

SENATOR PANKONIN: You talked about all the similarities. Let's tall about the difference. [LB980]

BRYAN McGEE: Sure. [LB980]

SENATOR PANKONIN: What's the difference between a bank and a credit union? [LB980]

BRYAN McGEE: Well, the taxation difference? Is that the main one you want to get on the table? [LB980]

SENATOR PANKONIN: That's the main one I'm talking about. [LB980]

BRYAN McGEE: Sure. [LB980]

SENATOR PANKONIN: I mean, you want to compete with all the same kinds of business, but how come you don't pay taxes? [LB980]

BRYAN McGEE: Well, I'm not here to testify about whether we pay or don't pay taxes and I'm not prepared to testify on that. [LB980]

AUDIENCE: It's a federal issue. [LB980]

SENATOR PANKONIN: Thank you. [LB980]

SENATOR PAHLS: Any other... [LB980]

BRYAN McGEE: Can I answer Senator Langemeier's questions from earlier for Brandon? [LB980]

SENATOR PAHLS: Well, certainly. I'll let you. [LB980]

BRYAN McGEE: Would that be all right? Really what we would do...what I do is simply sales. I go out and talk to folks who bring in new business. If I'm going out and talking to a real estate professional or if I'm talking to a title company that wants to do business with us, they understand the realm that we have to work within. And I would tell them...and they maintain on average...not real estate agents themselves, title companies maintain four, five, six different deposit accounts on average for earnest money funds, 1031 real estate exchanges. If you guys are familiar with 1031 exchanges, which can be a very nice sized account to have in your institution. We would simply let them know these are our rules to Yahtzee. These are the types of accounts and the people that we can serve. And the Omaha MSA would actually be relatively easy to do. Anybody within that five county area that we service, we could take those deposits because they qualify or they're eligible for membership. They maintain multiple accounts in most cases. If they couldn't make that deposit with us, they certainly could make it with another institution. I recently had a conversation last week with a title company that is owned by a bank out of California. All of their noninterest bearing trust funds, earnest money funds go to the bank in California. Now, they're perfectly willing to do business with me and I could get that business and keep those funds in Nebraska as opposed to letting them go to California. Any other questions? [LB980]

SENATOR PAHLS: Seeing none, thank you, Bob (sic: Bryan). [LB980]

BRYAN McGEE: Good. Thank you. [LB980]

SENATOR PAHLS: Appreciate it. Anymore proponents? Opponents? [LB980]

JERRY STILMOCK: (Exhibit 4) Senators, my name is Jerry Stilmock, S-t-i-l-m-o-c-k, registered lobbyist on behalf of the Nebraska Bankers Association testifying in opposition to LB980. I do have a handout, Ryan, if you would please. We're opposed to the measure because of the issue of membership, and my understanding of insurability. Liken it to a stool. A stool obviously has three legs and in this hour of the night, if I could use the analogy of a bar stool, a bar stool needs three legs. In the same way, a real estate transaction, we're going to have a buyer, a seller, and the real estate broker. In

order for insurability of those funds once deposited, that those three parties have to be members in that credit union. If not, there's not going to be insurance coverage similar to what anybody would enjoy in a bank with FDIC coverage. So though there may be the possibility of they might qualify to be a member. If they're not a member and that institution fails, those that are not members are not going to have insurability. And that's our primary basis in coming in and objecting to this type of legislation. I've shared with you in handouts a highlighted page from the lawyer trust accounts. And you ask, Jerry, how's that related? Lawyer trust accounts are established in Nebraska for attorneys that handle other people's, their client's trust funds, money belonging to the client or to another party. The IOLTA, as that acronym is used, has already stated that credit unions cannot be used by attorneys to put somebody else's funds into that account. Why? Because there are membership rules and the regulations prohibiting that type of activity. I've also included as a handout...and I point out that that was prepared for Bob Hallstrom, so the record should reflect that it's me appearing. The second item is attached from the state of Colorado, from its real estate commission. Again, commenting...I haven't highlighted, but the depth of that one page article is that because of membership rules and regulations, which apply to credit unions, the state of Colorado is not able to use credit unions for these broker real estate accounts. For those reasons as I've set forth in the testimony, the Bankers Association is opposed to LB980 and we ask that it be indefinitely postponed. Thank you. [LB980]

SENATOR PAHLS: I have a question. You're telling me on a piece of paper that you highlighted in yellow... [LB980]

JERRY STILMOCK: Yes. [LB980]

SENATOR PAHLS: ...that is saying that is not legally be done? [LB980]

JERRY STILMOCK: For attorney trust accounts, and if I'm able to compare attorney trust accounts and who that money goes in for, and real estate brokerage accounts for those same reasons that credit unions cannot be used to deposit trust accounts for attorneys, we believe it also applies for credit unions, Senator. [LB980]

SENATOR PAHLS: Okay. You're making...if it applies here, it should apply there. [LB980]

JERRY STILMOCK: Yes, sir. [LB980]

SENATOR PAHLS: Okay. Senator Langemeier. [LB980]

SENATOR LANGEMEIER: Chairman Pahls, thank you. Jerry, how are banks handling the $100,000 limits on trust accounts? [LB980]

JERRY STILMOCK: They have the ability... [LB980]

SENATOR LANGEMEIER: Because they exceed them a long ways. [LB980]

JERRY STILMOCK: Please? [LB980]

SENATOR LANGEMEIER: They exceed that quite a bit. [LB980]

JERRY STILMOCK: They have the ability upon disclosure to let the client know that they can obtain additional coverage, should the client want to obtain coverage beyond the $100,000 so that coverage would be in place, and that would be up to the option of the participant. [LB980]

SENATOR LANGEMEIER: So if they don't purchase that, they only have $100,000 coverage even though a 1031 could have millions of dollars in a trust account. [LB980]

JERRY STILMOCK: Right. [LB980]

SENATOR LANGEMEIER: So that would be uninsured over $100,000? [LB980]

JERRY STILMOCK: That's my understanding, yes. [LB980]

SENATOR LANGEMEIER: Okay. Thank you. [LB980]

JERRY STILMOCK: Yes, sir. [LB980]

SENATOR PAHLS: Senator Carlson. [LB980]

SENATOR CARLSON: Senator Pahls. Jerry, on this sheet from Colorado. [LB980]

JERRY STILMOCK: Yes, sir. [LB980]

SENATOR CARLSON: That's stating a position of Colorado, would you say? [LB980]

JERRY STILMOCK: Absolutely. [LB980]

SENATOR CARLSON: Why did they allow credit unions to carry real estate trust accounts? [LB980]

JERRY STILMOCK: You're comparing an item that was handed out by one of the proponents? [LB980]

SENATOR CARLSON: Uh-huh. [LB980]

JERRY STILMOCK: Yeah. I'm not aware of why they allow it. It was my information from dating back to that article in 2003 that they did not...the state of Colorado did not authorize credit unions to be used. And because it is a 2003-dated item and what I've presented appears to be in contrast to what the proponents prepared, I'd be glad to look into that, Senator, and... [LB980]

SENATOR CARLSON: But this is 2003. [LB980]

JERRY STILMOCK: Yes, sir. [LB980]

SENATOR CARLSON: Okay. Thank you. [LB980]

SENATOR PAHLS: Senator Christensen. [LB980]

SENATOR CHRISTENSEN: Thank you, Chairman Pahls. Jerry, you referred to the membership being a possibility. Now, if they're going to put the money in there, they've got to become a member first, right? Or are a member? They couldn't...I guess the way I understood you saying that was because they're not a member, then they shouldn't be able to deposit there. But if they have the eligibility to become, they can become a member and put it in there safely? [LB980]

JERRY STILMOCK: It's my understanding that insurance coverage for a failed institution, for a failed credit union, that coverage is not going to be extended to a nonmember, senator. So though the money, perhaps by the credit union standards or regulations, may be allowed be allowed to be deposited, if that credit union fails there's not going to be any insurance coverage for that nonmember. That's the part that you totally walk away from with a bank in Nebraska. You're going to always have that FDIC coverage. There's no requirement, obviously, of membership. [LB980]

SENATOR CHRISTENSEN: So you're saying the realtor and the person that's holding the money and who it's going to, all three, need to be members then. [LB980]

JERRY STILMOCK: The seller...yes, sir. [LB980]

SENATOR CHRISTENSEN: Seller, buyer, and realtor. Okay. [LB980]

JERRY STILMOCK: Yes, sir. Yes, sir. [LB980]

SENATOR PAHLS: Seeing no more questions, thank you. [LB980]

JERRY STILMOCK: Thank you, senators. [LB980]

SENATOR PAHLS: Anymore proponents...or opponents? I'm sorry. [LB980]

LES TYRRELL: My names is Les Tyrrell, L-e-s T-y-r-r-e-l-l. I'm director of the Nebraska Real Estate Commission, and I'm appearing here today on behalf of the members of the commission in opposition to LB980. The representatives of the Nebraska Credit Union League did meet with the commissioners, and the commissioners did have questions and I think it was fairly represented by Brandon what their concerns were. And as a result of that, the commission asked me to talk with our legal counsel and have our legal counsel look into the credit union statutes and how a real estate transaction operated in Nebraska. As you know, the license act currently requires that a certain list of financial institutions be the ones that hold trust accounts, and that those accounts have to be insured. And the reason for that is, as you've been talking, is to protect the consumers and their money. Our legal counsel, looking at the statute for credit unions in the United States, has come back to us with an opinion that only member's monies are insured in a credit union trust account. At best it would be only the nonmember, but potentially the way the credit union laws are written, it could be the entire account. So it wouldn't just be if one nonmember's money got in there that the account wouldn't be covered. Potentially it's the account, not the member of the individual, but it's the account that would be uninsured. You need to understand that in a real estate transaction who owns that money...and I'm not an attorney, so bear with me on that, but you need to understand that during a real estate transaction the ownership in that money that's being held in that broker's trust account can change. And as I understand it, it's called a equitable interest. And that during the transaction as that money is being held in a real estate broker's trust account, it may belong to a member of a credit union, and the broker may be a member of the credit union and everything is fine and dandy. But as the conditions to the contract are met, according to our legal counsel, an equitable interest transfers to the other party. And at that point in time, if that party is not a member of that credit union, that again, that money would not be covered or potentially the entire account would not be covered by insurance. We have another problem that the commission indicated, and I think Brandon alluded to, is the interest-bearing nature of the account. Our legal counsel has looked into the definition of whether they would say what the definition of noninterest-bearing means. And in their looking at the statute and other legal documents that they've looked at, they've indicated that any benefit, profit, dividends that would be paid to a member as a part of that trust account, if that member were the broker, that that would be...no matter what you call it, it's a profit, whether it be called an interest, a dividend, or whatever. And they would think that if there are any dividends or profits paid to a member that that, too, would violate the noninterest-bearing nature of the account. So with that , we would ask you not to advance LB980 and that it not go any further, and I would be happy to answer any questions that you might have. [LB980]

SENATOR PAHLS: Senator Pirsch. [LB980]

SENATOR PIRSCH: Thanks very much for testifying here today. Have you...the proponents have testified that it is currently in structure or in place in other states. Have you seen or examined how other states...how that goes on in other states? [LB980]

LES TYRRELL: No. I'm not familiar with all other states. I can tell you that they did have a document that they presented to the commission, it's not the document that you have there, that did have excerpts from laws of three states. In just reviewing those over, it appeared to me that some of those did not have a requirement that they be noninterest-bearing. We didn't find verbiage that indicated they needed to be insured or how they needed to be insured. So not being familiar with the other states, you know, it's pretty tough for me to make a comparison as to what our laws state. [LB980]

SENATOR PAHLS: Senator Hansen. [LB980]

SENATOR HANSEN: Thank you, Senator Pahls. Les, I think the question Senator Pirsch is asking is this map, and I have a very similar question. Did your legal counsel ever talk to any of the other real estate commissions in a surrounding...I mean, Nebraska kind of sticks out there in the middle, to see why it's legal in all those other states and not...because they are federal laws and there are federal rules and there are federal regulations that pertain to the credit unions? So why is Nebraska different than the other states? [LB980]

LES TYRRELL: Not knowing the other states' laws and only having the three excerpts that they gave us that we looked at when they met with the commission here a week and a half ago, ten days ago, whatever it was...those laws from looking at those as I remember, and our legal counsel had them, too. Those three excerpts from those laws that they showed us, I don't believe indicated whether they had to be insured or not in at least two of the cases, and didn't indicate if they needed to be interest-bearing or noninterest-bearing. In fact, I believe Iowa requires trust accounts to have interest, but the interest then goes to, I believe it's a housing fund of some kind. So no, I have not looked at the other state laws, and I'm not familiar with that. But those would be our...of just what we saw, that was our point of view on it. [LB980]

SENATOR HANSEN: Thank you. [LB980]

SENATOR PAHLS: Any other questions? Thank you. Appreciate it, Les. Any... [LB980]

KIM ROBAK: Chairman Pahls and members of the banking committee. I felt like I was in Health and Human Services earlier today, so I'm remembering where I am. My name is Kim Robak, R-o-b-a-k. I'm here on behalf of the Heartland Community Bankers Association, an organization that represents savings and loans. And we, due to the late hour, would also just indicate our opposition to the bill for the reasons that have previously been stated. I'd be happy to answer any questions. [LB980]

SENATOR PAHLS: Any questions for Kim? Seeing none, thank you. Anymore opponents? Anybody in a neutral? Senator? The senator waives closing. That ends the hearing on... [LB980]

Disposition of Bills:

LB825 - Held in Committee.
LB969 - Held in Committee.
LB980 - Held in committee.

Chairperson

Committee Clerk