[LB171 LB292 LB513 LB518 LB666 LR10]

The Committee on Health and Human Services met at 1:30 p.m. on Wednesday, February 21, 2007, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB171, LB292, LB513, LB518, LB666, and LR10. Senators present: Joel Johnson, Chairperson; Philip Erdman; Tom Hansen; Gwen Howard; Dave Pankonin; and Arnie Stuthman. Senators absent: Tim Gay, Vice Chairperson.

SENATOR JOHNSON: Good afternoon everyone, this is the public hearing of the Health and Human Services Committee. Let me start by first introducing senators. And as usual, at this time of the year, there are people coming and going because of bills that they might be introducing in other committees. Who we have here today is Senator Pankonin, from Louisville; the spot next to him will be occupied by Phil Erdman, of Bayard; next to me, I left one out and that's Senator Tim Gay, from Papillion; Jeff Santema is our legal counsel. On my far left is Senator Gwen Howard, from Omaha. We then have Senator Tom Hansen, who, of course, is in the chair; and Arnie Stuthman, from Platte Center; and Erin Mack is our committee clerk. The proceedings are recorded and transcribed. If you have a cell phone on now, would you please mute it or we will mutant you (laughter). The committee will first hear proponent testimony, followed by opponents, and then neutral. Please be respectful of the time. We do not use a light system, but we like to have people give their testimony in three minutes or so. And we will ask you, please don't come up with a three-page letter with the intent of reading it. There is a sign-in sheet and if you want to be on record one way or another, there is a sheet that you can indicate your official position on this and it will become part of the official record. For those testifying, please spell your name as well as give it. If you have copies of information, we like 12. If you didn't bring 12, we'll make copies and pass them out for you. I think that's about it. Erin, I didn't forget anything, did I? All right. And with that, let's begin the afternoon, Senator Hansen on LB292. [LB292]

SENATOR HANSEN: Thank you, Senator Johnson. My name is Tom Hansen, T-o-m H-a-n-s-e-n, representing District 42. I would like to explain a little bit to start off with. LB292 would allow county boards to transfer general assistance funds to the Department of Health and Human Services Finance and Support prior to those payments being made to the providers, and the providers we are talking about today are some hospitals in the state. These funds would then be considered the state's match which would result in additional federal funding being available to the disproportionate share hospital. That acronym is DSH, but I won't use that. The disproportionate share hospital program compensates hospitals for serving a disproportionate share of low-income individuals who are part of the Medicaid system, or are uninsured. The DSH or disproportionate share hospital program started in 1981. LB292 will allow additional federal funds to be brought into Nebraska's economy without any new state or county funds being required. Nebraska state law does not currently allow for the

intergovernmental transfers from counties to the state, to occur. Legislation is being proposed to add the following sentence to the Section 68-104 of the Nebraska statutes, to allow, but not to require, these intergovernmental transfers. Notwithstanding any other provision of these statutes, the county board may transfer general assistance funds to the state Medicaid agency for the benefit of disproportionate share hospitals under the Medicaid program. We have testifiers behind me that will certainly be more qualified than I to answer any questions. I would take any questions at this time though, if you have any preliminary ones. [LB292]

SENATOR JOHNSON: Senator Hansen... [LB292]

SENATOR HANSEN: Yes. [LB292]

SENATOR JOHNSON: ...can you give us any numbers, do you have them handy, for what it might mean to, I'll just take your area, North Platte? [LB292]

SENATOR HANSEN: Okay, I have some preliminary numbers here, Senator Johnson, but I have been advised that HHS has some--when they testified that they will be testifying on is a new set of numbers, so I'm not sure that that's relevant, or... [LB292]

SENATOR JOHNSON: Okay, all right, okay. Well, maybe we just as well wait until then. [LB292]

SENATOR HANSEN: ...maybe we better wait and find out some, a little harder numbers... [LB292]

SENATOR JOHNSON: Okay, all right. Sure. Fine, thank you. [LB292]

SENATOR HANSEN: ...would be my suggestion. [LB292]

SENATOR JOHNSON: Any other questions? Seeing none, thank you. [LB292]

SENATOR HANSEN: Thank you. [LB292]

SENATOR JOHNSON: All right, what we do now is first we will go with proponents and then opponents and then neutral. How many proponents do we have? A half a dozen or so? Opponents? Okay. Very good. Welcome. [LB292]

DAVID BURD: (Exhibits 1, 2, 3) Thank you. Good afternoon, Mr. Chairman and members of the committee. My name is David Burd, D-a-v-i-d B-u-r-d. On behalf of our 85-member hospitals, the Nebraska Hospital Association, NHA, supports LB292. LB292 would allow county boards to transfer funds designated for public assistance, otherwise known as general assistance, to the Department of Health and Human Services

Finance and Support for the purposes of payments to providers who serve recipients of medical assistance, or low-income uninsured persons, and meet federal and state disproportionate share, or DSH, requirements. The DSH program was created by the United States Congress in 1981 to compensate hospitals for serving a disproportionate share of low-income individuals who are part of the Medicaid system or are uninsured. Under current law, DSH payments are subject to a series of caps, both on the amount of DSH money an individual hospital can receive as well as on the total amount of DSH payments made within the state. The Medicare Modernization Act of 2003 increased state allotments annually by 16 percent over a five-year period for low DSH states. A state is designated as a low DSH state if their DSH expenditures are less than 3 percent of their medical assistance expenditures. Nebraska is designated as a low DSH state and consequently is eligible for additional federal funding for the DSH program. Although Nebraska is currently eligible for additional federal funds, in order to receive these funds, the state must first produce its matching portion of the DSH payment. The NHA and our member hospitals, have been working in cooperation with Health and Human Services Finance and Support, to find a solution that would not require new state funds. After much discussion and research, we found a way to accomplish this goal and avoid losing millions of federal dollars made available to assist hospitals that treat an above-average number of Medicaid and uninsured patients. The solution contains two parts: general assistance payments and behavior health regional payments. Currently, general assistance payments are made directly from the county to the provider. The first part would give counties the option of making general assistance payments to Health and Human Services Finance and Support, prior to the payments being made to the providers. The intergovernmental transfer would utilize approximately $3.1 million from current county general assistance payments as a state match and would potentially result in additional federal funding to the DSH program of approximately $4.3 million per year. LB292 would allow this to occur. Similar to general assistance, behavioral health payments are currently made directly from the region to the provider. The second part would involve regions making behavioral health payments to Health and Human Services Finance and Support, prior to the payments being made to the providers. This would also qualify as an intergovernmental transfer utilizing approximately $4 million from current behavioral health regional payments as the state's match, potentially resulting in additional federal funding to the DSH program of approximately $5.5 million per year. After taking payment caps into consideration, this solution as a whole, would result in additional funding within the DSH program of approximately $7.3 million for FY2007 and $8.5 million for FY2008. This increased funding would go directly to the providers and continue at this new level for future years. Please keep in mind that we would be using existing funds. This additional funding can be achieved without requiring any new funds from the state, counties, or regions. Health and human services Finance and Support submitted a plan amendment to the Centers for Medicare and Medicaid Services, CMS, which contained these proposals. The plan amendment was recently approved by CMS. Thank you for the opportunity to testify in support of LB292. The NHA and our member hospitals appreciate all of the effort and

assistance from Health and Human Services Finance and Support, and look forward to continued collaboration with HHS, county boards, and behavioral health regions to make this possibility a reality. Currently, hospitals are experiencing reduced reimbursement from multiple resources. Taking advantage of available federal funding to assist Nebraska hospitals in their mission to provide quality care to all patients 24 hours a day, is essential. The NHA appreciates your attention to this important matter and it urges you to support and advance LB292. And before I answer any questions that you may have, I would also like to submit, for the record, letters of support for LB292, from Great Plains Regional Medical Center in North Platte, and also Regional West in Scottsbluff, and I do have copies of those for the committee as well. [LB292]

SENATOR JOHNSON: Okay, thank you. Any questions? I see none, thank you very much. [LB292]

DAVID BURD: Okay. Thank you. [LB292]

SENATOR JOHNSON: Next please? [LB292]

JAMES CAVANAUGH: (Exhibit 4) Senator Johnson, members of the Health and Human Services Committee, my name is James Cavanaugh, I'm an attorney and registered lobbyist with the Creighton University Medical Center. We have a handout for the committee. I'm submitting as an exhibit, a letter of endorsement of LB292 from the chief executive officer of Creighton University Medical Clinic, Linda Ollis. And we commend Senator Hansen, cosponsors Senator Harms, Senator Johnson, for bringing this matter before the committee. As you can see from the letter and its attachment, which is a projection generated by HHS last August, if LB292 were enacted and if the counties availed themselves of its mechanism, with the approval of the intergovernmental transfer from CMS, this would result in substantial enhanced funding for disproportionate-share eligible hospitals around the state. We're talking substantial, as Mr. Burd indicated, for the monies that we are currently spending, we can put them through this intergovernmental transfer and receive a 60 percent match to our 40 percent from Medicaid through the DSH program which would then be redistributed to the entities currently receiving in a large part, the general assistant monies from the county which are not eligible for the 60-40 match. So without any further expenditure of Nebraska-based funds on the local or state level, we could received a 60 percent match. This, to me, is as close to a no-brainer as you can get and it would go a significant way to addressing the ongoing concern we have about Medicaid funding and the rise in Medicaid funding at the state level. And this committee, I know, has worked hard over the last few years in addressing the Medicaid question and I think this follows up on the intent of your Medicaid findings in terms of reforming how we do some of our business with Medicaid. For no additional cost to receive this type of a return, would seem to me to be in the best interests of the findings of the Medicaid Task Force. You can see from the analysis here, and possibly HHS has more current numbers than

these, that from a 2004 DSH payment to the state of $4.2 million, you could in the first year, go to $8.7 million, the second year $11.5 million, the third year $12.8 million dollars; that's spending at current levels. Our concerns as expressed in the letter is that we do just that--that we spend at current levels or above, that we don't use this as a mechanism to cut back our level of local investment in order to capture the 60 percent federal investment and then say, well, we're where we started out--this is not the intent that we see that this bill should be used for. We're interested in it to enhance the DSH program which helps us deal with the poorest, sickest people in our society. I'd be happy to answer any questions that you might have. [LB292]

SENATOR JOHNSON: Any questions? I see none, Mr. Cavanaugh, thank you. [LB292]

JAMES CAVANAUGH: Thank you. [LB292]

SENATOR JOHNSON: Next please? [LB292]

ERIN MASS: (Exhibit 5) Good afternoon, Senator Johnson, members of the Health and Human Services Committee, my name is Erin Mass, E-r-i-n M-a-s-s, and I am the manager of reimbursements for the Nebraska Medical Center. Thank you for providing me with the opportunity to speak to you today in support of LB292. I would like to address the committee today regarding the opportunity that has arisen which would allow the state to increase the amount of disproportionate share funds it has available for disbursement to disproportionate share hospitals. The Nebraska Medical Center is one of many disproportionate share hospitals within the state of Nebraska. Disproportionate share, or DSH-eligible hospitals, receive higher Medicaid reimbursement than other hospitals due to the fact that they treat a higher percentage of Medicaid patients. States will determine if a hospital meets the criteria to be considered a DSH-eligible hospital, then establishes a formula used to calculate the amount of the payment the hospital will receive subject to certain minimum standards under the law. States can enhance the funds that they have available for disbursement to DSH-eligible hospitals by claiming the federal match for the DSH program. Passage of LB292 would allow the state of Nebraska to take advantage of matching federal funds for the DSH program without requiring any additional dollars from state funds. It has been estimated that the Nebraska Medical Center could receive as much as $800,000 in 2007 and $1 million in 2008. The 2008 funding level would then remain at that level for subsequent years. These additional funds would be beneficial in helping us offset the shortfall we incur in providing treatment to Medicaid patients. During our fiscal year, 2006, we experienced a shortfall of $14.3 million as a result of treating these patients. It would also help to blunt the effect of federal reimbursement cuts proposed in the President's budget which will be felt by many providers within our state. The Nebraska Medical Center is in support of this bill and respectfully requests that the Health and Human Services Committee vote in favor of its passage. Thank you for your time and consideration and I'd be happy to answer any questions you might have. [LB292]

SENATOR JOHNSON: Thank you. Are there no questions? [LB292]

ERIN MASS: Thank you. [LB292]

SENATOR JOHNSON: Further proponents? Welcome. [LB292]

MARY STEINER: (Exhibits 6 and 7) Thank you. Good afternoon, Senator Johnson, and members of the Health and Human Services Committee, my name is Mary Steiner, S-t-e-i-n-e-r. I'm the Medicaid Director for the Department of Health and Human Services Finance and Support, and I'm here to testify in support of LB292. LB292 proposes to allow counties authority to transfer funds to the Department of Health and Human Services Finance and Support for payments to hospitals qualifying for disproportionate share hospital payments. Medicaid disproportionate share hospital payments, a special type of Medicaid funding for hospitals with large populations of low-income patients, are an essential component of financing unreimbursed costs to eligible hospitals and health systems. The Department of Finance and SAupport supports efforts to increase DSH Payments to hospitals for the uncompensated care costs of services provided to low-income patients. In 2004, Medicaid DSH Payments covered approximately 37 percent of the costs incurred in treating the uninsured and underinsured at qualifying hospitals. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, provides additional federal funding to states designated as low DSH states. Nebraska is deemed a low DSH state as we have less than 3 percent of our Medicaid expenditures spent on DSH. As a result of the additional federal funding, Nebraska will receive a 16 percent increase annually in federal DSH allotment each year from 2004 to 2008. That allotment is the maximum that we can spend in total on disproportionate share. LB292 facilitates the use of cash funds as state match. It is estimated that approximately $3.1 million annually, could be available in transferred funds as a state match portion of the DSH payment. This would allow approximately for a $3.1 million annually in additional federal funding. The Centers for Medicare and Medicaid Services, or CMS, on January 26, 2007, approved the use of intergovernmental transfers for this purpose in Nebraska. It is anticipated that this bill will impact Medicaid for federal FY2007 DSH payments. This proposal would not require any additional general fund appropriation. In addition, HHSS is in support of an amendment related to Medicaid provider tax and I have that. This amendment addresses a recent federal law change. Specifically, this new federal law lowers the maximum allowed rate from 6 percent to 5.5 percent of facility revenues for allowable Medicaid provider taxes. Nebraska's ICF-MR provider tax will be impacted as it has a 6 percent tax specified in statute. Overall, this federal law change will lower revenue to the state General Fund by about $170,000. However, it's required since the federal limit has been specified in federal law now. I would be happy to answer any questions. [LB292]

SENATOR JOHNSON: I've got a couple. [LB292]

MARY STEINER: Okay. [LB292]

SENATOR JOHNSON: One, is how does it feel to testify as a proponent? (Laughter) [LB292]

MARY STEINER: It feels pretty good, and yeah, it is my first time. [LB292]

SENATOR JOHNSON: No, I have one legitimate question and what it is, is this: and, again, it's just for the record, but I was asked to ask you this. With LB292, will county government assistance monies be added to Nebraska's disproportionate share Medicaid application? [LB292]

MARY STEINER: Right, that's what we're planning on using is county money as the state match so we can bring in more federal money. Right now, there's federal money in our allotment, but we can't qualify for it without the match, and we can use that county money for that. [LB292]

SENATOR JOHNSON: We just wanted it, you know as a specific statement in the record. [LB292]

MARY STEINER: Yep. Um-hum. [LB292]

SENATOR JOHNSON: Any other questions? I see none, thank you very much. Next please? [LB292]

SENATOR HANSEN: Senator Johnson, I've got to go somewhere, I'll waive closing. [LB292]

SENATOR JOHNSON: All right, thank you. [LB292]

SENATOR HANSEN: Thank you. [LB292]

KERRY EAGAN: Good afternoon, Senator Johnson, members of the committee, my name is Kerry Eagan, I'm the chief administrative officer for Lancaster County. I work directly with the Lancaster County Board of Commissioners. Lancaster County does support LB292. There aren't too many opportunities where we get a chance to work together with our friend the state, and our friends the hospitals, but this is definitely one. While it is discretionary on the part of the counties, the Lancaster County Board would see huge advantages for the citizens of Lancaster County and the citizens of the state if this legislation is passed, and it's an excellent example where different levels of government and hospitals can work together to serve the poor and we can just see no

reason why we should not support this legislation very strongly, quite frankly. So, that's it. [LB292]

SENATOR JOHNSON: Thank you. Any questions? Thank you very much, Sir. [LB292]

KERRY EAGAN: Thank you. [LB292]

JON EDWARDS: Good afternoon, Chairman Johnson, and members of the committee. My name is Jon Edwards, J-o-n E-d-w-a-r-d-s. I am with the Nebraska Association of County Officials and we are here today in support of LB292. I think all the technical aspects have been covered and we certainly want to work with the state in elevating their ability to increase their Medicaid standing. So we certainly do support this bill. [LB292]

SENATOR JOHNSON: Any questions? Thank you very much, Sir. Any more proponents? Seeing none, let's go...are there any opponents? Any neutral? I see none. Therefore, that closes the hearing on LB292. The next bill that will be heard might be different than what you have seen, but it will be LB666 by Dwite Pedersen, and he should be here momentarily. Senator Dwite Pedersen, welcome--LB666. [LB292 LB666]

SENATOR PEDERSEN: Thank you, Senator Johnson, and colleagues serving on the Health and Human Services Committee, good afternoon. For the record, I am Senator Dwite Petersen, representing the 39th Legislative District. I am here today to introduce to you, LB666. This bill was brought to me by the Nebraska Advocacy Services. It provides intent language stating that legislative action is needed to aid individuals with psychiatric disabilities, to maintain their eligibility for federal benefits during incarceration. And upon release, to enable them to access federal benefit programs such as Medicaid, Supplemental Security Income program, and Social Security Disability Insurance for which they are eligible, to be speedily reinstated or enrolled in federal health programs for which they are also eligible, to obtain temporary healthcare coverage and income support while receipt of federal benefits is pending. And to receive mental health services including case management, medication, and substance abuse services. It is also designed to ensure that upon release from incarceration, individuals with psychiatric disabilities are connected to community-based mental health services. The bill provides that upon release from incarceration, individuals with psychiatric disabilities shall be given access to services under the medical assistance program established by the Medical Assistance Act, and that they shall be provided with a 30-day supply of any psychiatric medications they were taking prior to release. It also requires the Department of Correctional Services and the Department of Health and Human Services to identify and assist individuals with psychiatric disabilities. It requires those agencies to offer assistance to these individuals in filling out applications and getting connected to programs for which they are eligible. LB666 provides for a process by which an incarcerated individual with psychiatric disabilities, can apply for a

temporary Medicaid card which will assist them in obtaining services upon their release. It also requires that these individuals be provided with a photo I.D. before being released that lists an address other than a correctional facility. The bill states that the policy of the state of Nebraska requires that the Department of Correctional Services provide access to mental health services while a person is incarcerated, and that the Health and Human Services Department is responsible for case management services upon release, which shall be provided through contact with community mental health agencies or community mental health providers. The bill provides that case management services shall be provided well in advance of an individual's release, if possible, at least 90 days before an individual is released from custody. The case manager is to work with the individual to arrange for shelter, mental health services, and other support as well as helping them to access federal benefit programs. That explains the bill and what it does, technically. As you know, I work quite a bit with inmates, both in my personal profession and in my capacity as a state senator. I see many, many cases where individuals with serious psychiatric disabilities are released from incarceration without the necessary assistance to help them navigate through the system which has been designed to help them. In some cases, the Department of Correctional Services is able to help these individuals make the right contacts, but in others, that assistance may either not be offered or may be refused. What ends up happening is that people with serious psychiatric disorders end up on the street with no idea of where to turn for help. In many cases, they end up back in jail. The goal of this legislation is to provide a type of safety net so that after a person serves their debt to society for the crime they have committed, they will be able to access services that will allow them to have the best possible chance of living successfully in their communities as law-abiding citizens. Access to medication, financial assistance, and mental health services, is vital to such success. And this bill is an attempt to make that happen in Nebraska. I have not outlined any specific cases for you, but I will be followed by those who have much more experience in the area of advocacy. And I'm sure they will have stories to share that will highlight the need for this type of legislation. If you have any questions for me, I would be more than glad to try and answer them. I will not be closing because I'm needed in the Judiciary Committee. My closing would be: pay now or pay later. Thank you. [LB666]

SENATOR JOHNSON: Any questions of Senator Pedersen? Senator Pedersen, I have got one or two here. My question comes from a large group of e-mails that have been sent and obviously a group of individuals have been talking on line to each other. LB666 is an honest effort to assist those incarcerated individuals returning to society, etcetera. The last statement however is this, and it's impalpable: I am absolutely opposed to this bill without a provision that includes proof of citizenship. Would you respond to that? [LB666]

SENATOR PEDERSEN: Well, I haven't met any individuals and we may have some, but I haven't met any individuals who have come into the prison system who are not citizens

of this country. [LB666]

SENATOR JOHNSON: It would seem like... [LB666]

SENATOR PEDERSEN: There may be some, but I haven't...any of the ones that I have met and especially in the mental health field or that type of abuse field, have not. [LB666]

SENATOR JOHNSON: More likely to be in federal prisons anyhow, wouldn't they? [LB666]

SENATOR PEDERSEN: And it very well could be, yeah, deportation is one of the biggest things unless they are very, very dangerous. [LB666]

SENATOR JOHNSON: Any other questions of Senator Pedersen? Dwite, I see none, thank you very much. [LB666]

SENATOR PEDERSEN: Thank you very much. [LB666]

SENATOR JOHNSON: Proponents please? How many proponents do we have by the way? Opponents? Okay, about three or four of each. [LB666]

BRAD MEURRENS: Good afternoon, Senator Johnson, members of the Health and Human Services Committee, for the record, my name is Brad, B-r-a-d, Meurrens, M-e-u-r-r-e-n-s. I'm the public policy specialist and registered lobbyist for Nebraska Advocacy Services, Inc. Nebraska Advocacy Services is the designated protection and advocacy organization for the state of Nebraska, and our charge is to advocate for the rights of peoples with disabilities. I'm here today to offer our strong support for LB666. We would like to thank Senator Pedersen for introducing LB666 on our behalf. The legislation before you springs from model legislation compiled by the Bazelon Center for Mental Health Law. As the protection and advocacy organization, Nebraska Advocacy Services, Inc., is part of a national network of disability advocacy organizations, and the Bazelon Center provides technical assistance to that network. LB666 is on opportune vehicle to begin public discussion surrounding the issue of persons with psychiatric disabilities in our corrections systems and how Nebraska's corrections and health systems can collaborate on ways to provide the care, treatment, and support these individuals need so that they can recover, manage their conditions, and live lives of quality across the entire corrections spectrum from incarceration to release. LB666 directly addresses one of the most important aspects of the issue: building the transition from incarceration to community living. The Council of State Governments, CSG, recently completed two years of study and meetings of hundreds of individuals involved in criminal justice or mental health systems at the state and local levels. As the CSG found, individual's mental illness leaving... [LB666]

SENATOR JOHNSON: Brad... [LB666]

BRAD MEURRENS: Yeah, I'm sorry. [LB666]

SENATOR JOHNSON: You are kind of a professional at being here and so on, and kind of know the rules...we like three minutes... [LB666]

BRAD MEURRENS: Sure. [LB666]

SENATOR JOHNSON: ...and when you've got... [LB666]

BRAD MEURRENS: No, I've got... [LB666]

SENATOR JOHNSON: ...five or six pages, you're not going to get done. [LB666]

BRAD MEURRENS: No, I'm not going to... [LB666]

SENATOR JOHNSON: I hate to cut you off. [LB666]

BRAD MEURRENS: ...my testimony is abbreviated. It's not going to be all five pages. [LB666]

SENATOR JOHNSON: Okay, all right. [LB666]

BRAD MEURRENS: No, no. [LB666]

SENATOR JOHNSON: Go ahead, and excuse me. [LB666]

BRAD MEURRENS: Connections with mental health and other support services and housing are almost certain to decompensate which will in turn likely result in behavior that constitutes a technical violation of release conditions or a new crime. This confirmed a 1991 study finding that with 18 months of release from prison, 64 percent of offenders with mental illnesses were rearrested and 48 percent were hospitalized. Given the high cost of incarceration, LB666 is an investment in our corrections system and our communities, and moves the cost of providing services and supports from strictly state funds, to a blended federal, state, local funding stream. Currently, prisoners with mental illness are not given adequate support upon discharge from prison. Human Rights Watch reported in 2003 that, in Nebraska, no appointments with providers are made in advance and no provisions are made for the severely mentally ill who may not be able to explore treatment options independently, and that Nebraska prison officials told them they did not know how recently discharged prisoners go about applying for Medicaid and other benefits. And they do not help prisoners apply prior to release.

Moreover, Nebraska currently terminates Medicaid upon incarceration. Upon release, the individual must reapply for those benefits. Without such services and supports, the odds of successful transition to community living are long. As the CSG report recognized, people with psychiatric disabilities rely heavily on federal benefit programs to pay for housing, food, and other necessities and to receive health and mental health services. Medicaid provides access to mental health care and substance abuse services. Although these are federal programs, states can put in place, policies that will enable inmates with psychiatric disabilities to be enrolled or reinstated in these programs, receive immediate services speedily, and establish connections to the community-based mental health system prior to release. Rather than terminating benefits, LB666 calls for the suspension of federal benefits for the duration of a person's sentence. The Vera Institute's study of post-incarceration experiences in New York City, found that the lack of Medicaid was the biggest obstacle to accessing treatment following release from incarceration. Federal law prohibits Medicaid payments for care or services for any individual who is an inmate... [LB666]

SENATOR JOHNSON: Brad, you've gone right back to reading your six-page letter. [LB666]

BRAD MEURRENS: Sure. [LB666]

SENATOR JOHNSON: Now, we are not going now to allow you do it and you know the rules. [LB666]

BRAD MEURRENS: Sure, you're right, Senator. [LB666]

SENATOR JOHNSON: You've been here many times before... [LB666]

BRAD MEURRENS: Yes, Senator. [LB666]

SENATOR JOHNSON: ...and we're going to have you stop right now. [LB666]

BRAD MEURRENS: Not a problem. I'd be happy to answer any questions that you may have. [LB666]

SENATOR JOHNSON: Any questions? Thank you. [LB666]

BRAD MEURRENS: Thank you. [LB666]

SENATOR JOHNSON: Next please? [LB666]

LISA REHWALDT-ALEXANDER: (Exhibit 2) Good afternoon, members of the Health and Human Services Committee, my name is Lisa Rehwaldt Alexander, spelled L-i-s-a

R-e-h-w-a-l-d-t - A-l-e-x-a-n-d-e-r. I'm speaking today in favor of LB666 as a citizen and a member of a church group concerned about criminal justice issues. I value a safe society and a just society. I value a government that meets the needs of its citizens and stewards its resources. I support LB666 because it supports my values. It would improve the wellbeing of both mentally ill people who are incarcerated and the broader society. After having spent the last year talking with people involved in the criminal justice system, including jail administrators, I have become aware of a problem. The criminal justice system is not designed to care for those with mental illness, yet our jails include a large group of people with mental illness. Studies indicate that 10 percent or more of those incarcerated are seriously mentally ill. Often untreated mental illness expresses itself in ways that result in incarceration. These mentally ill people, on average, stay in jail longer than others with the same charges because of concerns about behavior. After they are released, they rarely receive support services or ongoing medication. In fact, studies indicate that fewer than 20 percent of this population receives follow-up services after release. Thus, because of their untreated mental illness, many end up back in jail. This cycle is harmful to, and expensive to, society. It is harmful to the people who are mentally ill and untreated. What is needed is a way to support that population after they are released so their mental illness is successfully treated. By providing support services upon release, including access to Medicaid, SSDI, and other community support services, recidivism will likely be reduced and creating a safer society. Moreover, such services will improve the wellbeing of the people themselves as they will receive adequate treatment. LB666 seems to be a win-win situation to an ongoing problematic relationship between people who are mentally ill and the criminal justice system. The society will be safer and more just and the needs of citizens will be better met. I strongly urge you to move this bill out of committee. Thanks. [LB666]

SENATOR JOHNSON: Thank you. Any questions? I don't see any. Thanks very much. Next proponent please? [LB666]

AMY MILLER: (Exhibit 3) Good afternoon, Senator Johnson, and members of the committee, my name is Amy Miller. My name is spelled A-m-y, last name M-i-l-l-e-r. I'm legal director and lobbyist for the American Civil Liberties Union of Nebraska. I plan to be brief and give you a few statistics and a few anecdotal examples from my own experience. I'm not going to give you a lot of statistics because the chunky report that's being handed out to you, has most of that information in it. This is a report that ACLU did after several years of work. It's entitled Criminal Neglect, with a beige cover. It was issued in 2003 and at that time we did distribute a copy to every Senator. Much of the report is looking at from beginning to end of someone, who with a disability, enters the criminal justice system and so you'll find information in there as well about people's experiences within the prison, not being diagnosed, etcetera, etcetera. But I'll point you to the fact that in the report on pages 11 and 13, the issue that would be solved by LB666 is described in greater detail. And we actually asked for the sort of reform that

LB666 brings. It is absolutely necessary because, are you prepared for the anecdotal evidence? I don't know what the average time is that one has to wait for the benefits to be granted from the federal system, I can only tell you anecdotally. Although I work for ACLU, I also do pro bono work on the side through the Nebraska Bar Association, assisting people who are unable to afford assistance from an attorney. And I've done several SSI applications, several Medicaid, Medicare applications for those people. The shortest one took two years for the individual to finally receive his assistance and his medical condition was relatively straightforward. It was diabetes so severe that he had regular problems with insulin delivery and was unable to work as a result. Two years for that individual, and he was, because of the nature of his disability, able to get supplementary help from community services such as the People's Health Center, trying to hook him up with manufacturers and pharmaceutical companies who would assist him in the interim. Someone with a disability who has just been released from prison is not as easy of a person to help. There is just not that system there in place. The clients I have are good people and so therefore find more people willing to step up and help them. People who come out of prison, often don't find people that are willing to do that for them. The other anecdotal note that I'd like to make is there is a large fiscal note attached to this bill and we know that. But it is hard to calculate the finances on the other side. The fact that these folks that have a serious disability, mental disability, that go back into the system with great regularity, you have to then count the cost of incarcerating them and the state Department of Corrections is currently estimating that's almost $30,000 per inmate per year. There is the cost of the prosecution for the state or county that is prosecuting them for their new crime and the cost of the public defender if that person is indigent. There are the costs to the victim if any, for the crime. And there's the cost to the family of the offender. Most of the people in the prison system are work-age men. The average age is 32 upon release. If a family member is taken away from the family, that family is more likely to have to go back onto state assistance. So it's a large fiscal note, but we also think on the other side, there's a large amount of money flowing towards this problem population that we are not currently serving. Finally, the question that you posed, Senator Johnson, about the e-mails that you received about citizenship status is that your instinct is absolutely correct. In Nebraska and nationwide, if someone is convicted of felony and is not a citizen, they will do their time in our state prison system and then be deported immediately upon release. So they wouldn't be here to access those psychiatric services anyway. Although I would not, that the idea that we would not provide psychiatric services to people in desperate need of them solely because of their country of origin, seems a bit inhumane. Nonetheless, there is not an actual practical problem with that situation either. I hope I didn't go over time? Do you have questions for me? [LB666]

SENATOR JOHNSON: I think you did quite well. Any questions? I see none, thank you. [LB666]

AMY MILLER: Thank you. [LB666]

SENATOR JOHNSON: Any other proponents? I see none. Let's go to opponents. Any opponents? Do you feel more comfortable in this position? (Laugh) [LB666]

MARY STEINER: (Exhibit 4) Yeah. Good afternoon Senator Johnson, and members of the Health and Human Services Committee, my name is Mary Steiner, S-t-e-i-n-e-r. I'm the Medicaid Director for the Department of Health and Human Services Finance and Support. I'm here to testify in opposition to LB666. I'm mostly concentrating on the Medicaid aspects...is far-reaching. I'll try to highlight those areas of expansion for us. LB666 requires the Department of Health and Human Services establish policies and procedures to enable clients with psychiatric disabilities, to apply for federal benefits when possible, prior to their release from a correction facility which is defined as jail, prison, juvenile detention facility, or other detention facilities operated by a state or local correctional agency. The legislation also establishes a program of medical care and maintenance payments for individuals with psychiatric disabilities that are presumptively qualified for a federal program but receive a negative federal decision. This program would be six months in duration. We view this as an expansion of the agency's state disability program which is available to those disabled who meet the severity standard of the Social Security Administration's disability program, except for the one-year durational requirement. The legislation would expand the agency's current procedure to individuals about to be released from juvenile correctional facilities, juvenile detention centers, and municipal and county jails. This Medicaid expansion in terms of program dollars and staff to accomplish the increased workload, would require additional state funds. Further, the legislation requires the decision on a Medicaid application within 14 days, which in many cases, is unrealistic. The CMS, or federal timely processing standard, for Medicaid, is 45 days for all categories except the disabled where there is allowed 60 days to process an application. We would need additional staff for this short time frame, or accept the loss of federal funds because of erroneous decisions. The expansion of the state disability program would require additional funds which would be funded with state funds. It appears that LB666 would require service by HHS to a new population of youth not currently in HHS or HHS-OJS custody. It requires services to any youth with a psychiatric disability in a juvenile correctional facility, a juvenile detention facility, or jail. Currently the Department of Corrections operates the juvenile correctional facility in Omaha and is responsible for them. Additionally, the majority of youth in detention facilities and jails are placed by law enforcement, probation, or the courts, and therefore the responsibility of the country or probation. Serving these youth would mean a large increase in HHS expenditures, both in terms of program and staff. This expansion would also be a shift from county costs to the state. LB666 is an expansion of Medicaid which is contrary to Medicaid Reform efforts for the future fiscal sustainability of Medicaid. I'd be happy to answer any questions that I can. [LB666]

SENATOR JOHNSON: Sure. Senator Howard? [LB666]

SENATOR HOWARD: Thank you, Chairman Johnson. I really have to ask you this: in my experience, most of these youth that are committed or under the wardship of the state already--they're under the juvenile court most likely. I suppose some would be under district court...what--do you know the numbers on this at all? When you are talking about additional youth? [LB666]

MARY STEINER: I don't have them with me, but we could get those to you, those that would be in county detention facilities, things like that. [LB666]

SENATOR HOWARD: Right, that are not state wards already? [LB666]

MARY STEINER: Right. Yeah. [LB666]

SENATOR HOWARD: Because if state wards, would be covered... [LB666]

MARY STEINER: Yep. [LB666]

SENATOR HOWARD: ...for medical... [LB666]

MARY STEINER: Um-hum. [LB666]

SENATOR HOWARD: ...and psychiatric and any other need they would have along those lines. [LB666]

MARY STEINER: We do cover them. Medicaid doesn't fund them with federal money, but the state would cover them as a ward, that is correct. [LB666]

SENATOR HOWARD: Exactly, exactly. Thank you. [LB666]

SENATOR JOHNSON: Any other questions? I guess the thing that kind of I'm reminded of is this: is as we toured the state last year, looking at mental health across the state, one of the things that commonly occurred with our youth, at least this is what we told, is their first psychiatric encounter is usually when they have an encounter with the law rather than a medical professional of any sort. I guess what I see Senator Pedersen trying to do here, is to change the, shall we say, the point of entry here, at least the point of exit. Would that be an adequate description? I realize that, you know, here's funds in HHS... [LB666]

MARY STEINER: Right. [LB666]

SENATOR JOHNSON: ...that do this and then so...do we save over here and spend more over here? And I guess those here and there being HHS and the prison system. And I guess I would like to see some better numbers about that, you know, the whole

system and effect that's there. So, anyhow...thank you. [LB666]

MARY STEINER: Okay. [LB666]

SENATOR JOHNSON: Any others? Thank you, Sir. [LB666]

RICK BOUCHER: Senator Johnson, members of the Health and Human Services Committee, my name is Rick Boucher. I am an attorney and registered lobbyist for the Nebraska Sheriffs Association. I appear before you here today to convey the organization's respectful opposition to LB666. The sheriffs oppose the bill to the extent is appears to add to duties of jailers and sworn officers by way of providing assistance to pretrial detainees or convicted persons for securing the benefits from federal programs. I believe the definitions section concerning correctional institutions and agencies, can be extended to local facilities of which county government is involved in approximately 64. In that sense, mandatory training has long been a staple of the requirements for both sworn officers as well as jailers, but it would extend beyond any reason or the need for mandatory training to include a familiarity or counseling level of federal benefit programs for local officers. We believe that the public safety, the safety of inmates, as well as the safety of fellow employees, is at a premium and to dilute the requirements from those activities, would be not in the best interests of the facility or the individual. So with that, I'd be more than willing to try to answer any questions you might have? [LB666]

SENATOR JOHNSON: Well, I've got one more (laugh). Wouldn't it provide for a safer jail facility and so on, if the person were receiving the correct and prompt treatment? [LB666]

RICK BOUCHER: Oh I would expect so. The sheriffs would certainly agree with you. With regard, particularly as facilities of state government begin to restrict, whether it's Norfolk or Hastings or otherwise, Senator, so they would certainly agree with you that it makes for a more manageable facility. But what at least this legislation seems to impose upon county employees, jailers and sworn officers, the requirement that they be familiar with programs and actually assist inmates and other confined persons in securing those benefits. We're saying as jailers and sworn officers are trained to do other things, but as a certainly general statement, they would concur with you that it more manageable facility and certainly benefits not only employees, but also those detained. [LB666]

SENATOR JOHNSON: All right. Thank you. I've got a question from Senator Howard. [LB666]

SENATOR HOWARD: Thank you, Chairman Johnson. If I recall correctly, Senator Pedersen stressed that this bill would also include case management services, do you recall that? [LB666]

RICK BOUCHER: I do recall it. [LB666]

SENATOR HOWARD: Good, good. And I'm sure that the individuals you represent are not interested in being case managers. [LB666]

RICK BOUCHER: Well, and that's...they are trained in their duty in life, their mission in life is to provide security for inmates as well as colleagues and the community, yes. [LB666]

SENATOR HOWARD: Well, and I do understand that and I do appreciate that. But with the provision in there for case managers, people that are specifically trained to offer the services, have knowledge of the programs that are available, and can help these individuals access these programs, would that present this in a different light to you? [LB666]

RICK BOUCHER: Yes, I mean that would be suitable and appropriate and we're taking in a very narrow version that you have the jailer who is then asked to switch hats and say these are the programs that are available. Yes, Senator, no question that it would be of great benefit to all concerned. [LB666]

SENATOR HOWARD: Oh, I appreciate that, thank you. [LB666]

SENATOR JOHNSON: I see no other questions, thank you, Sir. [LB666]

RICK BOUCHER: Thank you. [LB666]

SENATOR JOHNSON: Next please? [LB666]

JON EDWARDS: Good afternoon again, Senators, my name is John Edwards, J-o-n E-d-w-a-r-d-s. I'm with the Nebraska Association of County Officials. We are here today in opposition to LB666. While certainly the idea behind it can go quite a ways in helping with recidivism issues and so forth of inmates with behavioral health issues coming back through our system repeatedly, I think our opposition is just particularly in the way the language is within the bill in that it seems to provide a mandate that jailers get involved and the correctional agency gets involved in the process of working the inmate through their eligibility in terms of federal programs in trying to secure those federal programs for the inmate. And I think to address what Senator Howard was questioning previously, I think that the language within the bill certainly provides...that's open to interpretation exactly how this would work and that's our concern. If the services can be provided, that's great. We just don't want individuals who are not trained to do this and not equipped to do it, and are specifically trained to do another job that that's not intermingled to the point of where it lacks on both sides of the issue. So that's primarily

our point of opposition on this particular bill, so. [LB666]

SENATOR JOHNSON: Okay. Any questions? I see none, Jon, thank you very much. [LB666]

JON EDWARDS: Yep. [LB666]

SUSAN SMITH: My name is Susan Smith, that's S-u-s-a-n S-m-i-t-h. Chairman and committee members, thank you for this opportunity to speak with you on this. My concern about LB666 is that some of these services would be possibly going to illegal aliens. While some of the more violent crimes committed by illegal aliens may end up in deportation once they are released from our prison system, it does not necessarily mean that those convicted of lesser crimes are deported but released back into our community. Nebraskans are already spending approximately $126 million a year on services and benefits for illegal aliens and so even to allow the chance of one illegal alien to receive benefits, is one too many. This bill, I think, is really good, if it could just have the provision in it that proof of citizenship being an American, having legal authority to be here in our country, is requested. And I appreciate your time today. Thank you. [LB666]

SENATOR JOHNSON: Thank you, Susan. Any questions of Susan? I don't see any. Thank you. Any other opponents? Any neutral? That being the case, we'll close the hearing on LB666 as Senator Pedersen had waived closure. Now let's go back to the schedule that you might have in front of you and that is...there he is. Senator? LB171, Senator Kopplin. Welcome. [LB666 LB171]

SENATOR KOPPLIN: (Exhibit 1) Good afternoon, Senator Johnson, and members of the Health and Human Services Committee, my name is Gail, G-a-i-l, Kopplin, K-o-p-p-l-i-n and I represent the 3rd Legislative District. I'm before you today to introduce LB171. This is a relatively simple bill that would require the Nebraska Department of Health and Human Services to apply for and utilize any and all options and waivers available to Nebraska residents under the federal Food Stamp Program. As you probably know, the Food Stamp Program is 100 percent federally funded and is one of the federal government's primary public assistance programs. And in Nebraska that means food stamps mostly help feed children. According to the latest statistics available from the federal government, slightly over 50 percent of all food stamp participants are children 17 years of age and younger. In real numbers, that means 58,000 young Nebraskans are not going hungry because of food stamps, but we can do better than that. In this country of plenty, we still have too many people going to bed at night hungry. Recently U.S. Department of Agriculture figures state that 35 million people in this country don't have enough food. Twelve million of those who don't have enough food are children. The Economic Research Service reports that in Nebraska, on average, nearly 11 percent of Nebraskans are what is termed as food insecure. That

means they lack access to enough food to meet basic needs at all times due to lack of financial resources. Increased utilization of the Food Stamp Program through increased waivers and options, will improve the food security, health, and family stability of thousands of Nebraskans while bringing federal dollars into the state's economy. While the primary beneficiaries of the Food Stamp Program are low-income citizens, food producers, retailers, and the economy as a whole, benefit from the program. Another Economic Research Service study indicates that for every $5 of food stamps spent, generates $9.20 in the local economy. That meant in 2004, in Nebraska, the Food Stamp Program generated $199 million in economic activity. I know this proposal has been before the committee before and it has not been successful, in part, because of the fiscal note submitted by the department stating their need for a substantial increase in staff to administer the expanded program and the costs thus incurred. I would submit to you that one of the best things that we can do as a Legislature, is to ensure that the most basic of human needs, food, is adequate and available for all our citizens. And if in order to do that, we need to expand our ability to process and meet that need, then that is what we should do. However, I have seen the department's fiscal note on this bill and I want to address the department's reluctance to add additional staff. I have prepared an amendment that would provide the committee with an alternative to requiring that the department apply for all options and waivers available. The amendment would require the department apply only for all options available, not all waivers. This would still expand the Food Stamp Program in Nebraska and feed more hungry Nebraskans while at the same time, it addresses the department's concerns about excessive staff requirements. Thank you for your consideration. I believe there are testifiers following me who can better answer any technical questions, but I would be happy to try to answer any questions you have of me. [LB171]

SENATOR JOHNSON: Any questions of Senator? Let me just kind of ask one and what it is, is this: you know, a fairly sizable fiscal note there. How much and just give me a ballpark figure, if you can give one, how much money that you think we are talking about coming into the state through these programs and so on? [LB171]

SENATOR KOPPLIN: Well, I'm sure people can... [LB171]

SENATOR JOHNSON: Okay. [LB171]

SENATOR KOPPLIN: ...give you an accurate answer? I'll just give you my opinion if that's... [LB666]

SENATOR JOHNSON: Okay. [LB666]

SENATOR KOPPLIN: ...okay at this time? We're talking about federal funds. All the options and waivers could be substantial. I realize the cost and the fiscal note, and that's the purpose of my amendment. But I'd also like to tell you that these federal funds

are not really savings because if Nebraska does not make use of them, some other state will. They will be used for the hungry. I'm just proposing that we could, and in most likelihood, recover our costs simply by the amount of food stamps that we could receive. [LB171]

SENATOR JOHNSON: Thank you very much. Will you be able to be here to close? [LB171]

SENATOR KOPPLIN: Yes, I will close. [LB171]

SENATOR JOHNSON: Okay. Proponents? How many do we have? About four or five? Opponents? One. Okay, proponents please? [LB171]

JEN HERNANDEZ: (Exhibit 2) Good afternoon, members of the committee, I'm Jen Hernandez, H-e-r-n-a-n-d-e-z and I am representing Nebraska Appleseed. I'm here to thank Senator Kopplin for his leadership and for the opportunity to testify. As Senator Kopplin mentioned, the Food Stamp Program stimulates the Nebraska economy. In just a year's time, last year, in 2006, the Food Stamp Program generated $228 million in Nebraska. The Food Stamp Program helps workers keep working. Over 95 percent of benefits go to working households with incomes below the poverty level and nearly all of the remaining beneficiaries are elderly or disabled. In the last couple of months, 38 Nebraska counties have passed proclamations recognizing the economic benefits of the Food Stamp Program brings to their county and those are listed in the information that you have in front of you. I've also attached a map of Nebraska showing which counties have passed these food stamp proclamations which urge our state to educate people about their eligibility for the program. The state of Nebraska does currently utilize a number of options in the program including a five-month transitional food stamp benefit. However, there are several options that HHS is not pursuing that would result in families being served more effectively and more dollars coming into our economy. Currently, about 60 percent of Nebraskans eligible for the program, are receiving food stamps. To reach these families, Nebraska should pursue the federal outreach option which is a formal outreach program to educate families about eligibility and it is a 50-50 state and federal match. This option has the potential to educate 60,000 Nebraskans who are currently eligible and not participating. With an average monthly benefit of approximately $85 per person, if we reached just half of those who are currently eligible and not receiving food stamps, Nebraska would draw down more than $30 million in federal food stamp funds. So Senator Johnson, I think that is one example of an answer to your question. I do not concur with the department's suggestion that they would have to hire 82 new employees at a cost of more than $3 million to implement this bill. But just for the sake of argument, let's say Nebraska would invest that kind of money. Investing $3 million and drawing $30 million is quite a bargain. Frankly, it is unacceptable to be leaving that amount of money on the table. We all pay taxes and we should do our best to ensure that as many of those dollars as possible come back to

Nebraska. I've talked to the HHS department about pursuing this option for several years now. They've had a plan to utilize this option and never submitted the request. A bill like this shouldn't be necessary, but it necessary because HHS continues to not utilize the federal Outreach option leaving millions of dollars unclaimed for Nebraska and thousands of families without assistance. And with the amendment proposed by Senator Kopplin, I ask you to advance LB171. I'd be happy to take any questions you have. [LB171]

SENATOR JOHNSON: Thank you, Jen. Any questions? I see none, thank you very much. [LB171]

JEN HERNANDEZ: Okay. Thank you. [LB171]

SENATOR JOHNSON: Next please? [LB171]

SCOTT YOUNG: (Exhibit 3) I have some paper for you here. Good afternoon, Chairman Johnson, and members of the committee, my name is Scott Young, S-c-o-t-t Y-o-u-n-g. I'm the executive director of the Food Bank of Lincoln. I too, want to echo what Ms. Hernandez said about Senator Kopplin's efforts on behalf of hungry people in the state of Nebraska. And I wanted to share with you some observations as I speak in favor of LB171. According to a report prepared earlier this month for the Food Bank by Nebraska Health and Human Services Finance and Support, we had 51,626 household in 2006 participating in the Food Stamp Program. The average benefit per person was $87.76. Jen's numbers may be better than mine, but I think we are leaving anywhere from $60-80 million dollars worth of federal funding on the table. And these are dollars that would be spent in Nebraska communities if all of those that are eligible for the program participated. It's good for people, it's good for the state, and we think it's good for business as well, and the local economies. Many of the people we see or serve by the Food Bank are the working poor--hardworking poor people here in the state of Nebraska who are striving for self-sufficiency. And it's been my experience that the vast majority of those people are desperately eager to get off of any public assistance or charitable assistance. And they do what they can to get off the programs as quickly as they can. The Food Stamp Program is the number one tool in the fight against hunger across the country and doing what we can to assure that people who are eligible for food stamps, are receiving those food stamps, is not only the right thing to do but it's also the fiscally responsible policy as well. This feeding of hungry people will save the state millions of dollars in the long run, and of course that is an unquantifiable number, but it's common sense to ascertain what we can all make. Well-fed people are going to have better health. Children who are receiving proper nutrition, are going to be better students in school, and are going to be more healthy and productive Nebraskans as they grow older. So the savings and benefits that all Nebraskans receive from this Food Stamp Program, are enormous. And it's just not the low-income people that participate. Can I answer any questions? [LB171]

SENATOR JOHNSON: Any questions of Scott? I see none, thank you very much. [LB171]

SCOTT YOUNG: Thank you very much, Sir. [LB171]

SENATOR JOHNSON: Any other proponents? [LB171]

SUSAN HALE : Senator Johnson and committee members, I am Susan Hale. I am an advocacy educator and registered lobbyist with the Center for People in Need. And I have nothing to add in terms of why we should support this proposal. We see absolutely no downside to the measure and can see only benefits and would encourage you to advance it for further discussion. Oh, S-u-s-a-n H-a-l-e. I always forget that. [LB171]

SENATOR JOHNSON: Hold on one second...any questions? I see none, thank you very much. [LB171]

SUSAN HALE : Okay, thank you, Senator. [LB171]

JIM CUNNINGHAM: Senator Johnson, and members of the committee, good afternoon, my name is Jim Cunningham, J-i-m C-u-n-n-i-n-g-h-a-m. I'm the executive director of the Nebraska Catholic Conference which represents the mutual interests and concerns of the archdiocese of Omaha and the dioceses of Lincoln and Grand Island, testifying in support of LB171 for the reasons that you have heard. From our perspective, food is fundamental to human existence and assisting those are assisting those in need to meet their nutritional needs, is a social obligation. This bill is a practical way to carry out a more comprehensive and effective approach to meeting the subsistence needs of those who are eligible. And in essence, they are eligible because they daily battle against poverty. We supported a previous bill of this type in a prior session and see no reason to change our position on that and urge your advancement of this bill to General File. Thank you. [LB171]

SENATOR JOHNSON: Thank you very much. Any questions? I see none, thank you very much. [LB171]

JIM CUNNINGHAM: Thank you. [LB171]

SENATOR JOHNSON: Any other proponents? I see none. Any opponents? I thought we had two? Welcome again. [LB171]

SUSAN SMITH: (Exhibit 4) My name is Susan Smith, that's S-u-s-a-n S-m-i-t-h, chairman and committee members. I am opposed to LB171. If those who are eligible to receive the food stamp benefits already have access to the Food Stamp Program, I do

not understand what group we are trying to target to provide the food stamps for? Unless it would be for the illegal alien community that is in Nebraska, and that is my concern. This bill would be forcing Nebraska to ask for waivers to add more individuals to an already bulging Food Stamp Program, including illegal aliens. Bills like this and the senators who are introducing them may be in violation of our federal immigration law, Section 8 of U.S.C.1324 of aiding, abetting, inducing and encouraging, and in Section 274(A) harboring aliens. Nebraskans are already spending $126 million a year in benefits and services to illegal aliens. Those are people who are not legally authorized to be in our country or in our state. I realize that there are federal guidelines where you have to provide certain things for them, but to go one step further than what we absolutely have to, is really putting a financial burden and strain on the citizens of Nebraska. And I would ask that you not pass this bill to the floor. And I thank you for your time today. [LB171]

SENATOR JOHNSON: Thank you, Susan. Any questions of Susan? I see none. Thank you. [LB171]

MIKE HARRIS: (Exhibit 5) Good afternoon, Senator Johnson, and members of the Health and Human Services Committee. My name is Mike Harris, H-a-r-r-i-s, deputy administrator of the Office of Economic and Family Support for the Department of Health and Human Services. I'm here to testify in opposition to LB171 which directs the Health and Human Services System to apply for, and utilize any and all options and waivers available under the Food Stamp Program, including, and in addition, to a labor surplus area waiver. The bill stipulates that if the department is required to choose between or among waivers or options, the department shall apply for the waiver or option that is being projected the largest number of eligible persons, the largest amount of federal funds, or both. Food Stamp Program statutes and regulations provide state agencies with numerous policy options. State agencies use this flexibility to improve how the program works in meeting the nutritional needs of low-income people. Choosing certain options can facilitate program design goals such as removing or reducing barriers to access and sustained participation for low-income families and individuals, providing better support for those working or looking for work, targeting benefits to those most in need, streamlining administration and field operations, and coordinating Food Stamp Program activities with those of other programs. The Health and Human Services System currently utilizes 16 Farm Bill options and 19 waivers including a Labor Surplus Area waiver that covers all eligible areas. The federal Food Stamp Program has over 100 options and waivers available to all states. I might add here that the term, option and waiver, becomes a little bit unclear in the regulations, but I think there is a safe bet that there's between 40 and 50 options and then the rest would be waivers. Nebraska Food Stamp Program's policy staff routinely evaluate all waivers and options that are available using the following criteria: what is best for the families we serve; what is best for payment accuracy; and program administrative costs. Other states likely use similar criteria to select a package of tailored options and waivers

that work best for their programs and recipients. A federal report issued in February, 2006, showed that only nine other states implemented more options than Nebraska. The bill also requires the state to choose the waivers and options that are projected to bring the largest number of eligible persons, the largest amount of federal funds, or both. One option not currently being utilized by the state of Nebraska, but projected to bring in the largest number of eligible persons, is expanded categorical eligibility. This option is on President Bush's list of reductions in the proposed 2007 Farm Bill. This would eliminate resource limits and increase the gross income limit from 130 percent of the federal poverty level, to 200 percent of the federal poverty level. It is estimated that approximately 13,142 new food stamp cases could be added if this option is requested and approved. This option would allow families with little income or short-term employment with unlimited liquid resources, above the current $2-3,000 limit, to be eligible for food stamp benefits. This bill would require Nebraska to adopt this policy as it is the option that would bring the largest number of eligible persons. To be bound by legislation that would require the state to adopt options such as expanded categorical eligibility, would have an economic impact on state taxes, expand state government, increase training and require expensive reprogramming in the computer system. At the same time, this legislation will require the state to serve a new potential population that many might think have sufficient assets to purchase food without the government's help. This bill would also force the Food Stamp Program to adopt future options and waivers without the state being able to use discretion in developing policy. We do not deny any benefits to any able-bodied persons without children up to 130 percent of the federal poverty level if they are willing to perform 30 hours of community service a month. The administrative costs for the Food Stamp Program are funded at a rate of 50 percent federal and 50 percent state. Any impact on the number of eligible or value of food stamp benefits would be all federal with the exception of Electronic Benefit Transfer, or EBT transaction costs. If approved waivers constitute program expansions or increase caseloads, additional local office staff will be needed. It is estimated if the state would implement the expanded categorical eligibility option, that 75 percent, or 9,856 of the possible 13,142 new food stamp households, would actually apply for benefits. The addition of these cases would require 54 additional social service workers, ten case aids, ten client intake clerks, and five social services supervisors based on workload study caseload recommendations. The estimated cost for FY2007-2008, which is based on ten months to begin September 1, 2007, would be $3,220,999 and for FY2008-09 would be $3,414,700 of which 50 percent would be paid by state funds. The impact of other waivers or options is unknown at this time. Thank you for the opportunity to testify. I'd be happy to respond to any questions that you may have. [LB171]

SENATOR JOHNSON: Senator Howard. [LB171]

SENATOR HOWARD: Thank you, Chairman Johnson. I actually have two questions. I heard in earlier testimony that the state has had a plan for the federal Outreach option. Is this being utilized? [LB171]

MIKE HARRIS: The state of Nebraska does not have what's called a formal outreach program--we never have. We have kind of a passive outreach program. I'm not aware of a formal plan to submit an option to the federal government for that, Senator. [LB171]

SENATOR HOWARD: So you don't have a federal Outreach option in place, or you don't utilize it? [LB171]

MIKE HARRIS: The formal federal Outreach option would be actually hiring staff to perform the outreach activities as I understand it. Now Nebraska does have passive outreach activities. We have partnered with legal aid in terms of...they screen applicants that call them for legal advice. We do hand out information at grocery stores, a lot of distributional materials. Our staff across the state, when they are asked to speak in their local communities, will take about the Food Stamp Program. But as far as a paid position that their sole job is to do food stamp outreach, no, we do not. [LB171]

SENATOR HOWARD: Then that leads me into my next question. When you gave the figure of 80 additional staff, am I correct...79, 80, additional staff...would be required? You based that on the workload study, caseload recommendations? [LB171]

MIKE HARRIS: Yes. [LB171]

SENATOR HOWARD: Can you tell me what those are? [LB171]

MIKE HARRIS: It was a workload study that was completed in 1992 and it was based upon--it's used routinely in Health and Human Services bills when there is a possible expansion in programs. And it was based upon a joint labor and management recommendation and on the basis of this, 9,856 cases, just using that study, the requirement would be the 79 staff. [LB171]

SENATOR HOWARD: My question actually is, what are the caseload requirements? What is projected...well, let me ask this a different way. What's recommended in terms of caseload size? [LB171]

MIKE HARRIS: This figures out to be 182 food stamp cases per social services worker. And right now, that's a very good question--there's a lot of debate. I would say that the average program caseload for social services workers hovers around between 180 and 220. [LB171]

SENATOR HOWARD: So at the present time, you are already exceeding your own recommendations. [LB171]

MIKE HARRIS: Yes. [LB171]

SENATOR HOWARD: So your number for staff...if I take this math problem down further, your own number for staff would certainly be less than 79, or your request for additional staff based on this. [LB171]

MIKE HARRIS: I'm sorry? [LB171]

SENATOR HOWARD: Well, if we use the math problem that we're working on here, of the number of cases that workers are currently handling, and I'm not saying this as it should be, but if you take that number of cases, you certainly wouldn't require this number of workers. If you base it on the ideal number, you would, if you base it on the number that's currently being utilized? [LB171]

MIKE HARRIS: That would probably...I think what you're saying is true. [LB171]

SENATOR HOWARD: Thank you. [LB171]

SENATOR JOHNSON: Senator Pankonin. [LB171]

SENATOR PANKONIN: Senator Johnson. Thank you. Mr. Harris, were you here when the amendment that talked about... [LB171]

MIKE HARRIS: Yes, I was. [LB171]

SENATOR PANKONIN: ...would that, in your opinion, if we, did you see (inaudible) strike waiver, so it would still leave options in the bill? [LB171]

MIKE HARRIS: Senator, the waivers, like I mentioned before, it gets a little murky. But the waivers, when you are visiting with the federal government, are usually for administrative ease and simplicity. You can't apply for a waiver that's going to go against the regulations or the Food Stamp Act, but you could ask for a waiver that will ease administrative burdens, if you will. And so, to me, the term waiver never really fit into this bill because it would not, in most instances, ever bring in additional people. It is the option portion of this bill that actually, I believe, would...more targets that area. [LB171]

SENATOR PANKONIN: Okay, so in your opinion then, with the amendment, leaving the options in there, still doesn't change anything on the fiscal note? [LB171]

MIKE HARRIS: Oh it might, but very little, let's put it that way. It will to a small amount. [LB171]

SENATOR PANKONIN: Okay. All right. Thank you. [LB171]

SENATOR JOHNSON: Other questions? I see no other, thank you. [LB171]

MIKE HARRIS: Thank you. [LB171]

SENATOR JOHNSON: Any other opponents? Neutral? I see none. Senator Kopplin, want to close? [LB171]

SENATOR KOPPLIN: Thank you, Senator Johnson. Fifty-eight thousand young Nebraskans are not going hungry because of food stamps, but we can do better. I'm not here to cast any doubt on what Health and Human Services or the food stamp programs do, they do wonderful work for a lot of people. But we can do better; I'm convinced of that. I don't have data to dispute how many workers might be needed to put these programs in effect. I have doubts within me on the numbers that were give to us. It just doesn't seem accurate but I'm not going to dispute that. I like closings because you are the last one that gets to talk (laughter). And I'm going to tell you, it was been suggested that I should be impeached for even bringing a bill like this to you. After all, an illegal alien might benefit. I do not understand people that will say it's okay to let ten kids go hungry as long as one illegal alien doesn't slide in there; I don't understand people like that. Anybody that wishes to impeach me, my gosh, do me a favor, the way this year's going (laughter). If you don't want to elect me because I support hungry people, then go for it, I don't care. But do not sit here and tell me that we should not feed people because somebody might be an alien. Thank you. [LB171]

SENATOR JOHNSON: Thank you. And that ends the hearing on LB171. Next up, Senator Howard on LB518. Go ahead, Senator Howard. [LB171]

SENATOR HOWARD: I have to say good job, Senator Kopplin. Thank you, Sir. Good afternoon, Senator Johnson and members of the Health and Human Services Committee, for the record, I am Senator Gwen Howard and I represent District 9. I'm here today to introduce LB518. LB518 changes the provisions of eligibility for children less than 19 years of age and pregnant women with family income equal to or less than 185 percent of federal income poverty guidelines who receive medical assistance from Nebraska Health and Human Services System, under Nebraska's Kids Connection Program. The bill extends the initial length of coverage from six consecutive months to twelve consecutive months of continued eligibility prior to the redetermination of eligibility, and changes the provision for month-to-month redetermination review to twelve months of continuous eligibility between each redetermination period. Essentially, this would mean that eligible mothers and children would be reviewed annually for continued eligibility in Kids Connection's Medical Assistance Program. Eliminating the month-to-month review requirement following the initial period of eligibility, is not setting a new precedent for the Health and Human Services System. There are other public assistance benefits which they administer which have extended

redetermination reviews. This change, as indicated in the fiscal note, would save administrative costs which means case management costs. However, contrary to what is reflected in the fiscal note, this change would not enable individuals who no longer meet economic eligibility guidelines, to receive assistance once their eligibility has changed. Like other public assistance programs administered by Health and Human Services, participants would be required to notify their case manager if they experience a change in income that would alter their eligibility. Individuals who do not report changes in income that would make them financially ineligible, would be required to make restitution on expenses incurred by the system just as they do now with other programs. Kids Connection Programs are financed jointly through the state and federal funds. Most of the children who receive medical assistance from these programs, come from families with a working parent who is either not offered or cannot afford healthcare coverage. This bill would ensure that children who need healthcare coverage, would have continuous coverage without costly and time-consuming monthly redetermination reviews. Following my testimony, you will hear from the Nebraska Appleseed group who can offer you more details about the intent of this bill. I encourage you to listen closely to this information. Consider the stress that you could feel if you found yourself in a position where you were working and yet were not able to meet the basic healthcare needs of your child. Thank you. [LB518]

SENATOR JOHNSON: Any questions? Senator Howard, you've got a pretty healthy fiscal note as I see here. Where do you think you are going to go with that? [LB518]

SENATOR HOWARD: Well, you know, I think I'm singing to the choir when I say that there are expenses connected with medical assistance. [LB518]

SENATOR JOHNSON: (Exhibits 6, 7, 8) Let me say that there are letters of support from the Nebraska Association of Behavioral Health Organizations, Nebraska Planning Council on Developmental Disabilities, and the Nebraska Hospital Association. Any other questions? I see none, Senator Howard, thank you. [LB518]

SENATOR HOWARD: Thank you. [LB518]

SENATOR JOHNSON: How many proponents do we have? Six or eight? How many opponents? One, maybe two? All right, first proponent please? There's lots of empty seats up front, why don't you come on up and then we won't have to wait in-between? [LB518]

JENNIFER CARTER: (Exhibit 1) Good afternoon, Senators, my name is Jennifer Carter, that's C-a-r-t-e-r. I'm a staff attorney at Nebraska Appleseed. First, we'd like to thank Senator Howard for bringing this important bill, and I'm handing out my testimony, so I won't read it. But I'd like to cover a couple of key points: one is that as we mentioned, and frankly I haven't looked at the fiscal note recently, so I don't remember the

numbers. But while it obviously does cost money to cover children, we brought around today, I believe, to all your offices, what we entitled an explanation of benefits. We have to remember with SCHIP, over 70 percent of the funding comes from the federal government. That draws down a lot of federal money into the state which just, it flows into our economy, helps with business activity, can help create jobs. So we have to remember there's another side to the cost that we actually get quite a benefit from that as well. And the other two points we'd like to make are based on participation and continuity of care. When a child is cut off after six months, it forces the family, really the child ends up likely not participating in the program any longer. So if they were being treated by a particular doctor, in the seventh month when it is determined that they are no longer eligible and they get cut off, they likely can't see that doctor again if they can't afford it. If they were in the process of a diagnosis, that gets stopped and they are no longer able to treat particularly children with chronic illnesses. Those illnesses--often low-income families are working on shifts or maybe seasonal work and if in that seventh month--and I keep using that as an example because right now we're...continuous eligibility ends at six months. Maybe that month was a flush month for the family but then month eight or month nine it's not going to be. And that requires a family, often in situations where it's difficult for them to determine that, too, on their own, determine, what was my income? Is it worth it for me to take an afternoon off work which is often very difficult for these families, to go down and fill out what is now a 20-page application that often professionals have difficulty filling out, in order to get my child back onto the program? We just...we're putting up a lot of barriers. There are barriers to participation in the first instance, and this puts an additional barrier on families who actually made it onto the program and had the benefit. There are also physical benefits to having children on the program which is that they don't use the emergency room as much. They get primary care. They are not waiting until an illness gets to a point where it's much more expensive to treat. They are less likely to miss school. They get immunizations--there are so many benefits to this program that the state sees from keeping the children on. And the other point is just continuity of care. If you have a child working with a certain doctor that accepts Kids Connection, when they are cut off Kids Connection, they often can't return to that same doctor if they can't afford it, or they just stop going to the doctor because they don't think they have...can't afford it, don't have any health coverage, and they might choose another doctor the next time, and you don't have any one person who understands this child's history when they're examining them. So we think those are some of the more critical points, and I am more than happy to answer any questions. [LB518]

SENATOR JOHNSON: Any questions? Senator Stuthman. [LB518]

SENATOR STUTHMAN: Thank you, Senator Johnson. Jennifer, do you feel that if we make another six months, make this a year, are the people going to say well, oh, I got a full year of assistance and that relieves me, as a parent, of having to make enough money to help these children? Is all we are doing, in my opinion, for just extending it for

another six months of the family's accepting the responsibility that they have to make the choices for the children and make the expenditures for the children? Do you feel that could happen? [LB518]

JENNIFER CARTER: I don't because I think--I see your point--but I think when we are talking about the reality of what's happening in these families and what the cost of healthcare is today, either just for a doctor's visit or to actually buy your own insurance in the private market? Most low-income families are not getting employer-sponsored coverage. They would have to pay for it themselves, I mean, family coverage is running $700 to $1,200 a month. When you are barely taking home that much; if you're at 100 percent of poverty and you're a family of four making $20,000, there is no way with child care so that you can work, with rent, with food costs, everything else, that you could ever afford any of that. So I don't think it's a matter of families not making the choices, I don't think there is a choice. I think they go without healthcare or they are able to have the benefits of this program. So I don't necessarily think, for most of the families that we've heard from and that we work with, this is not them not prioritizing their economic needs, this is just an impossibility without having the critical coverage that Kids Connection offers. [LB518]

SENATOR STUTHMAN: Jennifer, do you feel that there is a system in place where if they are uninsured that they can get medical assistance through health departments? [LB518]

JENNIFER CARTER: I mean, I think there's some, and frankly I don't know as much about exactly what the health departments offer, but I mean I know there are immunizations that children can get through the health department. But in terms of your regular primary care and well-child visits, I don't think it works as well as Kids Connection works. And also I think when we're talking about families, do they know about those programs? Are they using them? I don't know that they are comprehensive enough, and that is not necessarily their role to be comprehensive in that way. What you end up is families visiting the emergency room and that costs all of us more. And I think that's something that's important and hard to see in our everyday lives, but more and more, we are going to have to come to terms with the fact that when we have an uninsured population that's growing, that actually costs all of us money. And it increases the healthcare costs in the entire system and it's a house of cards, it's going to collapse eventually. And aside from it being the right thing to do, I think it's...in the long term, it makes more sense to take care of this now. [LB518]

SENATOR STUTHMAN: Okay, thank you. [LB518]

JENNIFER CARTER: Thank you. [LB518]

SENATOR JOHNSON: We're getting kind of lonely here... [LB518]

JENNIFER CARTER: Yeah, I can really clear a room. (Laughter) [LB518]

SENATOR JOHNSON: Oh, thank you very much. Next please? [LB518]

BRANDI HOLYS TUMBLESON: (Exhibit 2) Good afternoon, my name is Brandi Holys Tumbleson, B-r-a-n-d-i H. T-u-m-b-l-e-s-o-n. I'm the director of programs and public affairs for the March of Dimes, Nebraska Chapter. I do have my testimony to pass out, so I'll just try to highlight a few things that haven't been mentioned already or emphasize what has been mentioned. We appreciate this opportunity to provide testimony on this issue and it is a foundation-wide priority for the March of Dimes Foundation to make sure our children have health insurance. According to a recent report from the Institute of Medicine, as it's already been said, whether or not a child has health insurance is the single most important factor in determining access to adequate care. The uninsured usually forego regular well-child checks and other preventive care. To put some numbers on the face of emergency care as it was mentioned before, this is actually numbers that were provided to me from a colleague in Texas that were from Harris County data. But from quick calls this morning to some Omaha-area clinics and hospitals, they confirmed that this is about right on for even the Nebraska area, that to provide treatment for an asthma attack for a child in an office, if they can go to their regular doctor or go to their allergist, or doctor that treats asthma, they can use a nebulizer and use medications and provide treatment for a severe attack for about $100 if it is addressed right away. If the family doesn't have insurance and they delay care and present in the emergency room and the child has to be hospitalized for three days, the cost can end up being around $9,000. So that is a good example of a pay now or pay later scenario that the State Children's Health Insurance Program can put us in...and a good reason why we shouldn't end coverage at six months and perhaps extend it to twelve. Another study that the March of Dimes did found that when parents had to recertify their children's eligibility, half dropped out of the State Health Insurance Program, so there was a cost savings initially but then one -quarter returned in two months. And then within the next six months, 70 percent returned. So it's seeming that the families aren't dropping off the program because they are making too much money and slipping through the cracks. The reason that they are falling off the program is simply the paperwork the process of getting the coverage extended. And most important to us, children's health insurance is very important to the March of Dimes, but most important is our infant health. Nationwide, of the approximately four million infants born in a hospital, more than 200,000 were uninsured in the year 2000. It is critical that every infant has a constant source of healthcare during the first year of life and that's especially important for the 150,000 babies born with birth defects and more than 480,000 babies born premature. These are babies that have complicated medical situations and they need to have that first full year of coverage. [LB518]

SENATOR JOHNSON: Arnie? [LB518]

SENATOR STUTHMAN: Yes, thank you, Senator Johnson. [LB518]

SENATOR JOHNSON: I just knew that you had a question. [LB518]

SENATOR STUTHMAN: Brandi, I want to ask you the same question I asked the other...do you feel that this program, if we extended another year, will just make the people have to...they've just got another six months that they don't have worry about being responsible for their child's medical attentions? [LB518]

BRANDI HOLYS TUMBLESON: You know, call me an optimist about this, maybe I am just too optimistic, but I truly believe it won't. You know, I mean, this kind of work that you do for a nonprofit, you don't do it for the money, so I certainly have a passion for what I'm insuring in our women's and children's health interests. Actually, in my personal life, my spouse, to put himself through school, he's finally finishing...has been working in the emergency room and he has seen many cases where he feels like, you know, we're seeing the same people in and out. We're seeing people not use their primary care doctors, things like that, and will come home very frustrated at the end of the day and I have to remind him if we take these steps to be proactive before, we will actually save money in the long run most likely. And also prevent these situations where emergency rooms are backed up, emergency rooms are mailing people huge bills, hospitals are raising their costs because of the costs they have to absorb for people that can't pay their bills that are on self-pay. And so I truly don't believe that parents are trying to, let's get an extra six months. I'm sure, you know, you could find somebody out there, but I don't think that's the majority of the cases. And especially with infants, we've found out anecdotally, I receive calls all the time from families that have a premature infant and their parents lose their job because they are spending time at the (inaudible) because they're critically ill, so I don't think that abuse is the primary reason for that. [LB518]

SENATOR STUTHMAN: Brandi, do you feel then if we would extend this to a year that next year we'd come back and say that worked out so good for having it a year, why don't we just make it two years? [LB518]

BRANDI HOLYS TUMBLESON: You know, I'm not going to shut the door to that but I think a year is a good time because I do think it's reasonable to have a review of salary and a review of requirements, the March of Dimes feels that way. We're not saying put people on this program indefinitely, we do need to worry about the costs to the state and we do need a review process. So I think a year provides a happy medium at that point? That it could be something like going back to school, or back to school time, you make sure you redo your paperwork if you still are qualifying for the State Children's Health Insurance Program. [LB518]

SENATOR STUTHMAN: Thank you, Brandi. [LB518]

SENATOR JOHNSON: I guess I'm onery here, I'm not going to get to my four o'clock meeting, so (laugh) no, but you kind of touched on one thing and it is a problem to us. And what it is, is this: you said your husband was a student or you are a student, or you both are, or whatever, the Governor's budget made no increase in the money for the university. Now you are proposing close to $14 million for this. Do you want us to cut the university $14 million? [LB518]

BRANDI HOLYS TUMBLESON: Well, those are difficult questions and you're right in being onery in asking (laugh) that of me. But I think... [LB518]

SENATOR JOHNSON: But that's our problem on this side of the table. [LB518]

BRANDI HOLYS TUMBLESON: Exactly, we recognize that. [LB518]

SENATOR JOHNSON: And that's where the difficulty comes through, when you have programs that cost this kind of money. [LB518]

BRANDI HOLYS TUMBLESON: The devil is in the details, isn't he? [LB518]

SENATOR JOHNSON: Yeah. [LB518]

BRANDI HOLYS TUMBLESON: I think and in phrasing it in that way, we have to decide where it's going to do the most good, and yes, education is something that we all need. And education does improve society but also the fact of that these families are the families with the lowest amount, you know? I don't make a ton of money but I certainly, I don't have children. I certainly couldn't imagine raising two or three children on my salary let alone on a $20,000 salary. I certainly couldn't imagine paying for the health insurance needs, to feed them, to clothe them, to educate them on $20,000 as a single mom. And I think that's where those decisions come in, you know? Yes, it would be wonderful to support the university. I would love you to support my personal student loan program, but I think we have to look at where the most needy people are and the most resources are. And the rest of us continue to do our civic duty and work hard. Thank you. [LB518]

SENATOR JOHNSON: Thank you. [LB518]

BRANDI HOLYS TUMBLESON: Thank you. [LB518]

SENATOR JOHNSON: Next please? [LB518]

SARAH ANN LEWIS: (Exhibit 3) Good afternoon, Senator Johnson, Senator Stuthman.

My name is Sarah Ann Lewis, L-e-w-i-s. I am the policy coordinator and registered lobbyist for Voices for Children. We would like to commend Senator Howard today for bringing forward LB518 and support the extension of coverage for children receiving Kids Connection to twelve continuous months. Currently the six-month continuous coverage is not meeting the needs of the children and families Kids Connection is intended for. It is unfortunate that such an effective program for children's health is not being put to effective use. Sixty-five percent of eligible persons by category, are children in the Medicaid program only taking up 26 percent of total expenditures. We say that Kids Connection provides health coverage to families making up to 185 percent of federal poverty level, but that isn't the whole truth. In reality, we provide and renew Kids Connection based upon three-month increments of income rather than annually. Even if a family's annual income falls below the qualifying 185 percent of federal poverty level, or around $30,710 a year for a family of three, the children could go uninsured yet be eligible. Income eligibility for Kids Connection renewal is determined on the prior three months of a family's income at the time of renewal. As the end of the six-month period nears, families are contacted through the mail asking if they wish to apply for an additional six-month period for their children. If so, they must complete a short review form and provide verification of any reported changes in wage stubs for the previous three months. The difficulty families are facing in applying and reapplying, prevents children from receiving care and cripples the effectiveness of this program. Recently we learned of one family who applied in October, was accepted in February, and received the renewal notice at the same time of acceptance. A large base of Nebraska's workforce is composed of individuals who are self-employed, seasonal, or part-time workers. As such, many of those individuals have incomes that fluctuate monthly. Imposing a review of three month's worth of income for eligibility redetermination results in kids shuffling in and out of the system as parents' income changes. We receive reports from health care providers that the burden involved in maintaining the children's enrollment in Kids Connection, is preventing many parents from even applying for coverage. Many apply only when the children are gravely ill. The 2002 reduction in eligibility from twelve continuous months to six was a cost-savings measure done knowingly that an estimated 10,000 children would be cut from the program and an additional 60 workers would be needed to review cases. If twelve-month continuous coverage is restored and income eligibility becomes based on annual income rather than the prior three months, it will relieve the burden on families and reduce the administrative burden on caseworkers, increase the overall health of the children in our state, and provide Nebraska with indeterminable cost savings by providing eligible children with health coverage. The goal of Kids Connection is not to prevent children and families from utilizing it, but to ensure eligible children receive health coverage statewide. Following this hearing today, one will be held on LR10 of which the majority of you sitting on this committee have introduced. I applaud your efforts and will provide support of the particular resolution. And at the same time, I respectfully ask as you urge the Governor in LR10, to use his best efforts to provide meaningful assistance to help identify and enroll children who qualify for Kids Connection, you do the same by voting

LB518 out of committee for debate by the full Legislature. I thank you. [LB518]

SENATOR JOHNSON: Any questions? Senator Stuthman. [LB518]

SENATOR STUTHMAN: Thank you, Senator Johnson. Sarah, what year did this Kids Connection Program start? [LB518]

SARAH ANN LEWIS: In 1998 was when federally, the SCHIP program... [LB518]

SENATOR STUTHMAN: In 1998... [LB518]

SARAH ANN LEWIS: ...um-hum, they will be coming up for a ten-year authorization. [LB518]

SENATOR STUTHMAN: Are you aware of the situation that happened when this program started and families that were paying for their insurance for their kids, took them off the insurance and put them into the Kids Connection Program? [LB518]

SARAH ANN LEWIS: No, Senator, I'm not. [LB518]

SENATOR STUTHMAN: Okay. Thank you. [LB518]

SENATOR JOHNSON: Any other questions? I see none. Thank you. [LB518]

SARAH ANN LEWIS: Thank you. [LB518]

SENATOR JOHNSON: Next please? [LB518]

SUSAN HALE: Senator Johnson and committee members, I'm Susan Hale, advocacy educator and registered lobbyist for the Center for People in Need. That's S-u-s-a-n H-a-l-e. I want to commend Senator Howard for proposing this measure. To state our reasons would be definitely redundant. I simply would urge you to advance this proposal for further consideration. Thank you. [LB518]

SENATOR JOHNSON: You get our blue star award for the day (laughter). [LB518]

SUSAN HALE: Would this help me get another bill out of committee? (Laughter) [LB518]

SENATOR JOHNSON: Thank you. Next please? [LB518]

ROSLYN FRASER: Good afternoon, my name is Roslyn Fraser, R-o-s-l-y-n F-r-a-s-e-r. I'm a health services researcher. I was asked to testify today independently in consult

with Voices for Children. And I wanted to start with just a touch of a little bit of history. In 2004, the state of Nebraska and the University of Nebraska Medical Center conducted research on uninsurance as part of the Nebraska State Planning Grant. This is currently in its third year and results of all the studies conducted are published and available to the public on the HHSS web site. I'm asked to reiterate some of the findings in this published research that are pertinent to a discussion of LB518. Part of the research was a household survey and the other part of the research was focus groups, 22 focus groups were conducted with 211 participants across the state. This is where this information comes from. Uninsured participants described barriers to obtaining public insurance and this includes SCHIP public insurance for their children. And these barriers included confusion over eligibility guidelines, lack of information or understanding due to illiteracy and/or language barriers, not understanding the healthcare system and the role of insurance, feeling confused by the application process, inability to repeat the application process due to inflexible work schedules, and feeling intimidated occasionally by caseworkers that they viewed more as gatekeepers rather than advocates. Additionally, Hispanic focus group participants reported numerous barriers to obtaining insurance that were specific to them. This included an errant fear that enrolling themselves or their eligible legal children in public plans, would result in possible deportation. So this is what the researchers heard. Under current enrollment guidelines, families are expected to overcome the barriers that I've just stated, a minimum of two times a year. So considering the importance of the continuum of care, and it's possible that moving to 12 months eligibility will be in the best interests of eligible Nebraska children. [LB518]

SENATOR JOHNSON: Any questions? Senator Stuthman. [LB518]

SENATOR STUTHMAN: Thank you, Senator Johnson. [LB518]

SENATOR JOHNSON: What did you have to eat before you...you were late getting here? You got all these questions? (Laughter) [LB518]

SENATOR STUTHMAN: I thought that's what this is about? (Laughter) [LB518]

SENATOR JOHNSON: Oh, I forgot--thanks, excuse us for having a little fun. [LB518]

SENATOR STUTHMAN: Roslyn, kind of following up on the question that I had asked the center before, of the people enrolled in Kids Connection, enrollment in that, is that for dental work also? [LB518]

ROSLYN FRASER: Uhm, I believe that SCHIP does cover what they would consider basic primary care and dental is included to my knowledge, yes. [LB518]

SENATOR STUTHMAN: And I'll just give you the situation that I am aware of dentists in

my community that were working on children doing their...and being paid the regular price. Now those children are enrolled in the Kids Connection and the dentist is not able to receive as much money for that thing and the children are from families that he's been working with for many years. And he was really upset about the fact that they enrolled them into the Kids Connection and now he had to do the work for a lesser amount, so I just wanted to clear... [LB518]

ROSLYN FRASER: And those children were still getting dental care though. [LB518]

SENATOR STUTHMAN: They were still getting dental care, but the families enrolled them in the Kids Connection where they just had their own insurance prior to that. [LB518]

ROSLYN FRASER: And this is something that you saw in 1998 when the change occurred? [LB518]

SENATOR STUTHMAN: Um-hum, yes, that's right. [LB518]

ROSLYN FRASER: Okay. [LB518]

SENATOR STUTHMAN: Okay, thank you. [LB518]

ROSLYN FRASER: Thank you. [LB518]

SENATOR JOHNSON: Jim? [LB518]

JIM CUNNINGHAM: Senator Johnson, members of the committee, my name is Jim Cunningham. I appear in my capacity as executive director of the Nebraska Catholic Conference in support of LB518. From our view, adequate healthcare is a basic human right which stems from the inherent dignity of human life. The increased continuity proposed by this bill equals greater stability, equals less disruption, equals less stress, all of which are better for the children and better for meeting their healthcare needs. Therefore we encourage you to move this bill to the floor for General File debate. Thank you. [LB518]

SENATOR JOHNSON: Any questions of Mr. Cunningham? I don't see any, Jim, thank you very much. [LB518]

JIM CUNNINGHAM: Great. Thank you. [LB518]

SENATOR JOHNSON: Next please? [LB518]

MICHAEL SHAMBAUGH-MILLER: (Exhibit 4) Good afternoon, Senator Johnson, and

members of the committee, my name is Michael Shambaugh-Miller, I'm a professor of health services research. I'm here in my role as the chairman of the legislative subcommittee of the Nebraska Minority Public Health Association. The NMPH would like to voice our support of LB518 and we would like to personally thank Senator Howard for bringing this argument forward for the children of Nebraska. It is known that the issue of uninsurance is a priority for the Nebraska Minority Public Health Association because it's known that racial and ethnic minorities are disproportionately affected by uninsurance. If we improve the health of minority children in Nebraska, we feel that this priority would also have a positive impact. As noted by one of the previous testifiers, in 2004 NHHS and the UNMC, did conduct a study on uninsurance in the state in which it was found that uninsurance negatively impacts physical and psychological quality of life. Uninsurance negatively effects the economic development, and decreases the overall health of Nebraska communities, and that the poor are overrepresented among Nebraska's uninsured with 79 percent of the uninsured living in households with a total income of less than 300 percent of the poverty level. It is also known that poverty disproportionately affects minority families. Hispanics are overrepresented among the uninsured with 27 percent of Nebraska's Hispanic population being uninsured versus 9.9 percent of the overall Nebraska population. Also Hispanic Nebraskans face numerous barriers to obtaining insurance including language and cultural barriers, confusion of the healthcare system as a whole, confusion of the rules of eligibility for public programs, and fear that enrolling themselves or their documented children, could result in deportation of the parents. Applying for Kids Connection places a burden on low-income families already short on time, transportation, and other resources. By moving from six months to 12 months eligibility, reduces this burden on the families and therefore will increase the number of eligible children who receive necessary healthcare. From this, and an increased number of Nebraska's minority children will have improved physical and psychological quality of health. The Nebraska Minority Public Health Association believes LB518 is the appropriate measure to maximize the number of Nebraska minority children who will receive uninterrupted Kids Connection coverage. We appreciate your attention to this measure. Thank you. [LB518]

SENATOR JOHNSON: Any questions? Sir, I see none. Thank you very much. Any other proponents? Any opponents? Welcome again. [LB518]

MARY STEINER: (Exhibit 5) Thank you. Good afternoon, Senator Johnson and members of the Health and Human Services Committee, my name is Mary Steiner, S-t-e-i-n-e-r. I'm the Medicaid director for the Department of Health and Human Services Finance and Support. I'm here to testify in opposition to LB518. LB518 changes the Medicaid eligibility for children to twelve consecutive months of eligibility. This an option under federal Medicaid rules that allows for continuity of services. When Nebraska implemented the State Children's Health Insurance Program, SCHIP, in 1998, as part of Medicaid, eligibility for children age 18 and younger was expanded from monthly to 12 continuous months. Later, Nebraska reduced the eligibility period for

children from 12 months to an initial six months guarantee with LB8 of the special session in summer of 2002. This change was made to save Medicaid funds and only removed children who no longer qualified. Nebraska Kids Connection Program provides healthcare services to over 129,000 per month. These children, under age 19, reside in families with incomes below 185 percent of the federal poverty level. For a family of four, this is $3,184 per month and $38,208 annually. The Medicaid Reform studies reported that increasing costs of the Nebraska Medicaid Program cannot be sustained into the future. If changes are not made, funding would not be sufficient to continue to fund the program as we know it. Expanding eligibility at this time would be contrary to efforts to reduce Medicaid spending and funding services to children who no longer meet eligibility criteria, is contrary to reform efforts. The additional cost to provide services to children for an additional six months when they no longer qualify, is $15 million total funds for the first full year, with $5.8 million of General Funds needed. This change is expected to impact 37,000 children in the first full year with incomes in excess of program standards, or those that fail other program requirements whose cases would no longer be closed at the six-month time period. As a clarification for a couple of things that have already been said, even though, under this bill, we would guarantee eligibility for 12 months, we would not do a test of the prior 12 month's income. We wouldn't wait until you've been impoverished for a year and then test income. The income would be tested if then your current status, and we do cover the first full year of life after birth now under the Medicaid program, that's part of the eligibility rules. That is not limited to six months right now for newborns. Any questions? [LB518]

SENATOR STUTHMAN: Thank you, Senator... [LB518]

SENATOR JOHNSON: There he goes, Senator Erdman...or Stuthman, excuse me. [LB518]

SENATOR ERDMAN: That's the best compliment you've had today, Arnie. (Laughter) [LB518]

SENATOR JOHNSON: Yes...yeah. (Laugh) [LB518]

SENATOR STUTHMAN: As far as the age wise, yes, thank you. (Laughter) [LB518]

SENATOR ERDMAN: Looks too, I would argue. [LB518]

SENATOR STUTHMAN: Mary, in your statement, it was stated here, and when you went from the 12 months to the six months and it said to save Medicaid funds, and only remove children who no longer qualify. Was that because of it was over six months or is that because there was people in the program that realistically shouldn't have been in there and they didn't qualify? [LB518]

MARY STEINER: Right. If beyond the six months the children still meet, who have qualification, their cases are left open until they report any income that's in excess of standards, or maybe a child leaves the household, there might be something that changes so the child no longer meets eligibility. But for the time that the children still meet eligibility, we continue on with their eligibility today. So what this impact is that there is a guaranteed 12 months so even though something might change, and income is reported, we don't act on it under a 12-month rule until that 12 months has elapsed. And then we do the income test again. [LB518]

SENATOR STUTHMAN: So, realistically, Mary, the fact that in seven months or six months, if there was a 12 month, they could be having enough income and everything but you would never check it and then these kids would still qualify? We would be... [LB518]

MARY STEINER: Those are what we're eliminating. [LB518]

SENATOR STUTHMAN: ...we would be paying and it's for kids that wouldn't qualify. [LB518]

MARY STEINER: Right. [LB518]

SENATOR STUTHMAN: And I think that's a good statement because realistically it's abusing the program because those families are not eligible for that child to be in the Kids Connection Program because of an increase of income or ineligible to participate. But if you go through a whole year, you only look at it for a year, will you? [LB518]

MARY STEINER: Right. [LB518]

SENATOR STUTHMAN: Okay. Thank you, Mary. [LB518]

SENATOR JOHNSON: I see no other questions, thank you. Neutral testimony? Seeing none, Senator Howard? [LB518]

SENATOR HOWARD: Just a couple of points of clarification. Senator Stuthman, I was interested in your comment regarding the dentist in your area that seemed to be suffering some financial losses. Curiously enough, I was recently at the opening of a dental clinic in Omaha called Small Smiles, and they are looking to specialize in children who need their care and they are willing to go through the Medicaid and the Kids Connection Program. And when I talked with them about this, they said really, there was no discernible difference in the payments that they expected to receive through each of these programs and were perfectly willing to work with both of them. So I hope that answers that particular question for you and possibly consoles the dentist in your area. It's impossible to know the stress for having to requalify for health insurance every

month to cover the health needs of your child unless you've been in that position. But imagine the decisions you'd be forced to make, would you start treatment for your child's long-term manageable illness if you knew that next month you would not be able to pay for it? Would you take a pay increase at your minimum wage job, a promotion that would increase your family's economic self-sufficiency, if you knew it might cost you your child's health insurance? Ensuring health coverage for children is critical not only to the health and wellbeing of the individual child, but to the overall wellness of our communities. And I certainly ask you to support LB518. I'd add, in addition, that 185 percent of poverty, if you can imagine that amount, Nebraska is among the ten lowest states in the country. Also, kind of an interesting point is that Nebraska Health and Human Services does provide a web site for Kids Connect, and on that web site, information for the general public, they state over the next five years, $15 million in new federal funds through Title XXI of the Social Security Act, and $5.5 million in matching state money, will be made available annual to Kids Connection. An estimated 24,000 Nebraska children under 19 who are at or below 180 percent of the poverty level, do not have health insurance. They follow that with recommendations for Nebraska's Children's Health Insurance Program, Medicaid coverage will be raised to 185 percent of the current poverty level for all children ages zero through 18. The second one I found very interesting: 12 months of continuous eligibility for Title XIX and Title XXI recipients. Thank you for your attention to this matter. [LB518]

SENATOR JOHNSON: Thank you. That closes the hearing on LB518. We'll proceed to LR10. Senator Erdman, can you be here for the next bit and take over? [LB518]

SENATOR ERDMAN: You got it, Mr. Chairman. [LR10]

SENATOR JOHNSON: All right. [LR10]

SENATOR ERDMAN: Can I see a show of hands for those who wish to testify on LR10? I see four? Okay. Senator Johnson, you are recognized to open on LR10. [LR10]

SENATOR JOHNSON: Senator Erdman and members of the committee, I'm Senator Joel Johnson, J-o-h-n-s-o-n. I represent the 37th District. We've heard much this afternoon about various programs. What this is, is just a resolution to petition the U.S. Congress to reauthorize the State Children's Health Insurance Program, in other words what we have right now, lest the state of Nebraska be left in a lurch. The children's program was started in 1996, known as Kids Connection. Health coverage is vital as we've all heard many times today. The SCHIP program has reduced the number of uninsured children in the United States by a third. Now the federal government has encouraged Nebraska's participation by paying 72 percent of the cost of this SCHIP program. Nebraska's Kids Connection Program has been equally successful, 137,000 children served by the program. Children account for 64 percent of the Medicaid population but only 25 percent of the spending. Now...got costs average $235 a month.

Now there are 30,000 children that still are reported to be uninsured. SCHIP is up for reauthorization in the Congress and a failure to reauthorize this program in a timely manner, and with proper amount of funding, will risk cutting off these critical health program services that are in place. Nebraska would have a shortfall of $14 million if this were the case. Now there's other people behind me that will testify regarding this, and with the lateness of the afternoon, I will conclude with that and let the other people address those questions. [LR10]

SENATOR ERDMAN: Thank you, Senator Johnson, any questions? I see none, thanks, Sir. Do you want... [LR10]

SENATOR JOHNSON: I will waive closing. [LR10]

SENATOR ERDMAN: You got her. We'll take you up on it. We'll take the first proponent of LR10. How many wish to testify in support of LR10? We had four and I'm assuming we have four? Okay, come forward. And if you are in the back of the room, please come forward and be prepared to move expeditiously to the chair. That way we can facilitate our process and get through all the bills today. [LR10]

SARAH ANN LEWIS: (Exhibit 1) Good afternoon, I will try to help with that. Senator Erdman, members of the committee, my name is Sarah Ann Lewis, L-e-w-i-s. I am the policy coordinator and registered lobbyist for Voices for Children in Nebraska. We are here today to support LR10 and we thank Chairman Johnson for bringing this issue to attention. For a number of months now, we've worked along with partners, both locally and nationally, to garner the necessary attention due to the projected SCHIP shortfalls facing Nebraskans and 16 other states, as well as the impending SCHIP reauthorization. As welcome relief, Congress passed H.R. 6164 before adjourning last year, delaying the projected SCHIP shortfalls by several months. In the interim, we support a timely SCHIP authorization to ensure Kids Connection continues to provide quality healthcare for Nebraska's children. LR10 expounds on the importance of providing children with health insurance, and the need to timely reauthorization of the SCHIP, which over the last 10 years has provided hundreds of thousands of Nebraska children with low cost, essential health coverage. It is no light matter when a simple checkup can prevent a child from filling a seat in the waiting room of the emergency room. Through timely SCHIP reauthorization and adequate federal funding, Nebraska has the continued potential to successfully close the coverage gap for our state's children and provide access to comprehensive healthcare which will keep our children healthier and more productive while saving our state money in the long run. For these reasons we support LR10 and we sincerely thank you for your timely attention to this matter. [LR10]

SENATOR ERDMAN: Thank you, Sarah. Any questions for Ms. Lewis? I don't see any. Thank you, ma'am. Next testifier in support? [LR10]

JENNIFER CARTER: (Exhibit 2) Senator Erdman, members of the committee, my name is Jennifer Carter, C-a-r-t-e-r. I'm still a staff attorney at Nebraska Appleseed (laugh). We'd like to thank Senator Johnson for bringing what we think, a critical resolution on a program that we obviously think is very critical to the children in our state. A lot has been said about how wonderful the program is. It has truly been a real success, both nationally and in Nebraska. It's cost-effective, it helps kids get healthcare which is sort of obvious. And so we certainly...it needs to be supported and I think our federal delegation needs to hear that we support it. Just one point about the funding, while the program needs to be reauthorized, it needs to be authorized at increased funding. When the shortfall that was mentioned that is scheduled to be about $14 million next year for Nebraska, that is only going to grow and that is, if the program is just reauthorized, we authorize at the current funding levels which is no longer enough to cover the current caseload that we have. One other point is in my last testimony on LB518, Mary Steiner pointed out to me afterwards that... [LR10]

SENATOR ERDMAN: Hold on a second, is this reflect... [LR10]

JENNIFER CARTER: No it's LB518, it's related to the funding that I want to clarify. When we say we get 70 percent of the federal match that is on SCHIP, that is correct unless we don't have enough money in SCHIP which is currently where we're at. And then we fall to a Medicaid match, which currently, in the Federal Register, is a little over 57 percent. So if we are not funded...if we don't get the amount of funding that we need, some kids will still be able to be covered under the program, which is great and it's to Nebraska's credit that that is how we've set up our program. But we end up losing what could be that differential between the 70 percent and the 57 percent. And so I think that's why we want to encourage our federal delegation to not only reauthorize the program, but reauthorize it at funding levels that will allow us to continue our caseloads at our current levels and not leave potential federal money on the table in terms of the differential for that federal match. So we are grateful for the resolution. We wholeheartedly support it and would urge you to move it to the floor, and I'll take any questions. [LR10]

SENATOR ERDMAN: Thank you, Jennifer. Any questions for Ms. Carter? I don't see any. I just wanted to make sure we weren't trying to rehash a bill that... [LR10]

JENNIFER CARTER: No, I wasn't, sorry. [LR10]

SENATOR ERDMAN: Very good. Thank you. Next testifier in support please? [LR10]

SUSAN HALE: Senator Erdman, committee members, Susan Hale, S-u-s-a-n H-a-l-e, advocacy educator and registered lobbyist for the Center for People in Need. We thank Senator Johnson and others who have proposed this resolution. We too, really would

like to see some language in there regarding the funding? As Jennifer indicated, we are going to be far short and since most of you on the committee are cosponsors, we are assuming the bill is going to advance. But I think it is really critical that we do address the funding problem within that by adding a provision and I would encourage you to do that. [LR10]

SENATOR ERDMAN: Thank you, Susan, any questions for Ms. Hale? You're off the hook. [LR10]

SUSAN HALE: Thank you. [LR10]

SENATOR ERDMAN: Next testifier in support? And I believe this is our fourth and final testifier? Is anyone else wishing to testify on LR10? I see none. [LR10]

BILL MUELLER: Senator Erdman, members of the committee, my name is Bill Mueller, M-u-e-l-l-e-r. I appear here today on behalf of the Pharmaceutical Research Manufacturers of America, in support of LR10. You've heard from people far more knowledgeable than me about the SCHIP program. I would add the support of PhRMA. In talking with our Washington people, we have been told that it would be very helpful to have a resolution from our Legislature asking that the SCHIP be reauthorized and for that reason would ask that you advance the resolution. Thank you. [LR10]

SENATOR ERDMAN: (Exhibit 3) Thank you, Bill. Any questions of Mr. Mueller? I see none. We have a letter in support from the Nebraska Hospital Association in favor of LR10, from Bruce Rieker. I see no other testifiers, Senator Johnson has waived closing. That will close the hearing on LR10, and I will turn the chair back over to Senator Johnson. [LR10]

SENATOR JOHNSON: Thank you, Senator Erdman. We'll just take a second while people clear the room and...okay, I guess we are rearranged. This is the hearing on LB 513, Senator Fulton, welcome. Go ahead. [LB513]

SENATOR FULTON: (Exhibit 1) Chairman Johnson and members of the Health and Human Services Committee, for the record my name is Senator Tony Fulton, F-u-l-t-o-n. I represent Legislative District 29 and I'm opening here, introducing to you LB513. LB513 requires direct billing for anatomic pathology services. Simply put, if you diagnose it, you can bill it; if you don't, you cannot. In studying this issue, it appears there is some confusion about what is and isn't allowed in terms of billing patients in Nebraska. This bill deals specifically and only with anatomic pathology services. These services include Pap tests and biopsies. These services are performed or directly supervised by pathologists or other physicians who render a diagnosis of a patient's specimen. The bill does not include clinical laboratory services which would, for example, be most types of blood tests, urine tests, or other fluid tests. I introduced this

legislation because a constituent who is a pathologist approached me and brought this issue to my attention. It ran close to home. As a small business owner who carries the heavy burden of covering the cost of my own healthcare, I pay attention to these costs. And I can testify to the rising costs of healthcare, as you have probably heard many times in this committee. The more I learned, the more I became convinced that it is important that we help clarify what is and isn't appropriate when it comes to the billing of these types of services. This should work in the interest of a coherent and consistent public policy with regard to healthcare in Nebraska. I believe LB513 will, first and foremost, help reduce healthcare costs--something I know this committee cares deeply about. I also believe that the medical community cannot solve this issue on their own, and in fact needs clarification to ensure that there is no confusion with the current billing guidelines. Senator Johnson understands the lingo better than anyone else in the room, and so with regard to terms and codes and the ethics policies behind the issue, and so I'll ask for your help in introducing this bill to clarify this issue for physicians in this state, and to help end the divisiveness which this issue seems to be causing. I do not believe that they are able to work this out themselves. Lastly, I believe we can learn something every once in awhile from the federal government, so I have a handout for each of you. When the Medicare program began, physicians billed Medicare for laboratory services they performed in their own office and for laboratory services they purchased at a discount from hospital and independent laboratories. Many physicians routinely marked up the cost of their purchased laboratory services when billing Medicare and other insurers. In 1980, the statute was changed to eliminate markups on purchased laboratory services. The law required physicians to disclose the actual cost of the laboratory services they purchased from other laboratories. Enforcement of this law was difficult and many physicians continued to purchase laboratory services at a discounted price and then to bill Medicare the marked up prices. In 1984, Congress again addressed the problem of physician laboratory markups. The Omnibus Deficit Reduction Act of 1984 prohibited physicians from billing for laboratory work they did not perform. The bottom line here is that I believe the best way to resolve this issue and to prevent a further division amongst the medical community is by making clear what is and isn't allowed. I believe LB513 will help to do this. This bill ultimately is about the rising costs of healthcare. It's the main reason why I agreed to sponsor it. It is about also the clear identification of services rendered to patients and to consumers. It's a means of educating the public about services rendered such that they can take ownership and responsibility for the services that they request or services that need to be performed on their behalf. You will hear later from the Nebraska Association of Pathologists today who can provide you with some more detail in terms of the issues at hand. I'll close then. I greatly appreciate your time today and I'd be happy to answer any questions if I can. [LB513]

SENATOR JOHNSON: Any questions of Senator Fulton? Yes. Senator Erdman. [LB513]

SENATOR ERDMAN: Senator Fulton, did you receive a copy of the letter from the Department of Health and Human Services regarding some technical recommendations for your bill? [LB513]

SENATOR FULTON: I did. [LB513]

SENATOR ERDMAN: Okay. [LB513]

SENATOR FULTON: Yes. And as far as...I'm learning this here in the Legislature, if there are any lawyers that take a look at something, typically there is the need to correct detail. And so I'm open to that so long as the intention has met the details by which we arrive at that intention, I'd be glad for the help. [LB513]

SENATOR JOHNSON: Any other questions? Senator Fulton, I see none. Will you be able to stick around and close? Okay, great. How many proponents do we have? Two. And how many opponents will we have to speak? Four, five, or there abouts. Okay. Let's go ahead with the proponents. [LB513]

GENE HERBEK: (Exhibit 2) Mr. Chairman and members of the Nebraska Health and Human Services Committee, my name is Dr. Gene Herbek, G-e-n-e H-e-r-b-e-k. I am here today on behalf of the Nebraska Association of Pathologists and the College of American Pathologists to support LB513 which would protect patients against physician markups of anatomic pathology services by requiring direct billing to the patient or insurer by the clinical laboratory that performed this service. Mr. Chairman, before I begin and go further, I don't recall, you and I spent a few hours many, many years ago while I was starting practice in Sioux City, yelling for the Huskers in the East Stadium so I do relish those memories. And fortunately I'm back in Nebraska now so I don't have to listen to Cyclone and Hawkeye fans. It's nice to be back among friends. [LB513]

SENATOR JOHNSON: Thank you. [LB513]

GENE HERBEK: I'd like to thank Senator Fulton for introducing this legislation. I know he did it with thoughtfulness. And I 'd also like to thank each one of you for your service to the state of Nebraska. I know we don't often enough recognize you for what you do, your commitment and the time you spend in public service, and thank you again for allowing me to present testimony today. I should disclose that I am a board certified pathologist. I practice at Methodist Hospital in Omaha. I am licensed in three states: Nebraska, Iowa, and South Dakota. I am a member of the Nebraska Medical Association and the Nebraska Association of Pathologists, and I currently have the privilege of serving as secretary-treasurer of the College of American Pathologists which has over 16,000 members. As stated earlier, I would like to begin by clarifying that this legislation only covers anatomic pathology services. Again, these are Pap tests and biopsies that are performed by physicians, pathologists, or supervised by a

physician who perform a microscopic exam and render a diagnosis of the patient's specimen. Again, this bill does not include clinical laboratory services such as blood glucoses or potassiums or hemoglobins or hematocrits. It also does not include urine tests or other fluid tests. The legislation that's here before you, if enacted, and has been enacted in similar form in 12 other states, and I'd like to give you copies of those states. As you will see, this list includes larger states such as California and New York and small rural states such as Iowa and Montana. In Iowa, the legislation received unanimous support of both the House and the Senate, and the Iowa Medical Society held a neutral position on this bill. I share this information because I think it is important for you to know that direct billing is working well in these states, and more importantly, it saves the patient money. In these states, state legislators decided that direct billing for anatomic pathology services was a simple, straightforward way to eliminate an abusive, hidden, and unethical billing practice known as markups or up-charging. This bill would not prevent physicians from using expert pathologists wherever they practice across the country. Markup or up-charging is when a physician who examines a patient and orders an anatomic pathology service, requires that the laboratory performing the services bill the physician rather than the patient or the patient's insurer directly. They bill the physician. This physician who orders the service then takes that laboratory bill, for example $50 is charged, and then charges the patient $75 to $100 for that service, a service they did not provide, and pockets the rest for profit. Markups inflate healthcare costs. By enacting direct billing, the Legislature can help control this inflationary aspect of healthcare. In 1992, a study found that laboratory test charges were 9.6 percent higher in states without direct billing. Further, without direct billing laws, physicians profiting from markups have an incentive to order more anatomic pathology tests. This same study show that 28 more tests were performed and ordered in states without direct billing, thus further creating another unethical, hidden profit for physicians. The American Medical Association explicitly considers the practice to be unethical and contrary to their billing and coding guidance. Furthermore, legal counsel to the Nebraska Medical Association explicitly advised the NMA this past August that the markup practice is "contrary to AMA codes." The guidance of NMA legal counsel on this issue was direct and explicit. The NMA legal opinion expresses the view that not only is an ordering physician markup of anatomic services unethical, but the practice is also a dubious legality. Given the benefit of that legal opinion, we are profoundly disappointed that the Nebraska Medical Association has taken a position to oppose the bill. As a member of the Nebraska Medical Association, I would have expected the association to adhere to AMA ethics policies that very clearly state, "When services are provided by more than one physician, each physician should submit his or her own bill to the patient and be compensated separately. A physician should not charge a markup, commission, or profit on the services rendered by others." The NMA's current position of opposition to this bill does not conform to AMA ethics policies, and in my opinion is a disservice to Nebraska patients. As you can tell from my remarks, there is a great deal of frustration within the medical community. The medical code of ethics is "the law" for physicians. In our mind, this legislation is about a medical code of ethics and helping the medical

community in Nebraska clarify once and for all what is and is not acceptable. It is important for this committee to be aware of the process to date, as I know that some are suggesting that this shouldn't be dealt with by the Legislature. The Nebraska Association of Pathologists has been involved in discussions with the Nebraska Medical Association for over one year on this issue. We participated in NMA legislative committee deliberations, task force meetings, and multispecialty discussions. In all of these forums, it became evident that there are physicians in Nebraska that are intent on protecting the status quo that allows them to financially exploit Nebraska patients through these unethical markup practices. In September 2006, we requested a definitive ethics opinion from the NMA on the markup issue, and in November we were formally denied an ethics opinion by the NMA Board of Councilors. The Nebraska Legislature should take special note that the NMA declined to provide an ethics opinion on this issue, notwithstanding the fact that NMA legal counsel had provided a clear legal opinion to its leadership. Today, the NMA is opposing legislation that addresses the very fundamental issue about which they could not make an ethical judgment. Thus, we can only conclude that their position in opposition to this bill is devoid of ethical considerations. Furthermore, the NMA is opposed to a bill that has been supported in the past several years by state medical societies in Massachusetts, Louisiana, and South Carolina. In all other cases but one, the medical societies have remained neutral. We come to the Nebraska Legislature became our attempts to work through the normal process of the medical community have all but failed. We cannot possibly imagine condoning markups of patients' bills when, according to the American Medical Association Code of Ethics, this practice is unethical. Our goals remain the same: to place patients first. Others may tell you that the legislation will hinder the practice of medicine or will deprive doctors of needed income. Those statements are simply not true. AMA coding mechanisms compensate physicians for their time in taking the specimen, caring for the patient, and discussing lab results with the patient. Physicians that markup are, in essence, attempting to double bill for a service that is compensated under other AMA codes. This double billing in some states has been considered unlawful fee splitting, in the state of Tennessee, and in other states has been determined to constitute criminal fraud, the state of Minnesota Attorney General Opinion. Direct billing for anatomic pathology has not harmed patient care in any of the 12 states with this law, and direct billing for pathology has been a part of Medicare law for over 23 years, first being enacted by President Reagan in 1984 with the Omnibus Deficit Reduction Act. The federal government enacted direct billing because it was known that pathology markups were inflating federal healthcare costs and direct billing would eliminate the abuse. This is about healthcare costs. It is about patient care. It is about sending a very strong message to the medical community. We ask for your help in doing this. Today, Nebraska patients with private insurance and those without private insurance deserve the same patient protections against these markups as Medicare and Medicaid patients and the patients in 12 other state with these laws. Therefore we ask for your support for LB513. We need your help. The medical community needs your clarification. Thank you. I would be happy to answer any questions. [LB513]

SENATOR JOHNSON: Senator Stuthman. [LB513]

SENATOR STUTHMAN: Thank you, Senator Johnson, Dr. Herbek. I've had some concerns that the dermatologists, they tell me that this legislation will prevent them from using the pathologists that they want to or they have been accustomed to in their state or their local community. Will this legislation prevent them from doing that? [LB513]

GENE HERBEK: This legislation will definitely not prevent them from doing that. As a matter of fact, as pathologists we use the same expert pathologists around the country. And we have arranged different billing directly, usually with the patient or the patient's insurer. This bill is not about insurance panels and who can do...who can actually see and do pathology interpretations. It doesn't stop anyone, whoever does the pathology interpretation should get paid for the pathology interpretation. [LB513]

SENATOR STUTHMAN: Another questions that I had then, in your comments you stated that markups sometimes are as much as 100 percent. Do you find that ever true? [LB513]

GENE HERBEK: We have had some testimony where it's more than 100 percent, from what the physician is billed by a pathologist, it's actually more than that in some cases. [LB513]

SENATOR STUTHMAN: Okay. Thank you. [LB513]

GENE HERBEK: You're welcome. [LB513]

SENATOR JOHNSON: Senator Hansen. [LB513]

SENATOR HANSEN: Thank you, Senator Johnson. You have alleged some ethic charges against other members of the medical community. HHS sent us a letter, and I don't know if you've seen this, but anyway at the bottom of the first page it says that if LB513's intent is to address fraudulent billing, such practice is already addressed by existing statutes, and then they list the statutes. Do you think there is anything above and beyond the statutes that are there now to regulate fraudulent billing? [LB513]

GENE HERBEK: I do not believe without direct billing, and we do not believe and the Nebraska Association of Pathologists, that there any enforceable law at this point in time to prevent markup billing. We have the Nebraska Board of Medical Examiners who also abide by the AMA code of ethics. That, again, is a regulatory...at least as I understand it, regulatory that is not working at this time. Markup billing is still occurring. [LB513]

SENATOR HANSEN: Is markup billing and fraudulent billing the same thing? [LB513]

GENE HERBEK: Well, I think that's a discussion for attorneys, but I think we believe that it is a dishonest...it's...your physicians are saying they are providing a service to a patient for which they have not interpreted or made a diagnosis. It's a service they did not provide so it certainly is dishonest, we believe. [LB513]

SENATOR HANSEN: But if there's on law on the books now, will another law make it change? Will it make it better? [LB513]

GENE HERBEK: It will make it better because in other states...and I come from Iowa, as well. I practice there for 20 years in a state that did pass this law. It has worked very well for the last two or three years. It has decreased. It has eliminated markup billing and it has caused no problems with patient care. And it is a very clear way that physicians and their business managers understand, that prevents markup billing. [LB513]

SENATOR HANSEN: Thank you. [LB513]

SENATOR JOHNSON: Senator Pankonin. [LB513]

SENATOR PANKONIN: Thank you, Senator Johnson. To me we have several issues here. The markup billing is one that I think is legitimate if the rules are against it and the statute is against it. But I'm also here to tell you as a consumer and as an employer that has folks that you are trying to interpret these bills, when you have a procedure it seems like you get about 18 bills already and then you've got to try to match them up with your insurance. I can see that some consolidation of this. Like I said, the markup is a different issue. But the direct billing sometimes is so confusing and so hard, and you're trying to figure it out with your employees or yourself. When you have a procedure, you get 18 bills, 14 deals from the insurance company. And our senior citizens especially, you know, I've helped parents when they were alive and aunts and uncles to figure this out. So I think we've got a couple things here. Transparency is important but I think we get so confused. Maybe you haven't ever had a major procedure where this has happened. It's not fun. It's frustrating. And so sometimes I think consolidation, when you had a procedure, the transparency and seeing where things go, but getting all these invoices and statements and then trying to match them up is sometimes not fun. [LB513]

GENE HERBEK: Sure. I think that's a valid point. My wife has just been to see several physicians in the last month or two, and I'm filtering through several bills, as well. And you mentioned Medicare patients. I think they are a perfect example. They get one bill from each provider. It's very clear. And they have dealt with it for 23 years. It works. And they know who provided the service and they know that they will get paid. Of course,

Medicare has its own fee schedules. And as far as receiving another bill, well, there's other laboratory tests that are possibly done, but anyway the number of bills that you get is a concern. I agree with that. But the key is, for us, is that you should be getting a bill from the person, the physician who actually provided the service, and let the patient deal with the payment issues or whatever. And also, almost all pathologists that I know in Nebraska participate in all of the healthcare plans so we have already agreed to accept as payment in full for whatever services are provided. [LB513]

SENATOR PANKONIN: A follow-up question. You know, new to this process, new to this year, didn't realize that we would have so many scope of practice ones. I'm a farm equipment dealer. I sell tractors and combines, so my expertise in this is just try to be commonsense about it. And I always...the question I always have is, what is the motive behind someone introducing a bill. So your motive would be more business for the local pathologists or...? I mean, you talked about the direct billing issue which I think is one that we need to talk about. But what is the...? [LB513]

GENE HERBEK: The motive is to get any savings that are provided to patients, they should or their insurer should get the savings. No markup. They should pay the physician who is providing the service, and this would prevent other physicians from marking up these services that the physicians who ordered the tests and didn't perform it, it prevents the markup, which drives up healthcare costs. [LB513]

SENATOR PANKONIN: Okay. [LB513]

GENE HERBEK: We think the discounts that pathologists give should go directly to the patient or the insurer. Plain and simple. [LB513]

SENATOR JOHNSON: Senator Erdman. [LB513]

SENATOR ERDMAN: A follow-up on Senator Pankonin's inquiries. If you are participating in an insurance program or an insurance plan, and they agree to pay X for said service, what is the incentive for an individual such as yourself to not offer to provide that service to a physician at that rate? Because if you provide your service at whatever the insurance rate is, there is no markup. And so I guess I'm trying to understand, is the issue...go ahead and then we'll follow up. [LB513]

GENE HERBEK: What is happening is physicians as a requirement, physicians who see the patients as a requirement, say to do Pap tests or to do skin biopsies, say to the pathologist, pathologist group, we won't refer these specimens to you unless you give us a discount that's lower than the stated payment rate for an insurance company. Therefore, they get, by billing them directly, it's behind the scenes, the patient doesn't see it, the insurer doesn't see it, they would pay, again, $50 for a test. They would bill $75 to $100, whatever that limit for the insurance company that they would pay, they

would then pocket the difference for that markup, between what the pathologist would bill them for because of the discounts they negotiated between the physician and the pathologist. There's a margin that they would mark that up, otherwise there is no incentive for them to do that. [LB513]

SENATOR ERDMAN: Okay. And so under that scenario, as I understand LB513 and according to the letter from the department, they believe that the issue of fraudulent billing is already addressed in the uniform licensing law. If you are a pathologist that is performing these services, and a doctor says to you that you have to underbid the insurance for us to be able to provide you this, and you know that the doctor is receiving the difference, why doesn't the existing law address that issue of that's a fraudulent bill? [LB513]

GENE HERBEK: Well, I think it does address it, but there has been no enforcement... [LB513]

SENATOR ERDMAN: Then what is the procedure? [LB513]

GENE HERBEK: ...and you are relying on disclosure by either the patient or physicians turning other physicians in, if they access to their books. As pathologists, we don't always know what is done, what the billing practices are of a particular practice. We would have to go in and ask for that or suppose it. But we do know what is paid or the insurance companies pay, and that these negotiated prices are usually lower than them. [LB513]

SENATOR ERDMAN: Okay. I don't want to take up more time. I'm sure there are others that will speak. But I'm trying to fit the square peg in the square hole here. And I think there are issues based on what you are telling me, and I'm wondering if this is a round peg or if this is a square peg, and I'm just trying to sort those two out. [LB513]

GENE HERBEK: Well, Medicare tried disclosure for four years, from 1980 to 1984. It didn't work. That's why they went to direct billing. They said this is the only enforceable way we can do this. [LB513]

SENATOR ERDMAN: And the reason why, I think in response to other questions, the reason why this bill is different than that, is because that only applies to Medicare billing. This bill would apply to others. And so the idea that we have a federal law that prohibits this under Medicare doesn't apply to private pay or direct pay. [LB513]

GENE HERBEK: Right. Medicare and Medicaid both do this already. [LB513]

SENATOR JOHNSON: Any other questions? I see none. Thank you, sir. [LB513]

GENE HERBEK: Thank you. [LB513]

SENATOR JOHNSON: We usually let the first person talk a little bit longer than the second one, by the way. Next, please. Go ahead, sir. [LB513]

STEFFAN LACEY: (Exhibit 3) Mr. Chairman and members of the committee, I am Steffan Lacey, spelled L-a-c-e-y. I am the president of the Nebraska Association of Pathologists and I'm here today to testify in support of LB513. I reside in Norfolk, Nebraska, proud hometown of the Speaker of the House. I'm a board certified pathologist. I have practice in Norfolk for almost 24 years and am licensed to practice pathology in the state of Nebraska. I have ten partners and one associate, and I my group has offices in Lincoln, Nebraska, and in Norfolk, Nebraska, and we serve 20-plus hospitals, as well as clinics, in eastern and southeastern Nebraska. I currently have the privilege of serving as president in the Nebraska Association of Pathologists, which is 132 members strong across the state, concentrated primarily in Omaha and Lincoln, but with pathologists in Fremont, in the major cities--Fremont, Grand Island, Hastings, Kearney, North Platte, Scottsbluff, and Norfolk. Most of our members are also members of the Nebraska Medical Association, of which I am also a member of the Nebraska Medical Association. I know you had a long day. I will try to be brief. Thank you for allowing me to speak to you today. My colleague, Dr. Herbek, has touched on a number of the key issues and has accurately portrayed the frustration and laid out the issues that in our minds are quite clear. I will add that the Nebraska Association of Pathologists is unified in their support of LB513. To be clear, I offer into the record the following documents which Dr. Herbek referenced: the American Medical Association Ethics Policy, which is quite clear; the Nebraska Medical Association's own legal opinion; the Nebraska Medical Association correspondence which states that it relies on the American Medical Association code of ethics, which then denies our request for an ethics ruling. There is much more in terms of the ethics policy, coding policy, in cases that have been published as well as discussions in other states. Legislation, as Dr. Herbek mentioned, has been passed in 12 states and is currently being debated in 9-10 other states. This information then is just really the tip of the iceberg as far as the ethics issue. We realize you are not a court in the official sense, and you are a court in the legislative sense, and we respectfully ask for your help. You represent the public. This committee represents the health and well-being of the public. We share this with you because we feel that this is the place that needs to be dealing with this particular issue. The house of medicine can't resolve this issue internally, and I will repeat that: The house of medicine can't resolve this issue internally. That has been tried and to this point has been unsuccessful. Furthermore, with the current position of the Nebraska Medical Association, it makes it all but impossible for us to further to try to mediate between us, and this then is our last resort, to come to the Nebraska Legislature. I would conclude by saying that the record in terms of medical code of ethics as Dr. Herbek mentioned, is quite clear. The American Medical Association has also made it quite clear. The legislation will provide clarity and end the discussion once and for all,

which allows us to get back to what we do best, and that's serving the patients of the state of Nebraska. As Senator Fulton outlined, this issued before you today is about patients. It is about healthcare costs and it's about providing clarity to the medical community. Simply put, as Mr. Fulton said, if you diagnose it, you can bill for it; and if you don't, you can't. This is not an easy decision for us as the Nebraska Association of Pathologists to come to this legislative hearing. This is a process which occurred only after discussions broke down and we want to make clear that we tried to participate in a mediation process, and the mediation process via other parties, i.e. dermatologists, rejected the mediator which was suggested by the Nebraska Medical Association, a former state senator known to many of you as Dave Landis, who as we know, is one of the best mediators in the state. The Nebraska Medical Association, quite frankly, is in a horrible position and the hole that they have dug themselves has become deeper by virtue of its decision to oppose this legislation by lacking an opinion related to the ethics. The inference is that they have condoned the unethical billing practices which Dr. Herbek has mentioned. The position has further splintered an organization that touts itself as, by its own vision and mission, the physician unification organization for the state, as well as patient advocate. And we feel that we, the Nebraska Association of Pathologists, feel that they are in this instance acting contrary to their mission and their vision. I have been a member of the Nebraska Medical Association for my entire length of time of practice here in Nebraska, which is, as I mentioned, just short of 24 years. The issue must be resolved and clarified, and we need the help of the Legislature to do this. With all respect, I sincerely believe that all physicians in the state need your help to put this behind us once and for all. I will repeat what I said earlier, that the house of medicine cannot resolve this issue internally. We need help as physicians, the patients need help, the healthcare industry needs help to decrease the healthcare costs. And it is a problem that is growing nationally and does exist in the state of Nebraska. The legislation will not prevent a physician from using a pathologist of their choice, as was mentioned earlier. And for those who say that this should not be legislated, I would say this is the only place where these issues can be addressed correctly. And with the help of the political system, this is the place and the only place where these issues can be resolved. Politics and medicine go hand in hand in many issues. Currently, the Legislature is dealing with the Clean Air Act, a Uniform Credentialing Act, an act of, quote, I'm sorry, which has been needed for many years, and this is an issue where the Nebraska Association of Pathologists need the help from the Legislature... [LB513]

SENATOR JOHNSON: Any questions of the doctor? Senator Stuthman. [LB513]

SENATOR STUTHMAN: Thank you, Senator Johnson. I will ask you one of the same questions I asked Dr. Herbek. Are you aware of markups being as great as 100 percent? [LB513]

STEFFAN LACEY: The markups that I'm aware of are probably 75 percent. I practice in a smaller town than where Dr. Herbek practices, and I can't speak for the Omaha

market. [LB513]

SENATOR STUTHMAN: Okay, thank you. [LB513]

SENATOR JOHNSON: Any other questions? Senator Hansen. [LB513]

SENATOR HANSEN: Thank you, Senator Johnson. Dr. Lacey, I appreciate you coming here today and testifying, especially on a state association because I've been there before and when we have disagreements. And I come from the cattle industry, so...I mean, we've got 5,000 members and 5,000 views. Does the...your testimony said where you have two memberships, dual memberships, one with the pathology society and one with the NMA or the Nebraska Medical Association. How long have you been working on this to resolve this issue? [LB513]

STEFFAN LACEY: The Nebraska Association of Pathologists started this approximately a year and a half ago, as far as trying to work through a direct bill to bring to fruition. I could go into the history of what has happened in that year and a half if... [LB513]

SENATOR HANSEN: No, that's fine. I just want to know that you've done this for a period of time. And is there an ethics board between the two organizations or within one? The Legislature doesn't have an ethics committee, thank goodness, so. But does the Nebraska Medical Association have an ethics committee? [LB513]

STEFFAN LACEY: To my knowledge they do not have an ethics committee. Ethics questions are addressed to, I believe, the board, and I don't...someone from the NMA may have to address that more correctly than I can do, but I would say I do not believe so. [LB513]

SENATOR HANSEN: Okay, thank you. [LB513]

SENATOR JOHNSON: Any other questions? I see none, sir. Thank you. [LB513]

STEFFAN LACEY: Thank you. [LB513]

SENATOR JOHNSON: How many more proponents? Any? Go ahead, sir. Opponents, how many do we have? Three, four, five. Okay. And again we'll let the first person, if he chooses, speak a little bit longer, but the longer we talk, the less attention you get out of this group on this side of the table. [LB513]

JOEL SCHLESSINGER: (Exhibit 4) Thank you, Chairman Johnson and the rest of the committee. My name is Joel Schlessinger and I'm a board certified dermatologist. I'm also...and that's S-c-h-l-e-s-s-i-n-g-e-r...and I'm the immediate past-president of the Nebraska Dermatology Society, and current I select Advisory Board Committee member

for the American Academy of Dermatology and current president of the American Society for Cosmetic Dermatology, which is a 1,500-member organization. I appreciate your taking time to listen to us on this, and what you have there is the most recent article that sums up the costs of what the pathologists bill will do to our patients. It's very important for this committee to know that even though the study that was quoted from, I believe it was 1992 showed an increase in costs with the idea of client billing, the most recent study which was finished approximately six months ago and was done at a nonbiased institution, the Wake Forest University School of Medicine, showed that, on average, once a client billing was done, the patient was charged an average of $120 for each pathology test, whereas in the system that would happen here if this bill were enacted, their costs showed $150 a test. So it seems like the tests, the data that has been stated, is not exactly true if you look at the most recent data. Now it may be that 15 years ago when their study was done that was the case, but interestingly enough the economies of what we would call, probably, deregulation have allowed us to provide tests at a lower cost to patients rather than a higher cost. Additionally, in case you wonder, this data was collected among 450 practitioners, an approximately even split between dermatologists and pathologists. And in a study of Nebraska that was done, the figures stood up for the dermatologists, meaning that those who client billed, the costs were approximately $120 a test. But interestingly enough, for the pathologists the costs were somewhere closer to $275 a test. So, again, if this bill were enacted, the differences would be quite a bit different with $120 a test for the current system for those dermatologists that had negotiated better rates versus $275 for the pathologists. I think that it's important, if you look through this abstract, this article, that if you look on page 5, about halfway through it, you'll see the data that I refer to, with a $120 figure versus $150 figure. If you look at page 6, it sums up one of the reasons under discussion that we want to do this, and that's the potential to save patients money. It also can be, as Senator Pankonin had mentioned, more convenient and less confusing for patients to receive one bill. Additionally, when the patients seek an in-network dermatologist, this allows that dermatologist or specialist or family practitioner to bill that person in-network for the pathological interpretation of their specimen because unfortunately when specimens are sent out of state, many times the network is not in place for the insurance companies. And that means that the patients suffer an out-of-network charge which is even higher than they would have normally been. Client billing is more efficient according to this article, and it saves much administrative time and it allows for pathologists to have less risk of nonpayment according to this article. The reduction in the risk is probably, according to the article, why this cost is lower when dermatologists negotiate rates rather than when they are forced to use direct billing. Lastly, on page 7, on the middle of it, this article states that based on limited data it appears that client billing markups do not add to the overall cost of care. And if there is an ethical problem in the client billing, it does not appear to be related to higher costs to patients. They also talk about one pathology lab, on page 8, that reported $984 for the interpretation of skin biopsies. You know, there are unfortunately egregious abuses on either side of the aisle, but I think that it's important that you see the fact that

unfortunately what has been painted by this bill is not necessarily the case. Additionally, after I come up, you will hear from my colleagues, Dr. Watts who is the current president of the Nebraska Dermatology Society, and Dr. Margaret Sutton who is also a practicing dermatologist in the state, about problems with access to care and problems with regard to the actual ability to send to the pathologist of your choice. Lastly, you'll hear from Robb Bohannon who is the member of the American Academy of Dermatology. He will present the position from the American Academy of Dermatology standpoint. I would like to also address, if at all possible, a couple of the, I would say, misconceptions that were proposed during the testimony before this. As far as the mediation process went, the dermatology community specifically was willing to participate in the mediation process, and we had a date set up and we had a mediator that was acceptable to all of us, but it was the pathologists at the last minute who canceled the ability to do that session. So that was something that was surprising to me. The AMA guidelines that they stated called this illegal, in fact don't necessarily call this illegal. They talk about certain ethical ideas but they specifically haven't come out against client billing. The reason, I think, that you see us here as a dermatology community is that we are somewhat unusual in that we have very limited access to people who specifically look at our types of specimens of skin. Skin is a very unusual thing for pathologists to look at, in general, and our board certified dermatopathologists go to school for up to several years extra to learn that particular interpretation ability. Now, general pathologists, in many cases, do look at skin but what luckily is the case for those of us who have access to pathology services outside of the state, we can send those specimens anywhere that we wish to, and it's very effective for us to be able to look at those specimens and have an expert pathologic interpretation. Unfortunately, if this bill passed, it would limit our ability. We currently have only two board certified dermatopathologists in this state that we can access on a one-to-one basis. There are several others but they don't have access to their services for everybody in this state. There are over 1,056 dermatopathologists in the country, so we only have two if this bill passes, and that's unfortunate. And although we would love to have those two are our dermatopathologists, I think we would like to have a little bit more choice than two. The Medicare rules, unfortunately once they came into effect, have done more to increase the price and decrease the availability of services to our Medicare patients. And I personally have seen, since the Medicare rules have gone into effect, about a double the increase price for Medicare patients since they've gone into effect. Before that rule was in effect, the negotiated rate that I had for my Medicare patients was $46.50. now it's over $90. Fee splitting illegality was addressed, and I think it's really very important to note that we already have rules for this, as your communique, I believe that you said, there are already rules in place that show that fee splitting is illegal. We understand that and I think if this were illegal, that would have been challenged already in state court. Dr. Herbek had also stated about the insurance panels and that they can get their specimens to anybody. But unfortunately many dermatologists submit their specimens, and thousands of specimens a year. So it's very difficult for them to send off specimens, thousands of specimens, outside of state, especially when, again, it's a financial

disincentive because they will lose money or they will have to bill the patient outside of their insurance pool if this bill is passed. So more than likely it will decrease the amount of specimens that go out of state to the more expert dermatopathologists. I think that lastly it's a very difficult thing when you compare Medicare rules to out-of-Medicare rules because most, if not every pathologist in this country, is under Medicare rules, whereas when we get to some of these more unique plans, insurance plans, they don't all participate with them so if we, for example, have a case for melanoma that we wish to send to Minneapolis or Connecticut or New York, we don't have likely that a pathologist on the insurance panel. So it would mean the difference of having the ability to send it or not to send it. Thank you very much for your time. I appreciate it, especially given the late hour. [LB513]

SENATOR JOHNSON: Any questions? Senator Erdman. [LB513]

SENATOR ERDMAN: Joel, this is lighthearted to start with, but you look pretty skinny for a guy that scored a touchdown in the national championship game in the Orange Bowl. [LB513]

JOEL SCHLESSINGER: (Laugh) Don't I wish. Don't I wish. [LB513]

SENATOR ERDMAN: For those that don't follow along at home, Joel Schlessinger was the name of a full back, as well. The letter that we have from the Nebraska Medical Association that was distributed to us by the proponents of LB513 state that the mediation session was canceled due to the...let me just say this..."After consulting with representatives of the various physician groups in preparation for the mediation session, the independent mediators concluded that it was unlikely that the specialty groups wold be able to reach a mutually agreeable resolution through the mediation process." Is that not true? You tell me that the proponents canceled the hearing, but as I read the letter that came from the Medical Association, it would appear that it was the observation of the mediators. And I think there is probably going to be enough he-said, she-said in this hearing. I'm just making sure that we're accurately talking about the same facts. [LB513]

JOEL SCHLESSINGER: My understanding was that we had a meeting set for, I think it was December 7, and at that day we had agreed to the mediator, we had agreed to the rules, and the pathologists refused to put a, I think it was called sunset so that anything that would be found in the hearing in mediation would be to ourselves rather than be admitted into evidence. And that's why they refused to go into the session. Am I correct? [LB513]

SENATOR ERDMAN: Others can speak on that if they want to. [LB513]

JOEL SCHLESSINGER: Yeah. Okay. That was my understanding was that we had a date set and the sunset rule or something like that wasn't acceptable to the pathologists.

[LB513]

SENATOR ERDMAN: And then the only other question I would have is, as I understand your testimony that you believe as has been shared with me through the department, that there are provisions in law to address these up-billings or whatever the actual term is. Am I to interpret your testimony that you don't believe that happens in this state or am I to understand that you don't believe that it's being enforced? Because I tend to get the idea that you don't feel that there's a problem, and I'm just making sure that I understand why you don't think there's a problem. Is it because no one is getting caught and therefore we can't prove it, or is it the fact that the discovery process is so difficult that no one can prove that it's being done and therefore it's not enforceable. [LB513]

JOEL SCHLESSINGER: I don't believe that there has ever been a single instance where this has been addressed in that manner. Now, I haven't followed this on a national manner, but--and Robb who will speak after me, can--but I don't believe there's been a single instance where they've found that this practice is, quote, unquote, fee splitting, and that it has been addressed in that manner, in a legal manner. I think that there have been many bills introduced to outlaw it, many of which are now being brushed aside because they see the data coming out that it's actually more expensive in the long run for patients, rather than less expensive. But I don't believe that that has ever been addressed from a standpoint of illegality, so. And to answer you question, there are many different billing practices that dermatologists in this state do. We have somewhere, about 30 dermatologists from across the state, and many of the dermatologist bill themselves. Some dermatologists contract with labs. Some dermatologists are dermatopathologists themselves. So it would be very difficult to say what exactly a figure is, if that's what you're asking. [LB513]

SENATOR ERDMAN: Hypothetically speaking then, if a circumstance was that, as was outlined by the proponents, where an individual was billing for certain services at X rate, and a physician was receiving X plus 10 percent, would you consider that to be up-billing? Would you consider that to be either, one, unethical or, two, illegal? [LB513]

JOEL SCHLESSINGER: I think that that's addressed by the article which says that basically if it's a question of the billing practices, the less, the lower-cost billing practices are under the current system. So their feeling was that it's, if you looking at ethicality as far as the final price to the patient, this current system allows the lowest cost price to the patient, by far. Now, I don't know... [LB513]

SENATOR ERDMAN: But that doesn't necessarily translate to the actual cost of the service. [LB513]

JOEL SCHLESSINGER: Well, it does in the end result, because in the end result is what the patient is charged. If the patient is charged $120 under the current system and

$150 under the system that is being implemented, then eventually the patient is going to suffer a $30 or more hit for implementation of this law. [LB513]

SENATOR ERDMAN: And I'm not speaking to the bill; I'm speaking generally. If you go to the $150 and the services were $120, and the doctor was reimbursed $150, there's a $30 difference there that somebody is going to eat. Now, if the insurance providers are going to pay that regardless of what the cost is, then the cost and the actual reimbursement are two different numbers. And then the question still comes back to, do you think that's unethical or illegal to be charging and being reimbursed two different amounts in the event that the amount being reimbursed is higher than the cost of the actual service provided? [LB513]

JOEL SCHLESSINGER: I put this to a deregulation versus a nonregulation situation. [LB513]

SENATOR ERDMAN: I don't want to cut you off, but just succinctly would you believe that that would be unethical or illegal, and just... [LB513]

JOEL SCHLESSINGER: According to the AMA guidelines, it is not. I will say that that's what I...I believe that the AMA has stated their regulation on this, that it is not unethical despite what the pathologists have said. So I'm going to go on that. [LB513]

SENATOR ERDMAN: And so the American Medical Association...and I can only assume that this is legitimate, from their Web site where it talks about services provided by multiple physicians, that the compensation is commensurate with the value of the service he or she has been rendered. Going through these guidelines which are also referenced in the letter that we received from the legal opinion, seem to be contrary to what you are telling me. And so I guess I need to do a little more research here and figure out where I'm either missing the boat or whether I'm just not tracking with your answers. And I don't want to take up more of your time. I want to let other committee members ask and I'll do some more reading. [LB513]

JOEL SCHLESSINGER: What I would like to say to that, is that our counsel from the American Academy of Dermatology will address that issue. But according to what we've seen, there is no ethical lapse in this service. And it essentially is a regulation versus deregulation phenomenon. It's just like, in my mind, when the airlines were allowed to be deregulated. Prices went down on air fare. Now, this will bring it back to regulation because you have essentially less people delivering the services. You have pathologists as the only option for billing versus pathologists and other people looking for a better way to deliver that service and a more economic way to deliver the service. And that's what the study, that is the most recent study, proves. [LB513]

SENATOR ERDMAN: And I hear what you're saying and I hear your arguments in a lot

of my responses against the bill, and I'm asking you questions outside of that, and so to go back to our football analogy, you just ran a 22 dive up the middle for a yard and not the touchdown that scored in the national championship. And it's partly due to my lack of understanding but I'll do some reading and let others ask you some more questions. [LB513]

JOEL SCHLESSINGER: And I would love to have Robb Bohannon from the American Academy of Dermatology answer that question because he probably is more familiar with that. [LB513]

SENATOR ERDMAN: Sure, and that's fine and I'll be here to listen to that. [LB513]

JOEL SCHLESSINGER: I apologize if I haven't answered it, but I'll let him be the arbiter of that. Yes. [LB513]

SENATOR PANKONIN: Senator Johnson, thank you. [LB513]

SENATOR JOHNSON: I think Senator Stuthman was ahead of you. [LB513]

SENATOR STUTHMAN: Go ahead. You started. [LB513]

SENATOR PANKONIN: Okay. Well, just to follow up on this example. I understand that when you're saying that because of deregulation, instead of $150 it's maybe we're getting charged $120. My question is if the cost is $90, is where you sent this off and the cost is $90, and you mark it up to $120, you think that's ethical and legal then? [LB513]

JOEL SCHLESSINGER: I don't do that practice myself. I have a very different relationship. I can perhaps...Robb can perhaps speak to that. I don't so I'm really not speaking on that. I don't use that practice but... [LB513]

SENATOR PANKONIN: So what practice do you use? [LB513]

JOEL SCHLESSINGER: With me, I have a pathologist who charges me a monthly fee. I can interpret one specimen or a thousand specimens. It's just a monthly fee. He is essentially an employee of mine. So I really don't...and I've been working with him for years, so. [LB513]

SENATOR PANKONIN: Fee per specimen or just a flat...? [LB513]

JOEL SCHLESSINGER: Just a monthly fee--flat fee. [LB513]

SENATOR PANKONIN: Okay. [LB513]

SENATOR JOHNSON: Senator Stuthman. [LB513]

SENATOR STUTHMAN: I'll pass. [LB513]

SENATOR JOHNSON: All right, fine. Thank you. Any other questions? [LB513]

JOEL SCHLESSINGER: Thank you very much. [LB513]

SENATOR JOHNSON: I see none. Thank you. [LB513]

ROBB BOHANNON: Mr. Chairman and members of the committee, my name is Robb Bohannon, B-o-h-a-n-n-o-n, and I'm the assistant director of state affairs for the American Academy of Dermatology. And I want to start off by addressing a few concerns with the bill outside of the concerns that have already been addressed and will be addressed, and then address some of the other her concerns we heard (inaudible) testimony earlier. One of the things I want to point out, and Dr. Schlessinger touched on this, is the issue of being in compliance with the Medicare law. Again, the issue is that Medicare is sort of a different animal than local healthcare providers here in Nebraska. Essentially all doctors have access to Medicare. It's a nationally known program. It's a nationally recognized program. The concern is if a dermatologist is utilizing a lab in New York or Texas or California, is that lab going to participate in a United Health Care of Nebraska network, a Blue Cross Blue Shield network, and cover those services for a Nebraska patient? And you can imagine that a lab that takes specimens from all over the country, if they were to do that, would have to participate in hundreds and hundreds of networks, and the administrative burden on that lab and their staff would be horrendous. So a lot of times they do arrange their billing this way for the benefit of the patient to get the service and get it covered by their insurance. One specific thing I want to address in the legislation is where it starts at line 23 on page 3. This bill is set up to prohibit indirect billing or client billing and legislate direct billing. We find it curious that this section says it "does not prohibit billing of a referring laboratory for anatomic pathology services in instances in which a sample or samples must be sent to another specialist." The way we have seen this go down in other states and interpret this is that this would allow client billing or indirect billing for a pathology lab, only. So they're saying that this is a bad practice that needs to be regulated, the Legislature needs to take action, but only they should be allowed to have this practice of sending a specimen to another specialist when it needs to be referred out for a second opinion. Essentially I think this makes the point that we're making and the doctors who are going to testify after me will make, in that, you know, if you have a melanoma or suspicious mole you think is melanoma, you want to send that to a melanoma specialist. If you have, depending on what the condition is that you are sending this specimen out for, you want to find the best specialist and the best lab that is equipped to handle that particular specimen. So I don't know why a bill would prohibit this practice but only allow it for one

particular specialist and the need for second opinions. We think that's something that all offices should be allowed, and that's why the physicians who are going to testify here today do participate in client billing or indirect billing arrangements. I also want to make a point that this affects other specialities, as well. I think it is painted as a dermatology versus pathology issue a lot of times. And if you look in the bill, it includes cytopathology, including smears, including the Pap test examination. Obviously this would affects obstetricians and gynecologists. Family physicians would also be impacted by this bill, as well. One thing...I want to bring up a couple points too that I heard in the first testimony from Dr. Herbek, as well. One thing the AMA policy dictates and is very clear on is that a physician choice of laboratory should be done for quality and not costs, meaning that when a doctor refers a specimen out they need to make sure that the lab they are choosing is the highest quality lab available to provide that service, and they shouldn't just choose a lab because of low cost. So that's a big concern. That's sort of our whole argument here, that the doctor needs to be able to make the recommendation to decide what lab the specimen to goes to, who can best perform the reading for the patient given the particular condition that the physician suspects is present. I should also add that in North Carolina there was a bill in 2006, and the Medical Association was not neutral. They actively opposed the bill. I have a friend and colleagues down there who worked on this issue. And this year we have a bill, bills in several states, in Texas and Idaho. And our understanding is the Medical Association is opposing the bills there, as well. So Nebraska is not alone in this issue. That wraps up my comments. I know everybody is running short on time but I'll be happy to answer any questions if I can. [LB513]

SENATOR JOHNSON: Any questions? Let me get back to just one thing, and that is this, is we kind of know that there were negotiations suggested; in fact, that they would actually be paid for by a third party. And yet that never came about, and we're having a you-said, he-said situation here. What's the status of your group? Why didn't they participate? [LB513]

ROBB BOHANNON: Well, the American Academy of Dermatology was not part of the negotiations or the discussions. I mean, I spoke with the dermatologists here when they asked my opinion on certain things and about issues going on across the country related to this, but our whole organization was not involved so I can't really answer that. [LB513]

SENATOR JOHNSON: Okay. All right, well, we'll ask somebody else that. Thank you. [LB513]

SENATOR JOHNSON: One second longer, I think. Senator Erdman. [LB513]

SENATOR ERDMAN: Senator Pankonin and I were having a side bar, trying to proceed here. As I understand, you are the guy that I'm supposed to ask these tough questions

to that our national champion doctor didn't want to field because he's not a trained attorney, and I don't blame him. [LB513]

ROBB BOHANNON: I'm not an attorney either, so I'll just state that up-front. (Laugh) [LB513]

SENATOR ERDMAN: So you're not the guy either? [LB513]

ROBB BOHANNON: But I'll do my best. [LB513]

SENATOR ERDMAN: Okay. So then you followed the conversations that we had. You know, I've got a legal opinion here from Dale Mahlman...or to Dale Mahlman, issued by an attorney. And unless the court tells you that that's the law, it really is one man's opinion. As I read through some of these examples that I have been trying to get my hands around, it would appear to me that based on the language from the American Medical Association's code of ethics that some of the examples are in direct violation of their code. [LB513]

ROBB BOHANNON: Okay. [LB513]

SENATOR ERDMAN: One of the examples would be, and this is from, I guess, E-6.10, "Services Provided by Multiple Physicians," paragraph 3: When services are provided by more than one physician, each physician should submit his or her own bill to the patient and be compensated separately, if possible. A physician should not charge a markup, commission, or profit on the services rendered by others. [LB513]

ROBB BOHANNON: Right. [LB513]

SENATOR ERDMAN: Okay. So if that's the AMA code, and an example is that it costs $90 to do a lab, and the cost that is being reimbursed is $120, would you agree that that $30 is some fee or some such amount above what it allows for, and that is that it shouldn't be over the services rendered? Or am I just not understanding? [LB513]

ROBB BOHANNON: Well, I know that part of the AMA code of ethics also states that physicians are entitled to be compensated for their work related to their staff time, there's collections, there is collecting specimens, there is mailing specimens. There is a whole lot of paperwork and whatever you do. I don't know exactly, I can't see what you have in front of you, but I know one of the policies states that, from the AMA, states that physicians are entitled to be compensated for those types of things. [LB513]

SENATOR JOHNSON: Are there codes available to do that? [LB513]

ROBB BOHANNON: I don't believe there are. I know there's a 99000 code that, (a), I

don't believe...and this is better asked of the doctor, I think too, but I don't believe many carriers would pay that code. [LB513]

SENATOR ERDMAN: And I guess then the follow up that I would have is that it further goes through and talks about that example or an example like I have given you. And one of the comments that was asked of this attorney is whether or not the existing...if this were to happen, would it be in direct violation of Nebraska law? They were unable to determine it but they make this qualifying observation: However, in the event a physician would purchase a lab service and then rebill the lab service to a patient or third-party payer in excess of the costs paid by the physician for said laboratory service without providing additional professional services to the patient, it would be reasonable to include that an administrative agency or court of competent jurisdiction could find that such practice would be inconsistent with applicable law, including but not limited to the provisions set forth above, which are the codes that they reference on the AMA, including but not limited to Opinion E-6.10, which is the one I referenced to you. I guess what I'm trying to understand, and I think your point is valid about why would we let one group do it if you're trying to curtail another? I think that's great, you've got them. Good point. The question that I have is probably bigger than this bill, and that is the fact that what happens under applicable law if we find ourselves in a circumstance where we can prove that this happens, and if we can prove that it happens what's the appropriate way to remedy that? Nobody wants to enforce it. The AMA code says explicitly according to this attorney, that it's not acceptable. The question is whether it's illegal. I think it's unethical. If I provide an appraisal service to somebody and it costs $400 to do that, and I charge them $700, that's not ethical. So I guess I'm trying to figure out where we go through this process and draw that line. If Senator Pankonin does a warranty service for a tractor, and they're going to say we're going to pay X amount per hour to fix that tractor, and he charges that amount to the warranty company but has it actually done for less, that's unethical. So I'm trying to make sure that, one, the perception isn't out there that we're going to ignore it if this happens, and, two, if it is going on out there, do you agree that we should remedy it? And if so, what would be the appropriate mechanism to accomplish that? [LB513]

ROBB BOHANNON: Well, I mean, you know I think the Medical Board has jurisdiction in the state over the ethical practice of medicine. That's an issue that they would be equipped as physicians who practice, who from various specialties would be best to address. I mean, I don't really think that my...I don't know how best to address it. I mean, I'm not an attorney, I'm not a physician. You know, I think that would be...that's kind of one of our points, too, is that something like this is left to the Medical Board. They regulate the practice of medicine in the state. [LB513]

SENATOR ERDMAN: Okay. And in fairness to you I'll make a copy of this so you can see what I was...so that you see, and then if you want to respond later we can (inaudible) conversation. [LB513]

ROBB BOHANNON: Okay. [LB513]

SENATOR JOHNSON: Any other questions? I see none. Thank you. [LB513]

ROBB BOHANNON: All right. [LB513]

MARGARET SUTTON: Chairman Johnson and members of the committee, my name is Margaret Sutton, S-u-t-t-o-n. I am a board certified dermatologist. I've been practicing in Lincoln for 25 years. I am here to express my opposition to LB513. I'm here to represent those clinical physicians, not just dermatologists, but any physician that takes a biopsy from a patient in their office. That might be a family practitioner, it might be a gynecologist, it might be a urologist, et cetera, et cetera. We feel that we are the patient advocate and that we are ultimately responsible for what happens to that patient's care. I'm going to give you an example. Let's say that your wife comes to my office for a suspicious looking mole, and I'm concerned that that could be a life-threatening melanoma. I'm going to remove that and I'm going to have that biopsied. And I have some options on where I can send that tissue. My option might include a world renowned individual in New York who is a worldwide expert on melanoma that spends all of his time looking at skin pathology. My other option might be a group of local pathologists that might be individuals that spend their time looking at bone tissue, at kidney tissue, at lung tissue, oh, and let's throw in maybe a skin biopsy now and then. So those are the options that I'm facing. Where would you like your family member to have their biopsy studied? I know where I would want to send that patient's biopsy, and that would be to the specialist--the person that's looking at skin tissue 100 percent of their time. Now, the proponents of this bill will argue, well, we're not trying to influence where you send that tissue. In essence and in reality it does affect it. Every one of us understands that healthcare is reliant on our insurers. And this physician in New York or Minnesota or Texas is not going to have coverage that allows them to have work done by people in these other states. In essence, this bill is a protectionist bill. It is forcing to us to utilize the pathologists that are in our insurance networks in this state. And I bring Senator Pankonin's comment to light. What is the motive of this bill? And I ask you to consider that. I would like you to...also, Senator Erdman, you bring up an excellent point. I feel that we are adding a valued service when we purchase these services from a pathologist and we, in turn, bill the patient. We client bill. I feel that we are adding a valued service to that patient. We are allowing that patient to have access to specialists throughout the country that they otherwise would not have because of their insurance coverage. I called this seamless access. The other value that we are adding to this service is convenience, and that's the other point that Senator Pankonin made, is that we are allowing for convenience. Patients don't want to receive bills from all over the country from physicians that they've never seen or even heard of. It's very confusing, especially to the elderly. I do want to note that in the few other states that similar legislation has been passed, that it has caused pandemonium, and the medical

communities are in a state of chaos. I also want to state that we feel that our two main points are, one, this is going to compromise the way we take care of patients, and two, it's going to increase healthcare costs. Thank you. [LB513]

SENATOR JOHNSON: Senator Pankonin. [LB513]

SENATOR PANKONIN: Guess what's coming for questions? I agree with you on the care, and if it's me or my family having that access. Now but the question has come, that bill comes from the best source. What do you do with it on? Do you mark it up? [LB513]

MARGARET SUTTON: Well, I tried to explain that I feel I'm adding a valued service. [LB513]

SENATOR PANKONIN: Okay, and I understand that. So how much do you mark it up? Is it a percentage? Is it a certain dollar? Is it up to where the insurance is going to pay? [LB513]

MARGARET SUTTON: Well, it varies. It varies. And you know, what I mark it up doesn't matter, because what the insurance pays me is what I have to accept. So I could mark it up $1,000 and I'd still get paid whatever the insurance is going to pay me. So what I'm saying is...and you'll see in those AMA ethics, it's okay to add a charge if you are adding a service. I am adding a service. I am taking the risk of nonpayment because, as you well know, it's not every time that a patient is going to pay my bill to them. So there might be some occasions when I'm paying the pathologist and yet I'm not going to get reimbursed by the patient. So I feel I am adding a service. I am allowing access to the best care in the country that the patient would not otherwise have access to. I am taking away all the risk for the pathologist because I'm paying the pathologist directly. They are getting paid every month, whereas otherwise I'm taking the risk. If someone doesn't pay their bill or goes bankrupt or whatever, I'm eating those costs. So I feel that I'm justified and I'm adding a valued service to this service that I am purchasing. Not to mention the convenience of the patient; also the fact that my office is doing the billing, not the pathologist's office, so those are all costs that are part of justification for additional valued service that that patient is receiving. [LB513]

SENATOR PANKONIN: And I would probably agree with that. My question is, what's ethical, what's fair, or what's on the statutes right now and how that is applied consistently. [LB513]

MARGARET SUTTON: I can show you just as many legal opinions that state that what we're doing is completely ethical, and if I knew that that's we were going to be presenting today, I'm certain we've had those types of legal opinions and we just didn't feel that the ethicalness of anything was going to be an issue today. Because there are

already laws that address ethics. That doesn't need to be addressed by this legislation. [LB513]

SENATOR JOHNSON: Let me ask a question. When you take out the specimen, what do you get paid for? [LB513]

MARGARET SUTTON: You mean...? [LB513]

SENATOR JOHNSON: When you remove this mole that you are talking about, and so on, what do you get paid for? [LB513]

MARGARET SUTTON: For the actual removal of it? [LB513]

SENATOR JOHNSON: Yeah. [LB513]

MARGARET SUTTON: I only get paid whatever the insurance pays me. [LB513]

SENATOR JOHNSON: No, no, no. Why do you get paid? [LB513]

MARGARET SUTTON: Why do I get paid? For removing that lesion, for the physical... [LB513]

SENATOR JOHNSON: And that's all. You don't get paid for doing the next step, depending on what the pathology report is. [LB513]

MARGARET SUTTON: Right. I get paid for removing that lesion. [LB513]

SENATOR JOHNSON: That's all. [LB513]

MARGARET SUTTON: That's all. [LB513]

SENATOR JOHNSON: So a surgeon, when he takes out an appendix doesn't get paid for taking care of the patient the next day, and so on, and making sure everything is going fine. [LB513]

MARGARET SUTTON: I don't understand your point. [LB513]

SENATOR JOHNSON: All right. Let's make it a gallbladder where the patient is going to have to be in the hospital a day or two or whatever, depending on the complications. Does he get paid only for taking out the gallbladder, or does he get paid for taking care of the patient the next day and perhaps the next day and seeing him in the office? [LB513]

MARGARET SUTTON: Well, the way I understand it, there's a different fee for seeing them the next day. And every time you see them, there's an additional charge. [LB513]

SENATOR JOHNSON: I think that's unique. I would think that it's pretty universal that the person who does the operation then assumes that he is going to take care of the wound, take out the stitches, and so on, and help the patient with the judgment, everything is okay. The biopsy was benign or it's malignant. We need to do this or I'll send you somewhere else. Do you charge for that, as well? [LB513]

MARGARET SUTTON: No. That's all part of the removal of the lesion--post-op care, suture removal. [LB513]

SENATOR JOHNSON: Okay. Then what is the charge for, that when you get the charge from the pathologist, what...and I understand that it's quite reasonable to charge for the billing costs--you have to have somebody there to do that. But I thought you just said that there was a charge for your interpretation of what to do, and so on. I'm confused. [LB513]

MARGARET SUTTON: What I meant to say was that I feel we are providing a valued service that's over and above just what our cost was to purchase these services, and that being that because we take the responsibility of the billing, we allow that patient access to an expert anywhere in the country. And I also know for a fact, Senator Johnson and committee, that this practice is not unique to dermatologists. There are radiologists that read x-rays, and yet the orthopedic surgeons charge for them. There are small hospitals that can't afford to have their own radiologist and they have their x-rays read by a radiologist in India. Now do you think that the radiologist in India is going to charge the patient? I mean, this is a common practice and this is done and this is an ethical practice. And... [LB513]

SENATOR JOHNSON: But I still don't understand what you are charging for in your instance. We're not talking about radiologists; we're talking about in your practice you said that you provided the valuable service when you got that report. And you know, the other physician who doesn't send these specimens to the doctor or the expert in New York, whatever, he makes the determination, too, of a good person to send the specimen to. So what is unique about what you do that would justify the increased adding to the bill? [LB513]

MARGARET SUTTON: Well, the fact that we are allowing that patient to get exceptional services for no extra cost. [LB513]

SENATOR JOHNSON: Well, you mean you would not try and get the best service for your patient under other circumstances? [LB513]

MARGARET SUTTON: Well, you didn't allow me to finish my sentence...at no extra cost. So to the patient, they're not having any extra cost, and yet we're allowing them to get services that otherwise would have been impossible for them to get. So we're the ones that are talking to the pathologists and establishing relationships and contracts. [LB513]

SENATOR JOHNSON: The other doctors don't talk to pathologists? [LB513]

MARGARET SUTTON: No. I mean specifically about this billing issue. I mean, we're negotiating with the pathologists to state we want our patients to utilize your services; they are not in your network; we will take the financial risk of not getting paid so that our patients can utilize the specialists in the country that they otherwise would not have access to because of their insurance. [LB513]

SENATOR JOHNSON: Senator Stuthman. [LB513]

SENATOR STUTHMAN: Thank you, Senator Johnson. Margaret, I have a real problem and it's getting cloudier all the time by your adding a valuable service. That valuable service is that you say I've got something, a wart, and you take it off and you send it in to what you feel is the best place to send it to have them give you a report, give you the report back. [LB513]

MARGARET SUTTON: Right. [LB513]

SENATOR STUTHMAN: Okay. That valuable service is a service to you that you can give to me as to what you recommend, right? It's not a value... [LB513]

MARGARET SUTTON: On your behalf. I mean, I'm doing this because I want to do what's right for the patient... [LB513]

SENATOR STUTHMAN: But the valuable service is to you so that you can... [LB513]

MARGARET SUTTON: No, I don't agree. [LB513]

SENATOR STUTHMAN: ...do the best thing for the patient. [LB513]

MARGARET SUTTON: Well, I guess the patient is the ultimate recipient of the value. It's allowing me to do my job so that I can be doing the best job for the patient, if that's how you would like to put it. [LB513]

SENATOR STUTHMAN: And because of that service to you from where you sent the sample in, that makes it your ability to make sure that person gets treated right. So that really...that valuable service to me is, first of all, to you. [LB513]

MARGARET SUTTON: It might be but I'm... [LB513]

SENATOR STUTHMAN: And not to the patient initially. [LB513]

MARGARET SUTTON: Well, ultimately it's to the patient. That's why we do these things is to do what's right for the patient. I mean, these things help us make decisions whether that patient should have surgery or not, whether that patient should undergo a powerful medication or not. So, I mean, ultimately this... [LB513]

SENATOR JOHNSON: Could I interrupt for a second? [LB513]

MARGARET SUTTON: Yes. [LB513]

SENATOR JOHNSON: Do you get paid for that? [LB513]

MARGARET SUTTON: I do, but not the service that I'm talking about. The service I'm talking about is different and unique. It's not a decision making service. It's the fact that I am getting access for that patient to utilize someone that they otherwise would not have been able to utilize. [LB513]

SENATOR STUTHMAN: But because of that, you're probably doubling the expense to me... [LB513]

MARGARET SUTTON: I'm not. [LB513]

SENATOR STUTHMAN: ...because of that. [LB513]

MARGARET SUTTON: No, and we've established many times in these testimonies that we are only paid whatever the insurance companies allow us to be paid. So it doesn't matter what I'm charging. I'm only getting paid whatever the insurance... [LB513]

SENATOR JOHNSON: Is that any different than the other person, the other physician who doesn't do this? [LB513]

MARGARET SUTTON: Everybody just gets paid what the insurance company allows. [LB513]

SENATOR JOHNSON: So what makes yours unique that you are worth more in charging? That's what we're trying to get to. [LB513]

MARGARET SUTTON: Well, I'm not saying that I'm worth more. I'm just saying that... [LB513]

SENATOR JOHNSON: You just got done saying you provide a special service. That...see, you've got us confused. That's the problem. What justifies that added expense? [LB513]

MARGARET SUTTON: Well, there isn't an added expense... [LB513]

SENATOR JOHNSON: Yes, there is. If you get a bill for $120 and you change it to $150, or take your number, that's an added expense. Now, what is the justification for it? [LB513]

MARGARET SUTTON: It's no different than the pathologist charging the $150 to begin with, so how could you say it's an added expense? Ultimately,... [LB513]

SENATOR JOHNSON: Senator Pankonin. [LB513]

MARGARET SUTTON: Okay. [LB513]

SENATOR PANKONIN: Let's use these same numbers. [LB513]

MARGARET SUTTON: Okay. Okay. [LB513]

SENATOR PANKONIN: I'm a business person. [LB513]

MARGARET SUTTON: Okay. [LB513]

SENATOR PANKONIN: And now what's coming out is your business model, and I think there's some problems here because you say you want the best possible healthcare at the best possible price. So if this test costs you $90 to send it off, and you know you are going to get $120 from insurance...and let's go off to the side and it's cheaper than $150 for the direct pathologist, that's good because that's lower cost. [LB513]

MARGARET SUTTON: Okay. [LB513]

SENATOR PANKONIN: And it may or may not be. But here's my problem. If you can drive...if you know the insurance cost and your cost is $90, you're going to get $30, right? Because that's what you kept saying. You are going to get what the insurance gets. [LB513]

MARGARET SUTTON: Okay. [LB513]

SENATOR PANKONIN: So if I am a business person, I drive down that $90 cost. Now I'm worried that maybe you're not sending it to the best person. You're going to send it

to the cheapest person. How do I know? Because if you were marking it up 10 percent for your costs, then I would feel better about it. I'm going to send it to the best person and mark it up a flat 10 percent, 20 percent, whatever it is, as a markup. That's how I do it in my business for my costs. If I have to take a diesel pump to Omaha to get it fixed, there's a certain percentage there. It's not what can I get versus this, and you are going to try to drive it down on the other end would be my fear. [LB513]

MARGARET SUTTON: Well, because I think we could never do that because, number one, we are held accountable for the quality of who we work with. And we have patients' lives at stake and we're not going to be going by price; we're going to be going on quality. And we have many, many different risks that we face if we're not using the highest quality. And we've taken an oath that states that we are going to be doing the best possible service for our patients. So there is no way that anyone would do something like that. [LB513]

SENATOR JOHNSON: Senator Erdman. [LB513]

SENATOR ERDMAN: I hope from you being here today, you don't feel like we're trying to blindside you in any way, and your comments were if you would have known we were going down this path, you would have probably had different information. And I did visit with the lobbyist representing your organization, and he told me the same thing: there was just as many opinions and I thought I was clear before I began any questioning, was that one person's opinion is only worth their opinion. And there's going to be different interpretations of statute or different interpretations of the AMA codes, or whatever. You provide a valuable service. These folks here that are in favor of this bill provide a valuable service. And ultimately it goes back to the customer or the patient and making sure that they get the care that they need. We're in the process here, of now that some of these issues have been brought, we're trying to make sense of them, first, to understand what the problem is, because there are two parts to this bill. One is the direct billing issue of who actually provides the service and then whether they get paid directly from insurance company A like the Medicaid program does, and then the second part is an enforcement provision. And some of the enforcement provisions are actually recommended from the department that they are under existing law, and so that's where some of these questions come up. Is something ethical...or something unethical but legal? Sure. Those things happens all the time because you have to reach a certain barrier in the law for it to be illegal. It still doesn't make it right, and we're trying to grasp around that. So I hope you don't go away from here thinking, well, that Health Committee doesn't like us or they're not interested in our position. We're probably more interested in this issue than we have all the other bills combined. And in fact we had a meeting at 4:00 that we blew through so that we could continue to be here than to listen to these issues and to try to sort them. So I hope you don't go away and hope the others don't go away and saying, well, you know, those guys didn't get it. We're trying to understand this. Senator Johnson is the only doctor in the group and he probably

understands some of these issues better than us, but the common folks, you know, it comes back to the fact that if I can only charge somebody X amount, is it ethical to get a higher amount? And as I understand the debate then is, well, the folks that have negotiated lower rate to be able to have access to a doctor who would refer them are getting left out of that profit. And then the question is, who gets that profit is really what this comes down to. Your arguments are valid that you provide a valuable service. But as we continue to go through this process, it just seems like we add one layer upon a layer of issues that have come out of this discussion, and it's probably why the moderators decided to cancel their hearing because they knew of some of these issues that would essentially drive wedges between groups and confuse folks. I passed a note to Senator Pankonin. I said, I've got a bill like this tomorrow between two warring groups that want different things out of the statute. So we're trying to make sense of it and I hope you don't feel like we're blindsiding you or whatever. [LB513]

MARGARET SUTTON: Not at all. [LB513]

SENATOR ERDMAN: We desperately appreciate your willingness to be here, because without your willingness and without the proponents being here we would be making a decision that could be blind. And so we appreciate your willingness to be honest and up-front with us. It's just we're grasping to actually understand what you're telling us and the questioning is going to that point and shouldn't be interpreted as antagonistic or anything else. It's simply trying to truly understand it. [LB513]

MARGARET SUTTON: It's not at all, and I do want to repeat that this type of direct billing is not unique to dermatologists at all. It's any speciality that does biopsies in their office, and it's also widespread between the radiologists, the orthopedic surgeons. As I said before, radiologists are reading x-rays, orthopedic surgeons are charging. It happens in small hospitals because they outsource a lot of their professional services. So this is a very...I mean, I think the ethical issue here has been proven and it's a very widespread practice. [LB513]

SENATOR JOHNSON: Well, let's get back to the x-rays for just a second. Who does the billing there? [LB513]

MARGARET SUTTON: Well, I'm going to use the example of the orthopedic surgeons. [LB513]

SENATOR JOHNSON: No. No, let's talk about the hospital. [LB513]

MARGARET SUTTON: And there are examples where hospitals do the... [LB513]

SENATOR JOHNSON: In general, who would, for the small hospital that you're talking about, who would do the billing? [LB513]

MARGARET SUTTON: Well, I can't speak to in general terms, but I... [LB513]

SENATOR JOHNSON: Would you give me your best opinion? [LB513]

MARGARET SUTTON: My best opinion is that it's a variety of sources of who does the billing... [LB513]

SENATOR JOHNSON: Okay. All right. [LB513]

MARGARET SUTTON: ...because I honestly don't know but I can give you specific examples but I... [LB513]

SENATOR JOHNSON: Okay. That's enough. [LB513]

MARGARET SUTTON: ...can't give you a general term. [LB513]

SENATOR JOHNSON: Senator Pankonin. [LB513]

SENATOR PANKONIN: One more question and then I think my colleague was trying to probably apologize for me being a little rough on you, Dr. Sutton, so I apologize for that. [LB513]

MARGARET SUTTON: Oh, it's no problem. [LB513]

SENATOR PANKONIN: The point I was getting at though is, of course, here's what my customers expect from me when I work on their tractors and combines: They want the best possible service but they want the best possible price. So when I come back to my example is when you say, well, we're saving over the direct billing, the $150 to $120, to keep using the numbers that we're after. But when I hear that we're always going to bill up to the insurance instead of what I want as a consumer, is $99. I think you need to get...and whatever that fair number is, a percentage on mailing it in, however you send it, how you get it back, the actual cost involved, that you need to look at it when it comes back. I understand that. But when you tell me we're going to just go right up to the insurance... [LB513]

MARGARET SUTTON: Well, I didn't mean to say that. [LB513]

SENATOR PANKONIN: That's what set me off because then... [LB513]

MARGARET SUTTON: I didn't mean to say we go up to the insurance. I said the insurance might only pay us $85. [LB513]

SENATOR PANKONIN: Yeah, but...and I understand it some time, but I just think that was where I was coming on my example, to get the... [LB513]

MARGARET SUTTON: Okay. Well, that was a misunderstanding. What my point was, is it doesn't matter what I bill. I only can receive what the insurance company decides to pay me, and it might be $95, it might be $85. I mean, it's not even close to what I'm billing... [LB513]

SENATOR JOHNSON: Ma'am, is that any different than the person who sends the specimen to another pathologist? [LB513]

MARGARET SUTTON: I think everybody gets paid the same amount, the way I understand it, so I'd say no if I'm understanding your question correctly. [LB513]

SENATOR JOHNSON: Yeah. That's fine. Any other questions? [LB513]

MARGARET SUTTON: Thank you. [LB513]

SENATOR JOHNSON: You bet. Thank you. Next please. [LB513]

DAVID WATTS: Senator Johnson, members of the Health and Human Services Committee, thank you for your thoughtful attention to these very complex issues that are facing you today. And I realize the hour is late; I'll try to, as much as possible with this very complex discussion... [LB513]

SENATOR JOHNSON: Senator Hagel has left now. Take all the time you want. (Laugh) [LB513]

DAVID WATTS: (Exhibit 9) I'll try to be concise anyway. My name is David Watts, W-a-t-t-s. I'm a board certified dermatologist practicing in Omaha and the current president of the Nebraska Dermatology Society, and I'm speaking on behalf of the dermatologists in Nebraska. As you can see, this is an issue that's not clear-cut and has a good deal of emotionalism and possibly even some questioning of motives of the other party, and that's made this difficult and probably played into the difficulties that the mediator encountered with...I agree with you, she probably came to the conclusion that there was very little common ground. At any rate, as a practicing dermatologist or as a physician, my responsibility, as Margaret said, is to be the patient advocate. There is a quote over the stairway of the institution where I trained that says, the best interest of the patient is the only interest to be considered. And that's the way that I try to run my practice--always have. It seems to me that this is a quality of care. It's access quality of care issue for the citizens of Nebraska, and others have very eloquently stated that we're trying to get the best-trained, most experienced person to look at the biopsy specimen that we can, to get the best help in the diagnosis. But it's not quite so simple

as just as a diagnosis rendered by a pathologist. This is a puzzle, and say that you come to me with a mystery rash. You come to me, we talk about your symptoms. We talk, we look at how the rash looks, and those are the pieces of the puzzle. I'm paid for that service. We take a skin biopsy to help in the diagnosis. I'm paid for that service. I send that pathology specimen to someone who can help me. I tell you I'm going to send this pathology specimen to a specialist who deals in rashes. I think, based on what you're telling me and showing me here, that you could have A, B, or C, but I can't narrow it down any further than that. Let's see if the pathology or the biopsy specimen can help. And so I want to send that pathology specimen or that biopsy specimen to the person that I think can give me the most information. Now, I can send it to a general pathologist if the insurance company dictates that I have to--someone who may be used to looking at all of these different tissues and may look at some skin. And frequently what I'll get is a description, a description of how this looks under the microscope. Well, I already knew that. I've had pathology training in my dermatology residency--seven months of it. And I can describe it. I just need help with it. And so I want to send this to the person, say, in Texas, who is a rash specialist who deals in what I think this probably winds up in the ballpark of. So I send the tissue specimen off and I get an answer back that this is B, C, or X--the extended suspicion list may include X, Y, or Z. And that's another piece of the puzzle. It's not so simple as just a pathologist rendering a diagnosis and getting paid for it. But I do get paid for the interpretation of that biopsy. And as Dr. Sutton was talking, there is an added value that I...that $30 markup to use Senator Erdman's example. And I guess that is not only the overhead of running an office and mailing off the specimen and billing and collecting and or in talking to the patient over the telephone, which I don't get paid for, to discuss that biopsy with them and put this all together. Now, I may get paid for a further visit but I don't probably get paid for the telephone call to the patient when I'm discussing that puzzle that we're trying to solve. So I think the value added service is partially also in the interpretation that I give to the interpretation that I got from the biopsy. So it adds, hopefully it reduces the complexity of it but sometimes it's still not clear, and that's where the art of the whole thing comes in. And I think that's, to me, the real value...the value...the biggest value that I add if there is a markup. And I do believe it's ethical if there is...I prefer to look at it as a discount, seeking some pathology laboratories we do have relationships with--volume relationships, what have you. And we do get a mark down or a discount and take what the insurance company will pay, pay the lab what they require. And if there is $30, I think that that is ethical. I think the AMA guidelines do say that there shouldn't be double billing for a service, but the catch words in that opinion are "if possible. And as Dr. Schlessinger mentioned, there are approximately 1,000 board certified dermatopathologists--people who specialize in skin and have had extra training in skin nationwide, that I have a choice to send my patients' tissue to. There may be a small handful in Nebraska. I want that choice. I want to be able to send the specimen where, in my judgment the best-trained, most qualified individual is going to get a chance to look at that biopsy specimen and give me the most guidance. The problem that I see with LB513 is that it is going to effectively exclude those specialists. And the

testimony has been given that that's not going to happen, but in effect it is because insurance dictates where we send those specimens. Like it or not, that is the reality that we face. And if the specialist in Texas is not on the plan, that patient is going to get a bill from the specialist. They're going to say, what the...? Doc, I'm not coming back. I won't even get a chance to solve that rash. In essence, it's going to make the best service inaccessible or prohibitively expensive for the patients in Nebraska, and that's my opinion. [LB513]

SENATOR JOHNSON: Any questions? Senator Stuthman. [LB513]

SENATOR STUTHMAN: Thank you, Senator Johnson. David, I'm getting mixed emotions again. We had one of the testifiers say that he sends a specimen in, whether he sends one or 100, he has a contract with that one. It's billed monthly. Okay. Another statement here and I think it came from you, that you've got a contract where you get a volume discount and you maybe make that $30 or $100 off of that one because you are working on what the Medicaid is going to pay you for that service. But then I also hear you say I'm going to send it to the best place where I can get the best results. Do you have a contract and a volume discount with everyone? [LB513]

DAVID WATTS : No. No. And that volume discount may be misleading because I do really want to send the biopsy specimen to the person who I think is going to give me the best information, give me the most information to help that patient, and that's bottom line. [LB513]

SENATOR STUTHMAN: And if that cost would be double of what Medicare is going to pay you, are you going to absorb that? [LB513]

DAVID WATTS : I have, as a matter of fact. I can give you an example. I sent a tissue--it was a rare inflammatory condition--I sent the tissue to, as someone mentioned, Dr. Ackerman (phonetic). I said, well, boy, Dr. Ackerman (phonetic) knows his stuff when it comes to this particular condition. He charged me $300. I charged the insurance company what they...the insurance company gave me what they would pay, which was $120. And, yes, I absorbed the difference. Now, I don't do that all the time obviously; I couldn't. And healthcare is a business unfortunately. I mean, I'd like it to be pure medicine but it is a business. [LB513]

SENATOR STUTHMAN: Thank you. [LB513]

DAVID WATTS: Yes, sir. [LB513]

SENATOR JOHNSON: I want to get back to where I was with your...the previous testifier. I'm not here to defend the pathologists, believe me. I have no interest or...in one side or the other here, but I was confused. When a surgeon takes out a gallbladder,

isn't part of the care, the after-care as well as the before-care, and so on, and in taking care of that patient? [LB513]

DAVID WATTS : I'm not sure exactly what you are getting at. [LB513]

SENATOR JOHNSON: Well, what I'm trying to get at is this, is that the previous testifier, as I understand it, said that I get an extra fee for interpreting what to do next when I get the report from the pathologist. Would not the person who takes out a gallbladder that finds that it is a cancer of the gallbladder rather than a regular gallbladder make that same type of determination? [LB513]

DAVID WATTS : That surgeon will probably be paid on a further...on a subsequent visit when he or she meets with that patient and tells them you... [LB513]

SENATOR JOHNSON: No, I don't think you will at all. The patient is still in the hospital. [LB513]

DAVID WATTS : The patient is still in the hospital. Well, I understand it...I don't have hospital patients but I understand that there is a fee every time you see the patient in the hospital. [LB513]

SENATOR JOHNSON: No, I don't think so. No. When you take out a gallbladder, you take out the gallbladder. [LB513]

DAVID WATTS: Uh-huh. [LB513]

SENATOR JOHNSON: Yeah. And then you see them after the operation. And so why is there a difference here in the interpretation of a skin biopsy and you get to mark up the price there when the surgeon who takes out the gallbladder and finds out that the...you know, whether it's cancerous or not, still makes that determination as to what to take care of the patient afterwards. I don't see the difference. [LB513]

DAVID WATTS : I can't answer your question. [LB513]

SENATOR JOHNSON: Okay, thank you. Any other questions? Thank you, sir. [LB513]

DAVID WATTS: Thank you. [LB513]

LESLIE SPRY: (Exhibit 5) Senator Johnson and members of the Health and Human Services Committee, thank you for the late hour and staying around. My name is Les Spry, that's L-e-s...well, my name is Leslie, L-e-s-l-i-e, Spry, S-p-r-y, and I am a nephrologist in Lincoln, Nebraska, and I am the chair of the Commission on Legislation and Governmental Affairs for the Nebraska Medical Association. I come before you

today on behalf of the Nebraska Medical Association to testify in opposition to LB513. This bill would require that certain billing codes be used exclusively by pathologists and other physicians for their interpretation of pathologic specimens and would prohibit physicians who do not interpret pathologic specimens from using these codes for a practice known as pass-through billing. The AMA code of ethics, as has been referenced here many times this afternoon, prohibits physicians from billing patients for services that are not specifically performed by that physician. The AMA code further suggests that the addition of excess markup for contracted services rendered by another physician is unethical. These issues, however, cannot be decided on a blanket basis, and we rather feel that there needs to be a consideration of individual office billing practices. With this in mind, it is the position of the Nebraska Medical Association that this issue falls under the jurisdiction of the Board of Medicine and Surgery and the Department of Health and Human Services. The board currently has the statutory authority under Nebraska Revised Statute 71-148 to discipline physicians if that physician is acting in an unethical manner. We believe this issue to be a regulatory issue and, as such, does not belong in the legislative process. It should be referred to the Board of Medicine and Surgery for specific decision in regards to its ethical aspects and investigation for determination by that board. We do think that the process of pass-through billing should be more transparent and physicians need to inform their patients when they are billing for purchased services. Patients need to be informed of the cost of those services and the markup made by the billing physician. The bill also, as currently written, excludes nonprofit medical practices and public access clinics from the prohibition against marking up pathology fees. This would mean that physicians employed by nonprofit entities would be exempt from this particular statute. Nonprofits such as the University of Nebraska, St. Elizabeth's Physicians Network, Physicians Clinic in Omaha, and One World in Omaha would be exempt from the provisions of the bill. Hence, the bill does not treat all physicians equally. As has been testified here earlier, there are a number of physicians who may be participating in this process and only those physicians who are in those areas would be exempt. It protects large hospital-based medical practices which are also nonprofit entities. It saddens us, as an organization for all physicians, to oppose legislation drafted and supported by one of our specialty areas in the house of medicine. We do not take this position lightly and stand ready to work with our colleagues and the Board of Medicine and Surgery to assure the ethical practice of medicine in the state of Nebraska. And I'd be happy to take questions. [LB513]

SENATOR JOHNSON: Any questions of Dr. Spry? Senator Erdman. [LB513]

SENATOR ERDMAN: I was going to say, what's up, Doc, but I didn't know that that would be funny at this late hour. (Laugh) So if I'm reading your testimony correctly, that the AMA code...this is the interpretation of the Nebraska Medical Association and you are their representative as the chair of the Commission on Legislation and Governmental Affairs, the AMA code suggests, which is a little murky, but suggests that

the addition of excess markup for contracted services rendered by another physician is unethical. [LB513]

LESLIE SPRY: That is true. [LB513]

SENATOR ERDMAN: So, in the example...and I think your testimony is accurate that you can't decide this on a blanket basis so I'm not going to use "everybody does this," I'm going to say in this example that I've been giving, if it costs $90 to provide the service and the insurance will reimburse $120, then the scenario is that it's a physician contracting with somebody, and there's a $30 difference, is that what you would consider to be a markup? Because as I read some of the additional language, there is some disagreement about what an actual markup is, but I guess to make sure that I understand, does this statement refer to the example that I'm saying that if there's a $30 profit made by somebody based on what it costs versus what they are reimbursed, that that is considered a markup and is unethical? [LB513]

LESLIE SPRY: If I served on the Board of Medicine and Surgery and looked at that particular practice, my opinion would be that's unethical. [LB513]

SENATOR ERDMAN: And so under the existing authority for the Board of Medicine, if that is, in fact, true, then the remedy is, is that physician who is collecting that $30 difference is then brought before the Board of Medicine for potential disciplinary action which could include them losing their license. Is that accurate? [LB513]

LESLIE SPRY: That would be accurate. [LB513]

SENATOR ERDMAN: And so to the second part of the bill which is the ethical or the enforcement provisions, you would state, based on your understanding of the Board of Medicine's authority under existing statute and regulation, that that issue is resolved consistent with what Dr. Schaefer has shared with us, that you have that authority. If there is this practice going on, the appropriate place to go is the Board of Medicine to remedy this. [LB513]

LESLIE SPRY: That's correct. We would offer, as I said in my testimony, that in some certain circumstances we think that the process needs to be more transparent. And if the Board of Medicine and Surgery would come out and say we think that there ought to be line item billing in all physicians' practices, we would heartily endorse that. But again we feel that this is already covered under statute. We would refer it to the Board of Medicine and Surgery. [LB513]

SENATOR ERDMAN: Great. And you're not an attorney? [LB513]

LESLIE SPRY: I'm not an attorney. [LB513]

SENATOR ERDMAN: Congratulations. [LB513]

SENATOR JOHNSON: Dr. Spry, in an attempt to get this transparency, which would cover the things I was in the discussion with our pathologist, would it not, the transparency so that the patient knew what he was paying for, wouldn't that cover what the problem is that we're seeing here? And furthermore, let me ask you this: Is that not the type of agreement that could have happened if two sides had sat down with the excellent mediator between them? [LB513]

LESLIE SPRY: In answer to your first question, I do believe that adding the transparency to this would at least expose that to something that has been tradition in the United States forever, and that is buyer beware. And if you know what you're buying then at least you can be beware of that particular practice. Now, what is an excess charge? I don't know. Now, in response to some questions that had occurred to the mediation session, and I don't want to get into he-said, she-said kind of situation... [LB513]

SENATOR JOHNSON: Right. I understand. [LB513]

LESLIE SPRY: ...but I can tell you that the Nebraska Medical Association who was the sponsor of the mediator had conversations with the mediator. And after the mediator did their due diligence between the two parties, they approached and said, this is a useless procedure. [LB513]

SENATOR JOHNSON: All right, thank you. Any other questions? [LB513]

SENATOR ERDMAN: And then here we are. [LB513]

SENATOR JOHNSON: Yes. (Laugh) Any other questions? Senator Pankonin. [LB513]

SENATOR PANKONIN: Doctor, I appreciate your testimony; I think it answered some of my questions. Probably the thing that's discouraging for me this afternoon is I probably have more questions and less respect for your profession after hearing this, this afternoon. So I agree with you--more transparency. You know, I can understand if someone said, you know, we've got to mark it up to cover our overhead. But when you talk about suggests that the addition of excess and don't define any of that, I think it's...for your profession, and what we've got to do for, is we're going to move to more transparency and whatever, those are the kind of things that are discouraging to me because when I hear about volume discounts and I hear about Dr. Schlessinger having one person, which I know how that model works. You know, if you are going to pay one flat rate, I would send a bunch of them. The per cost goes down. You know, I'm a business person, and so when I hear that we're going to get you the best possible care,

but if we can get a volume discount or if we can spread that over more, that doesn't...it's too conflicting to me and I have a problem with it. But...so I guess it's not so much a question but I think more that you can do, I think people would have more confidence, because right now mine has been shaken a little bit. [LB513]

LESLIE SPRY: Well, you can imagine the internal discussions that occurred within the Nebraska Medical Association were reflective just exactly of that--that this was something that we didn't want. And we really felt that there was a way to bring these sides together but it wasn't going to happen, and so. But I would say that you already have a statute, and I've approached at least two members of the Board of Medicine and Surgery, and they would be anxious to tackle this. And I think that if we heard from the disciplinary arm of our profession in this regard to say this is what we do in Nebraska and this is not what we do in Nebraska, be done. [LB513]

SENATOR PANKONIN: So how do we initiate that? [LB513]

LESLIE SPRY: You've got some ears from the Health and Human Services here, I would bet. I'm on the Board of Health so I'm a member of the Board of Health and we make recommendations to Health and Human Services. I can initiate it that way, but a letter from this committee to Health and Human Services would probably get a lot of attention. [LB513]

SENATOR PANKONIN: Thank you. [LB513]

SENATOR JOHNSON: Les, thank you very much. Any other testifiers? Any neutral? Come on up, Senator. [LB513]

SENATOR STUTHMAN: Thank you for your closing. [LB513]

SENATOR FULTON: I'll go fast. [LB513]

SENATOR JOHNSON: No, you take your time. [LB513]

SENATOR FULTON: Thank you, Chairman Johnson and members of the committee. That there is a need for this bill and that there is a need to have this debate, I think that's been established today. I think that after a year and a half, the Legislature probably is the appropriate remedy for this issue. Does this bill limit dermatopathologists available to dermatologists? Does this bill limit pathologists' services that are available to dermatologists? No. I had as my intention direct billing. And you can read through the green copy and that's what's going on here--we're asking for direct billing. Dermatologists can use whomever they choose and deem appropriate. This bill simply requires that whatever pathologist is chosen, bill for his services. If you diagnose it, you can bill for it. It's very simple to me, and I think that it would be a service to the

greater...to the public. I understand that this bill has political ramifications. Believe me, I'm new at this but I'm not new at politics, and I considered this before agreeing to sponsor the bill. But after having learned a little bit of the discussions and of the division that exists, I couldn't not introduce it. And I think after hearing both sides of this debate, you might understand why. I'm a new senator and I'm trying to do what I think is right, and I think that this is the right bill. I've tried to look beyond the political ramifications to consider this issue in the broader context of a properly formed public policy. And so I ask respectfully that the committee deliberate and advance this bill for the good of the public and for the healthcare system in general--both sides of this debate. So thank you very much. [LB513]

SENATOR JOHNSON: Thank you. And Senator. [LB513]

SENATOR HANSEN: Thank you, Senator Johnson. I've been quiet here for quite awhile. I've been waiting for you to come back, Senator Fulton. [LB513]

SENATOR FULTON: Oh, boy. [LB513]

SENATOR HANSEN: Have you ever been through a mediation? [LB513]

SENATOR FULTON: Yes, but it didn't last very long, so yes. [LB513]

SENATOR HANSEN: Okay. You can go through mediation, and one thing that when I went through it with my family, I mean it wasn't a good situation at all, but the mediator said, the first thing he said was, when we get done, when we resolve this, neither side is going to be happy. I mean, good legislation is, neither side is going to be happy but we've reached a compromise. In the words of my good friend Don Stenberg, try, try, try, try again for mediation. I think that's the way they need to solve this problem. I'm not sure it needs to be done in this committee. [LB513]

SENATOR FULTON: I appreciate your input. [LB513]

SENATOR JOHNSON: (Also Exhibits 6, 7, 8, 10, and 11) And I'll close by saying that 40 years ago someone told me, do what's best for the patient and everything else will take care of itself. Good night everybody. [LB513]

Disposition of Bills:

LB171 - Advanced to General File, as amended.
LB292 - Advanced to General File, as amended.
LB513 - Held in committee.
LB518 - Indefinitely postponed.
LB666 - Indefinitely postponed.
LR10 - Reported to the Legislature for further consideration with amendment.

Chairperson

Committee Clerk