[LB753 LB807 LB818 LB835 CONFIRMATION]

The Committee on Health and Human Services met at 1:30 p.m. on Thursday, January 31, 2008, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on several gubernatorial appointments, LB753, LB807, LB818, and LB835. Senators present: Philip Erdman; Tom Hansen; Gwen Howard; Dave Pankonin; and Arnie Stuthman. Senators absent: Joel Johnson, Chairperson; Tim Gay, Vice Chairperson.

SENATOR STUTHMAN: Good afternoon, ladies and gentlemen, and welcome to the public hearing of the Health and Human Services Committee of the Nebraska Legislature. I am Senator Arnie Stuthman of Platte Center, and I would like to introduce the members of the Health and Human Services Committee. To my far left, Senator Gwen Howard from Omaha; Senator Tom Hansen from North Platte; and my committee clerk is Erin Mack to my immediate left. And to my right, Jeff Santema, he's with the committee; and the committee member of Bayard, Phil Erdman. I would like to...these proceedings are recorded and transcribed, and if you have a cell phone, please take it off, shut it off, don't have the vibrator on or anything. We will take action immediately upon any noise from a cell phone. The committee will first hear proponent testimony, followed by opponent, and then neutral testimony. It's limited hopefully to three to five minutes. We may have a lot of people that want to testify today, so respect the people that have come a long distance to testify, and be respectful as far as giving them some amount time, also. I'm going to set some ground rules that haven't been adopted or presented before. When an individual is going to testify, I would appreciate if you would come to these front chairs, so that when the testifier is done testifying, you can immediately go to the chair to testify. Also if you have the material to be handed out by the page, and the page, I would like to say, is Matt Pederson, and we welcome him here this afternoon. Please place your testimony on the desk and they will hand it out to the committee members. The first thing on the agenda today is...we have some gubernatorial appointments. We have Larry Brown from the Foster Care Review Board, and we also have Douglas A. Dilly with the Nebraska Rural Health Advisory Committee. I understand that Douglas is not with us at the present time. He will come a little bit later, and when he arrives we will go to that gubernatorial appointment. So at the present time, the legislative bills will also be heard in the order that we have them listed. So with that, and no other announcements, I would like to have Larry Brown from the Foster Care Review Board come forward, please. Welcome. [CONFIRMATION]

LARRY BROWN: Thank you. Good afternoon. [CONFIRMATION]

SENATOR STUTHMAN: We would appreciate if you give us a little bit of your history... [CONFIRMATION]

LARRY BROWN: Sure. [CONFIRMATION]

SENATOR STUTHMAN: ...and tell us of your appointment and what you plan to do, being appointed. Thank you. [CONFIRMATION]

LARRY BROWN: (Exhibit 1) Well, Senators, it's my honor to again be presented to this committee for confirmation. I've served on the Foster Care Review Board for two years, and am being re-presented to you for confirmation for another term. I am a board-certified pediatrician and internal medical specialist, a member of Nebraska. I've been here for most all of my life. I'm a community advocate and have worked with children and families for most of my medical career, including directing a federal project from the federal Senate, looking at infant mortality health disparities in the state of Nebraska. I served in academics for nine years and am now in private practice. I'm an ordained Baptist minister. The significance of that is my community advocacy and the work that I've done with many folks in the foster care system prior to serving on this committee is driven by my passion for the health of our kids. [CONFIRMATION]

SENATOR STUTHMAN: Thank you. Does the committee have any questions? Senator Hansen. [CONFIRMATION]

SENATOR HANSEN: Thank you, Senator. It's good to have you here, Mr. Brown. Do you go by Reverend or Doctor or... [CONFIRMATION]

LARRY BROWN: Doctor is fine. [CONFIRMATION]

SENATOR HANSEN: Okay, Dr. Brown. [CONFIRMATION]

LARRY BROWN: Thank you, sir. [CONFIRMATION]

SENATOR HANSEN: Really appreciate you doing this and especially if you're willing to volunteer for another go-round with the Foster Care Review Board. [CONFIRMATION]

LARRY BROWN: Thank you. [CONFIRMATION]

SENATOR HANSEN: Appreciate you doing what you do up there and for the state of Nebraska. [CONFIRMATION]

LARRY BROWN: I appreciate that. [CONFIRMATION]

SENATOR STUTHMAN: Any other questions from the committee. Seeing none, thank you very much, and thank you for serving. [CONFIRMATION]

LARRY BROWN: Thank you. [CONFIRMATION]

SENATOR STUTHMAN: Thank you, Reverend. We will now go into the testimony on legislative bills. We have LB835 by Senator Preister, and I would also like to get into the record that we have been joined by Senator Dave Pankonin. And welcome. We will stand at ease. []

EASE []

SENATOR STUTHMAN: Oh, he is here. Thank you. Senator Preister. [LB835]

SENATOR PREISTER: Thank you, Senator Stuthman. My apologies for delaying the proceedings. [LB835]

SENATOR STUTHMAN: You did not delay it. Thank you. [LB835]

SENATOR PREISTER: (Exhibit 1) Good. Thank you. My name is Don Preister, P-r-e-i-s-t-e-r, and I am here as the primary introducer of LB835. I do have some handouts for the committee, and an amendment. Thank you. LB835 will prevent the sale of any childcare article or toy in this state which contains a specific amount of lead. Lead poisoning can cause irreversible learning disabilities and behavior problems at high levels, seizures, coma, and even death. Recent tests on more than 1,200 children's products, most of them still on store shelves, found that 35 percent contain lead in levels far above the federal recall standard used for lead paint. Of the 1,268 items tested, only 23 toys and children's products were recalled last year. The majority of the toy manufacturing base has moved overseas. Approximately 80 percent of the toys sold in the United States are made in China. Last summer, more than 20 million toys manufactured in China were recalled because of lead paint and other hazards despite the fact that lead paint was banned from toys in the United States 30 years ago. It was recently discovered there is a connection between electronic waste we export from the United States to China and the lead found in recalled toys and children's products made in China. A July 2007 article in the Wall Street Journal reports that two recent studies indicate that the lead in children's products can be traced back to lead solder from e-waste electronic circuit boards. Children and family members disassemble these waste products and are exposed to toxins, such as lead, which is a neurotoxin, and cadmium, which is a carcinogen that damages lungs and kidneys. Informal e-waste processing is also a common household business in these developing countries. I passed out to you some pictures, and on those pictures and, Mr. Chairman, if it's all right with you, I'm going to share copies with the people that are here in attendance as well. [LB835]

SENATOR STUTHMAN: Yes. [LB835]

SENATOR PREISTER: And if they want to circulate these, I'll send two copies around so they can see what I'm referring to, particularly since we have nursing students here

today. I think this is real important. You'll see in the one picture a young person who is carrying on their head a lot of the electronic waste. And you can obviously see there are no environmental standards, health standards or much concern for that young person. You see in another picture a young lady who is sitting in the midst of a lot of electronic wiring. Again, these are almost cottage industries in these developing nations where they're taking our electronic waste and recycling it, effectively recycling it. The third picture is very alarming to me. You'll see in that one a man using his own home cooking tools, where he's melted down the lead in very likely the same thing he's going to feed his family with later--no standards, no understanding of the impact of that lead on his own family or his own children. These pictures, and you might be interested in looking at the January issue of the National Geographic Magazine, where we got these photos. And I will mention that Natalie Behring was the photographer, and we did get the authority to reproduce these pictures for you today, as long as they weren't used for any other commercial purposes or used in any other way. As you can see, the pictures are alarming. I would mention to you that as soon as I leave here, I'm also going over to the Natural Resources Committee, and I have a bill in Natural Resources today up for hearing to deal with setting up a program where we, in Nebraska, deal with our electronic waste so we're not just sending it over to third world countries. So I'm dealing with both ends of it, this one today deals with the lead. In 1972, the Consumer Product Safety Commission was created to protect the public against unreasonable risks of injury associated with consumer products. However, due to budget and staff constraints, the commission has been unable to keep up with the demands of the modern global marketplace. In 1974, the first year of operation, the commission had a staff of 786 full-time employees and a budget of $35 million or the equivalent in today's dollars of $146 million. It grew to a high of 978 employees in 1980. Since the mid-eighties, the budget of the commission has been steadily reduced. In 2007, the commission budget was only $62 million, and the number of full-time employees had dropped to 420. Currently, there are only 15 port inspection staff nationwide, hardly enough to check all the containers of all the products coming into the country. And the President's 2008 budget proposes a further reduction in commission staff. The states cannot currently look to the federal commission to protect children from dangerous toys and other children's products. Federal legislation has been introduced, but experience shows this process can take many years before a bill or standards are enacted. In the meantime, it is left up to the states to take action to prevent the sale of these products. Foremost, this is a health and safety issue which targets our children. But lead poisoning also has an economic impact on our healthcare system and our school system, causing increased special education costs. In addition, a number of studies have found evidence that lead, the neurotoxin, causes impulsivity and aggression, which leads to higher crime rates. Studies have found identical decades-long association between lead poisoning and crime rates, not only in the United States, but also in nine other countries. Currently, at least ten other states have either introduced or passed legislation to ban the sale of toys and children's products containing lead and other toxins. Nebraska needs to join these states in passing legislation to ensure that children's products and

toys do not cause harm to our children. I've spoken with a number of interest groups who have raised several practical concerns with the bill as currently drafted. I did give you an amendment that takes into account these concerns. It addresses concerns raised by the state Chamber of Commerce, the Nebraska Retailers Association, and transportation interests. The amendment makes the following changes, additions to the bill: (1) It clarifies that these provisions do not apply to the sale of a collectible or ornamental toys not marketed to or intended to be used by a child. (2) It deletes the prohibition on transferring any toy or childcare article. This is to address transporter liability concerns. (3) We added the authority for enforcement to the act to the Attorney General's Office. (4) The civil fine may be waived if the Attorney General determines that a person acted in good faith to be in compliance, pursued compliance with due diligence, and promptly corrected any noncompliance after discovery of the violation. (5) If a federal law or standard is adopted which is at least as stringent as this act, then the act goes away. It makes November 1, 2008, the effective date of the act in order to give retailers time to work with manufacturers and renegotiate any contracts they may have. The original date was the first of July. And the reason that I was willing to move it back was to give that time. But I also wanted to make sure we didn't go too long, because I'd like it to be in effect before we start all the Christmas toy sales and before all those sales and specials get out there, and to give retailers that negotiating time with any contracts they may have sold. In addition, I've made a commitment to work with health and prevention groups to address other issues that they have raised, including the need to identify the entity responsible for testing the products, the need to provide funding for the cost of testing, and the establishment of a protocol for testing, including quality assurance. There may be other issues that arise as we work through this process. And I am committed to work with all interest groups to resolve their concerns. I believe that the health and well-being of our children is in all of our best interest. I don't expect to have any opposition testimony. But I do believe that there are legitimate issues and concerns and I remain available to work with the committee and all interest groups to help address those so we can move forward with this legislation. With that, Senator, I'd be happy to answer any questions. [LB835]

SENATOR STUTHMAN: Okay. Thank you, Senator Preister. Does the committee have any questions? Senator Hansen. [LB835]

SENATOR HANSEN: Thank you, Senator. Senator Preister, good to see you again here. [LB835]

SENATOR PREISTER: Thank you, Senator Hansen. [LB835]

SENATOR HANSEN: The retail business, the retail industry I think within the next couple of months will be ordering all their Christmas toys. They do that way ahead of time. [LB835]

SENATOR PREISTER: Yes. [LB835]

SENATOR HANSEN: So if they're ordering those toys, they're probably going to be made prior to the December date that you suggest in your amendment. How are we going to have quality assurance on those products that are...I don't understand...we're getting quality assurance on these anyway. Who's doing the testing? Who's doing...finding out the news that are coming into the country and the paint and all of that? I guess, I don't understand the process of quality assurance with toys. [LB835]

SENATOR PREISTER: At this point, we're starting a new process because we really haven't had action at the federal level. And as I said, we don't have the inspectors to test. The compliance and the assurance is a problem, it is an issue. So we can do nothing and we have no assurance or we can take action and begin working on developing and refining that. My approach is to begin that. We don't have all the testing assurance, we don't know. But if we're in process of passing this, and I commend the retailers, they've been working with me on this right along. And they have the same concerns. The retailers see these recalls and it reflects negatively on them and they are seen as irresponsible. They don't want to be seen that way and they feel they are being responsible. And I think that's why they're trying to be very cooperative with this. It does allow for renegotiating any contracts should they have purchased toys inadvertently that they didn't know did have lead in it. So do we have all the answers for testing every single thing that comes in? We don't have all that in place here, no, I can't give you that assurance. But with all of the recalls we've had, I think, right now we're identifying them sometimes after the fact, but many of them aren't being caught at all. Fortunately some of the health departments are setting up their own testing. The equipment to do the testing is available, it can determine the amount of lead. And there are people here from health departments who can talk about some of what they have been doing already. [LB835]

SENATOR HANSEN: One other question. Very briefly, the collectable or ornamental toys, now when I think of ornamental...or collectibles and ornamental toys something that might hang on a Christmas tree, would that be a possibility? That's in the range of those little toddlers that come around. I know the cat and the kids always used to take the ornaments off the tree and they're both going to be licking them and so I can't see how you can exempt that myself. Even the garland and everything that we put on Christmas trees anymore, so... [LB835]

SENATOR PREISTER: Well, and I wouldn't think of garland as being a collectible. When I was thinking this, I was thinking of the little toy tractors, some of the little G.I. Joe soldier kinds of things that are very expensive and that are traded on eBay and that people put up on shelves. And they don't want anybody getting ahold of them. And many of those things actually stay still in the box because they have a higher resale value and as a collectible. So when you're talking about garland or some of those types

of things, that wasn't what I had in mind. [LB835]

SENATOR HANSEN: Okay. My sons use my 1971 Husker football to play with, so...(laughter), unbeknownst to me. Darn kids. Thank you. [LB835]

SENATOR PREISTER: Thank you for the question, Senator Hansen. [LB835]

SENATOR STUTHMAN: Senator Howard. [LB835]

SENATOR HOWARD: Thank you, Senator Stuthman. And thank you, Senator Preister, for bringing this in. As you know, I signed onto this bill with you because I think this is certainly something we have the responsibility to look at and to be vigilant. Parents are very concerned about this, as they should be. And, you know, I read that the U.K. has a much higher standard for safety for toys for children than we do. I think it's time that we get serious about the standards that we say are in place, the standards that people want to believe are there to protect our kids from lead in toys. And so I really thank you for taking this issue seriously and bringing it in. [LB835]

SENATOR PREISTER: You're welcome, Senator Howard. Thank you for signing on. [LB835]

SENATOR HOWARD: Thank you. [LB835]

SENATOR STUTHMAN: Any other questions from the committee? Senator Preister, I have one. [LB835]

SENATOR PREISTER: Sure. [LB835]

SENATOR STUTHMAN: In the photographs that you had passed around, that recycling waste, is that shipped from like our country to some of those other countries to be recycled? You know, if we're doing that from our country, we get the product and we have kids playing with it, and then they send them back and they're recycled, and they play with it again, and we then we get them back here again as another toy because of the recycling fact. It's just a continuous use of that lead. And that, I think, is a problem. Do you see that we can stop this in any way by not sending it to those companies or to those countries? [LB835]

SENATOR PREISTER: Thank you for that question, Senator Stuthman. That's a part of what I'm going to be doing with my next bill when I go to Natural Resources is to create a take-back program. And the manufacturers are on board with this so I have some support. Where instead of having all this electronic waste accumulate and put in containers and shipped to third world countries, like China, and Africa, and India, Afghanistan, we would break them down, we would remove the component parts, the

lead, the cadmium, the mercury, all of those things. And each of these screens in our computers has roughly six to eight pounds of lead. It serves a very functional purpose there. It protects us from the radiation coming through the screen, much as the lead shields protect you when you get x-rays or protect the technicians. So it has value. But once you take it apart, once you melt it and you begin separating it, then you can breathe the vapors, you can get it on your skin, and the skin is the body's biggest organ; it absorbs everything. So if you put it on your skin, you might as well eat it, because your body is going to absorb it. So I'm hoping to deal with that component and set up programs in this country so at least in Nebraska we're not shipping all these things over to these third world countries. But the article I discussed, in the Wall Street Journal, clearly identified where this is happening and that it's that very lead that is then being used in the paints that, just as you identified, is then put in the toys and comes right back to the United States. And children naturally teethe, they put things in their mouth, everything goes to the mouth. And it doesn't take long, as they're chewing on those toys, even the binkies, some of which have lead in them, soon that lead gets in the system. And once that lead is there and the damage is done, in some cases it's irreversible. And that child then lives with that and society, the family, we all pay that cost. So I'm trying to deal with the problem at the source, with my other bill. But I'm also trying to take a preventive step here and that's preventing the kids from even getting it. [LB835]

SENATOR STUTHMAN: Okay. Thank you, Senator Preister. Will you be here for the closing? [LB835]

SENATOR PREISTER: Because I have to do the other bill, Senator, I probably won't close. I will stay for a while until I get a call. And the pages might let me know when they call to have me go to the other committee. [LB835]

SENATOR STUTHMAN: Okay. Thank you. [LB835]

SENATOR PREISTER: Thank you, Senator. [LB835]

SENATOR STUTHMAN: Can I have a show of hands of how many proponents we will have? One, two, three possibly. Any opponents? Okay, we will start with the proponent testimony. Welcome. [LB835]

KARA EASTMAN: Good afternoon, thank you. My name is Kara Eastman. I'm the executive director of the Omaha Healthy Kids Alliance. Our mission is to eliminate childhood lead poisoning in Omaha. And we are here as a proponent of this bill. We have actually been doing a number...over a dozen toy testings that we've sponsored in Omaha and also in other places in Nebraska, and have been astounded at the number of toys that we're finding that are not on recall lists that are coming up with amounts of lead that are higher than the industry standard that they allow. So Senator Preister

mentioned the binkies. We're finding teething rings, bibs, things that are designed for children to be putting in their mouths that are coming up with high levels of lead. And we feel like this bill is a step in the right direction to preventing childhood lead poisoning because we, you know, we're watching the nation go from moving towards where we're, you know, we're getting geared up to preventing this disease so that we're not poisoning our children, because once lead poisoning is there, our children can be permanently damaged. [LB835]

SENATOR STUTHMAN: Okay. Thank you, Kara. [LB835]

KARA EASTMAN: Thank you very much. [LB835]

SENATOR STUTHMAN: Any questions? Senator Howard. [LB835]

SENATOR HOWARD: I'm wondering do you find the lead in name brand toys as well as those that maybe would be considered off-brand, like I know Fisher Price and some of those standards that parents really trust? [LB835]

KARA EASTMAN: Absolutely. There are actually a number of name brand toys that we've been trying to get in contact with, through our connections nationally, with the Consumer Product Safety Commission. So, yes, it's not just kind of the generic toys from dollar stores that we're finding, but also name brand toys. So, you know, I think there's a lot more lead out there in these toys than we actually know about. [LB835]

SENATOR HOWARD: Have these companies been cooperative with you in dealing with... [LB835]

KARA EASTMAN: Some of them have. Some of them have been very cooperative. I mean, it scares them to some extent, obviously, and some of them haven't. So again, we're kind of, you know, we're an Omaha based organization so we're trying to pass this information on to the appropriate people nationally. But we have been in touch with the Attorney General's Office in Illinois that's been doing a lot of work in this area, and watching how they enforce this. So we feel like we also have a lot to lend to this, if the bill does pass. [LB835]

SENATOR HOWARD: Okay, thank you. [LB835]

KARA EASTMAN: Thank you. [LB835]

SENATOR STUTHMAN: Any other questions from the committee? Kara, I have one. Is there any labeling or anything on these toys as far as alerting the people that there is lead in them? [LB835]

KARA EASTMAN: Most of the toys do not have any kind of label. We're finding now that especially at Christmastime there were some jewelry items and things that came up where people were labeling them that they didn't have lead in them. The question that we asked is, did you actually test them? It's very difficult to test every single toy that comes in. But I think with a good quality assurance program, you can at least be beefing up what's happening now, which has been pretty pathetic. So it's very seldom that you'll see something that says this does not contain lead. And that disclaimer of nontoxic does not necessarily transfer over to lead, because, you know, the definition of toxic can change, depending on how you're using it. [LB835]

SENATOR STUTHMAN: Okay. Seeing no other questions, thank you. [LB835]

KARA EASTMAN: Thank you very much. [LB835]

SENATOR STUTHMAN: Next testifier, proponent. [LB835]

REID STEINKRAUS: Good afternoon, committee members. My name is Reid Steinkraus and I'm here on behalf of the Douglas County Health Department. [LB835]

SENATOR STUTHMAN: Would you spell your name, please? [LB835]

REID STEINKRAUS: Sure. It's R-e-i-d, and the last name is S-t-e-i-n-k-r-a-u-s. I'm the program manager of the childhood lead poisoning prevention program for the Douglas County Health Department, and as such I'm fully aware of the lead hazards that children encounter every day, they are many. In Omaha, while lead-based paint and contaminated soil are the predominant lead hazards, we've also identified other products that contain lead in them that are primarily imported from other countries. Lead in jewelry, Mexican candy, toys, folk medicines, cosmetics, and pottery are some of those sources. Senator Preister has noted some of the problems that lead causes in children--behavior problems, speech problems, language problems, lower IQ scores and so on. These medical problems can be prevented if we have the tools to do so. In my profession we like to say childhood lead poisoning is entirely preventable. But realistically right now, with the flood of these products containing high sources of lead, lead poisoning is really not preventable. The passage of LB835 would give us the tools to keep these products made with lead away from our kids, it would give them a chance to grow and learn successfully. So thank you. [LB835]

SENATOR STUTHMAN: Thank you, Reid. Any questions from the committee? Seeing none, thank you. [LB835]

REID STEINKRAUS: Thank you. [LB835]

SENATOR STUTHMAN: Any other testifiers in the proponent side of LB835? Any

testifiers in the opponent? Any in the opposition? Any testifiers in the neutral position? Seeing none, that will close the hearing. And Senator Preister waives closing. We will not have the next bill, LB807. Senator Aguilar. And we have... [LB835 LB807]

MARGARET KOHL: You get me instead. [LB807]

SENATOR STUTHMAN: Okay. That's perfectly okay. Welcome. [LB807]

MARGARET KOHL: (Exhibit 1) Thank you. Good afternoon, committee members and Senator Stuthman, acting as Chair. My name is Margaret Kohl, spelled M-a-r-g-a-r-e-t K-o-h-l. I'm standing in for Senator Aguilar because he's around the corner introducing another bill. LB807 is a fairly simple bill. It asks for Medicaid coverage of approved tobacco cessation products and counseling, and provides for a report to the Legislature. Providing this coverage will align Nebraska Medicaid's tobacco cessation efforts with the recommendations of the CDC, the U.S. Public Health Service, and the U.S. Preventive Services Task Force. These organizations all strongly recommend the coverage of smoking cessation services based on the clinical evidence that show quit rates double when counseling and pharmaceuticals are used together. Forty-one other states already offer some type of tobacco cessation services for persons with Medicaid coverage. Smoking rates have been shown to be higher in low-income populations. The numbers come out to be 32.9 percent versus 18.7 percent in the general population, and that number holds true for Nebraska. Given that statistic, this is one area that prevention can have a very significant impact. The Campaign for Tobacco-Free Kids estimates that Nebraska spends over $130 million in Medicaid for smoking-related health costs. Nebraska is only one of eight states that do not offer any tobacco cessation services in their Medicaid program. If we look at the surrounding states of Iowa, South Dakota, Wyoming, Colorado, and Kansas, we find all offer these services in their Medicaid programs. Wyoming and South Dakota offer low-cost or free statewide cessation programs to any resident in their state. Missouri and Nebraska are the only Midwest states that do not offer tobacco cessation services under their Medicaid program. In Missouri, however, their Governor, Matt Blunt, announced earlier this month that he will recommend an unprecedented $11.6 million to help Missourians quit smoking and to prevent young people from getting hooked on tobacco. He's campaigning around the state to garner support and that would be their first comprehensive smoking cessation and prevention initiative. Tobacco use has proven to be the leading preventable cause of disease, death and disability in the United States. Research has also shown that tobacco cessation programs is one of the top three preventive services in terms of preventing those same disease, death and disability. Decreasing the rate of tobacco use in Nebraska residents with Medicaid coverage would offer long-term cost savings for the state of Nebraska and better health for persons with Medicaid coverage. In 2006, Nebraska began a quit line. The quit line provides counseling sessions for people trying to stop using tobacco products. It also makes referrals when necessary. Some states also provide free or reduced cessation

products, but we do not. I see...Senator Aguilar sees the quit line as a resource to build on and one that could be used to keep the fiscal impact of this bill at a minimum. So that you have a comparison of quit lines in various states, in the packet that's being handed out is a comparison of four different states. Some have free products; some do not. If the quit line is used for the counseling portion of this bill, providing cessation products, by our estimate, would be somewhere near $250,000 to $300,000. That's not really much in the scheme of things. That's only one-quarter to one-third of 1 percent of the current tobacco tax that goes into the General Fund. There are several ways to control the fiscal impact if that becomes an issue. This bill does not spell out the specifics of the program because the CDC and CMS recommendations are very clear and I'm sure that Nebraska Health and Human Services personnel are capable of figuring out how best to mesh those recommendations with our current resources. It's rare, however, that CMS makes such a strong recommendation, so they see that the cost benefit is overwhelmingly on the positive side, so much so that Medicare for those 65 and older covers tobacco cessation products. We all know that low-birth-weight babies often have higher costs associated with their birth and their health in the first few years of life. We all know that smoking by the mother has a direct correlation to low birth weight. Just think of the human cost in addition to the dollars saved if this program helps one or two or three pregnant women who can only use the counseling side of this equation to quit smoking. If we avoid one baby in a neonatal intensive care unit, it could fund this program for a whole year. One person who quits smoking, instead of having heart surgery after a heart attack, would easily pay for this program. Is every smoker on Medicaid going to use this program right away? No. Will all people who use tobacco quit? No, but many will. Forty-one states and our federal agencies recognize the value of investing in tobacco cessation. The U.S. Public Health Service has been directing physicians to screen all adults for tobacco use since 1996 and to make referrals to community programs for counseling support and medication. Is tobacco cessation being seen as a benchmark of a quality health system today? It certainly is. In fact, the lack of coverage for this most basic of medical interventions raises questions about the quality and cost-effectiveness of any health system, including Nebraska's Medicaid program. Our very own state employees are strongly being encouraged to use tobacco cessation and other wellness measures. Shouldn't we also then provide Medicaid coverage for tobacco cessation for our friends and neighbors who may be less fortunate or who may be disabled? Medicare covers it, minors on Medicaid are covered with a physician's prescription, so why not include the adults in-between those ages? Few services that you cover under Medicaid save money. They almost increase costs...they almost always increase cost. The question you face as a committee is which ones provide the greatest health benefit per dollar. You rarely get to consider a service that yields net savings. You cover other preventive services that are equally or less effective, such as flu shots and cholesterol screenings, and it's good to cover those services. Logic dictates, however, that a service that is just as effective or more and saves more lives should certainly also be included. Nowhere is the old adage an ounce of prevention is worth of pound of cure truer than in this instance. Senator Aguilar urges you to support

this bill and to advance it, and he again apologizes that you got me instead of him. [LB807]

SENATOR STUTHMAN: Thank you, Margaret. Any questions from the committee? Seeing none, I would like to ask how many proponents are going to be testifying on this bill? How many opponents? Okay. We will have the first testimony from the proponents. [LB807]

MARGARET KOHL: Thank you, Senator. [LB807]

SENATOR STUTHMAN: Thank you. Seeing none, first proponent. Welcome. [LB807]

HEIDI HANISCH: (Exhibit 2) Thank you. Senator Stuthman, members of the committee, my name is Heidi Hanisch, that's H-e-i-d-i H-a-n-i-s-c-h. I'm a fourth-year pharmacy student from the University of Nebraska Medical Center. This month I'm on rotation with the Nebraska Pharmacist Association and I'm speaking on their behalf today. The NPA represents pharmacists in the state of Nebraska, as well as pharmacy students, technicians, and other friend of pharmacy and they would like to offer their support for LB807. It certainly is in line with the role of a pharmacist to look out for the good and the well-being of a patient, and also to be an advocate and to serve the individual and out community and out society. So we support this bill because it makes available to patients medications that will assist them in their efforts to stop smoking and also increase their chances of being successful with that attempt. And certainly, as I'm sure you'll hear in the proponents who will follow me, we certainly recognize the toll that smoking takes on Nebraska in terms of health, the environment, productivity, and financial costs. The two things I would like to touch on during my time here, I think you were passed a packet and the middle and the last page talk about Medicaid coverage that has been made available to Medicaid patients who are in states surrounding Nebraska. I would just like to stress the variety of options you have in front of you as you decide what medications will be covered there are two prescription medications that are used in smoking cessation. And then there are a variety of over-the-counter products that provide nicotine replacement therapy. And states have taken just a variety of approaches as far as what they will cover. So you will see some include both the prescription medications. There are states that run the gamut, they will include just about every smoking cessation product that is out there and they make that available to their Medicaid patients. So there's a lot of variety as far as the different approaches states have taken as to what they will cover. You have the options of putting limitations in place as far as duration of coverage or how often in the course of a year a patient can...they might try one period on a smoking cessation product and not be successful. But they would like to try again within that course of 12 months. They have some of those limitations in place as well. And in some, require prior authorization for their patients before they will approve the funding of these medications. The patient has to have been enrolled in a quitline or they have to give some kind of proof that they're in a

behavior modification program. So I just want to stress the variety of options that are available to you if you choose to set up this program, and there are a lot of different approaches the states have taken. And then in closing, I would just like to offer the assistance of the NPA. They would be happy to assist you, give you any help that you would like to have in setting up these guidelines, and happy to offer their professional experience and their knowledge of the drugs to familiarize you with the drugs and also with their specifics. So thank you. [LB807]

SENATOR STUTHMAN: Thank you, Heidi. Any questions from the committee? Senator Hansen. [LB807]

SENATOR HANSEN: Thank you, Senator. Heidi, nice to have you here. [LB807]

HEIDI HANISCH: Thank you. [LB807]

SENATOR HANSEN: Especially as a student of pharmacy. Pharmacy I'm sure you're more used to your industry prescribing pharmaceuticals for people to quit smoking. Could you give any idea what help the quitline would be in a series of days or a series of weeks, anyway whatever it takes for the counseling for the quitline? Do you have any expertise in that or experience or anything? [LB807]

HEIDI HANISCH: Yeah. I'm not very familiar with the quitline itself and with that program and with that service. I know there's evidence that when you combine counseling with the medication you'll have a higher chance of having success. So I would assume that the quitline with that extra support, the one-on-one talking time that are given to patients through quitlines, I would assume that they have higher success rates with that program in place as well. [LB807]

SENATOR HANSEN: Okay. Thank you. [LB807]

HEIDI HANISCH: Um-hum. [LB807]

SENATOR STUTHMAN: Any other questions from the committee? I have one, Heidi. Do you see the youth of today entering into the habit of smoking greater than years ago or are less people getting addicted to smoking? [LB807]

HEIDI HANISCH: Certainly it's still a problem. I think there are a variety of factors that play a role. In my own personal experience, just the years through which going through college I noticed that I spent my first couple of years of college in a community college setting where you would have students come, maybe single moms, they were working night jobs, coming and working in the community, taking classes at the community college and you found probably a lower socioeconomic group of people where I went to school there. And I saw much higher smoking rates than at the med center where, you

know, my fellow classmates have a real high...first of all they have a greater level of education. But also education has been focused on healthcare and the ills of smoking and you just don't see smoking. So I think that would be one thing that I personally have seen the difference and education correlates to the difference in smoking rates. [LB807]

SENATOR STUTHMAN: Okay. Thank you, Heidi. Next testifier as a proponent. [LB807]

DAVID HOLMQUIST: (Exhibit 3) Senator Stuthman and members of the Health and Human Services Committee, my name is David Holmquist, H-o-l-m-q-u-i-s-t. I'm a registered lobbyist and I represent the American Cancer Society. Thank you for the opportunity to testify today in support of LB807. In tobacco control and prevention, we often speak of tobacco's toll on people who use tobacco, those affected by secondhand smoke, and the toll on our resources, both human and economic. I'd like to frame this discussion by using the term "burden" instead of toll. First, let's look at tobacco's human side and the burden it places on our people. Smoking causes heart attacks and strokes, emphysema, and causes several types of cancer. It also contributes to the burdens of numerous other chronic diseases. Exposure to cigarette smoke triggers asthma attacks and other acute allergic reactions. Children living in homes with smokers are much more likely to suffer from asthma. When a mother smokes during pregnancy, her baby may have a low birth weight and a number of additional burdens are placed on the unborn fetus and on the newborn. There's also a very real personal toll for the families of those who suffer as a result of smoking and other tobacco use. Family members may be burdened with physical ailments as a result of secondhand smoke. Death and disease caused by tobacco use bring about emotional burdens on family members as well. Illnesses caused by smoking and other tobacco use often bring about severe financial hardship both for patients and family members. And smoking kills more people than alcohol, AIDS, car crashes, illegal drugs, murders, and suicides combined. And thousands more die from other tobacco-related causes such as fires and smokeless tobacco use. I believe the above information is pretty sobering. But there's more. We're here today to look at the financial burden that tobacco use places on Nebraska's financial resources and, from my standpoint, the desirability of providing smoking cessation services to Medicaid recipients. Here are some of those numbers: Lost productivity in Nebraska as a result of illness caused by tobacco use is now over $1.1 billion annually. I need to correct that. It says million in your copy, but it's billion. Annual healthcare costs in Nebraska directly caused by smoking are $537 million. Nebraska's Medicaid program presently spends $134 million annually to treat recipients for tobacco related illnesses. An estimated 39 percent of Medicaid recipients are smokers, compared with about 20 percent of the general population. And the annual tax burden on Nebraska taxpayers as a result of tobacco is equivalent to roughly $8 for every pack of cigarettes sold in the state. In other words, you and I pay $8 for every pack of cigarettes that smokers purchase to recover costs associated with that smoking. This is based on the costs associated with lost productivity as a result of chronic diseases caused by smoking, premature deaths, increased insurance premiums, and increased

healthcare costs. A very real burden for Nebraska's economy is the rising cost of Medicaid. Some of you, along with your fellow lawmakers, have worked diligently to address this burden and attempt to keep costs contained. As a taxpayer, I applaud efforts to reduce the burden of Medicaid for all of us. But as a taxpayer, I also believe that state has an obligation to invest in the health of our citizens. Providing smoking cessation products and services is an efficient and cost effective way to invest in healthier Medicaid recipients and an efficient and effective way to reduce and contain long-term costs to the system. When smokers quit, their long-range health prognosis improves. You're probably all familiar with the somewhat cynical saying you can pay me now or you can pay me later. In this case, I don't think it's cynical at all. Providing cessation services and products now will reduce the long-term burden on all of us. It's much more cost efficient to help smokers quit than it is to treat them for a chronic disease. And when those diseases result in long-term disability or death, an even greater burden is placed on Nebraska's financial resources in addition to the cost of Medicaid treatment. Carefully consider the cost effectiveness of providing for smoking cessation for the Medicaid population. Comparisons from surrounding states and from the 42 states that already provide for cessation will demonstrate the low cost of implementing at cessation benefit in Nebraska. I urge you to advance LB807 to General File. Passage of LB807 will reduce the burden of smoking on Medicaid recipients and will further reduce the tax burden from Medicaid for all of us. Thank you. [LB807]

SENATOR STUTHMAN: Thank you, Mr. Holmquist. Any questions from the committee? Senator Howard. [LB807]

SENATOR HOWARD: Thank you, Senator Stuthman. Well, you've clearly devoted your life energy to this problem and to try to address it and I have a question. You may not know the answer to this. But I'm wondering, children who have parents who smoke pattern after their parents behavior. We know that from all other behaviors that children grow up with. What percentage of those children do you think go on to become smokers themselves? [LB807]

DAVID HOLMQUIST: I don't have a specific answer to that. I can tell you both of my parents smoked. I have a brother who's ten years older who never smoked and in fact gagged if he had to dry a clean ash tray. I, on the other hand, started when I was 13 and smoked for 25 years, and later next month I will have been smoke-free for 24 years. I do believe that the modeling of behavior is one of the critical pieces for why children take up smoking, however, and the more good modeling we can do, the better off we'll be. There was a bill a few years ago introduced to eliminate smoking on school campuses. Think of it. If the football star is out on the field on Friday night as the quarterback and his dad is under the bleachers smoking, what kind of message does that send to other students? So modeling is...thank you, Senator Howard. That's a very important piece. But I can't give you a specific answer. [LB807]

SENATOR HOWARD: Well, thank you for your insight. I certainly think that's valuable. Thank you. [LB807]

SENATOR STUTHMAN: Any other questions? Seeing none, thank you Mr. Holmquist. Next testifier, a proponent. Welcome. [LB807]

RICHARD BROWN: Thank you. I appreciate the opportunity to make testimony here. I don't have copies to pass around, but I've got one copy I'll leave. [LB807]

SENATOR STUTHMAN: Okay. We can have the page make copies so you can continue. [LB807]

RICHARD BROWN: (Exhibit 4) Okay. My name is Richard Brown. I'm the CEO of Charles Drew Health Center located in north Omaha, and I represent one of two community health centers that are in Omaha and one of five community health centers located in the state of Nebraska. Now, we were the first federally qualified health center in Nebraska and we've served for about 25 years the population of north Omaha. I've been in this business of health administration for more than 30 years at both the administrative level, and about 10 years at the academic level teaching healthcare management at the university. We at Charles Drew have struggled for 25 years taking care of the population of north Omaha, about 50,000. And the unemployment rate is high, 14 percent. We're among the highest where infant mortality rates are concerned. Selected data from our services indicate that we had about 1,000 individuals who visited us with asthma problems; diabetes, 2,000; heart disease, 900; hypertension, 3,500. And we had about nine deaths, I believe, as a result of failure to gain weight of children and failure to thrive. Now, we serve about 40 percent of the Medicaid population or our population consists of about 40 percent. We have a healthy start program that designed to decrease infant mortality. This smoking cessation bill actually could complement that. But because while we're doing all that we can to decrease infant mortality, we know that part or the reason has to do with mothers who smoke. Last year we had about 37,000 encounters. Now, the harmful effects of tobacco use you've heard. I'll just mention a few. I'll try and be brief. But we've known for 20 years that tobacco is harmful for both humans and animals. I actually last year on TV saw a lady who was...many, many years of smoking and having some real problems sitting there where her dog and the dog was actually coughing on TV. We know for a fact that tobacco is the leading cause of preventable illness and death in the United States. But it is very difficult for people who are addicted to nicotine to quit. And it's even harder for the Medicaid population to quit smoking because they're dealing with other kinds of poverty issues, such as lack of money, lack of food, lack of transportation, shelter, and a lot of other things. We know that it is linked to cancer, emphysema, hearth disease, poor blood circulation, and ulcers in adults. Among children, smoking is linked to low birth weight and infant mortality. Research studies shows that the secondhand smoke can be blamed for about half of all asthma, chronic bronchitis, and frequent wheezing in children ages two

months to two years. The benefits of stop smoking include lower risk of disability, death from heart disease, shortness of breath and coughing. Pregnant women eliminate smoke related injury to their unborn fetuses if they don't smoke, if they stop. People have fewer colds, fewer sicknesses, and fewer trips to the doctors office resulting in significant savings to the healthcare system. A review of the total body of scientific data on smoking cessation intervention shows that self-help strategies alone are ineffective. A smoking cessation intervention that uses the combination of counseling and pharmacotherapy can significantly improve the success rates for those who want to quit. At Charles Drew, we're focused on prevention, we're focused on health maintenance. We receive state dollars to help take care of the uninsured. And therefore three years ago, we implemented smoking cessation program at our center because we continued to see an increasing number of patients coming to see us who smoke for smoke related illnesses. We've got classes now that last for eight weeks. Once a night, the referrals are made from the medical providers and the dental providers to the program. They ask the patients two questions: Do you smoke and do you want to quit? The program provides a combination of tools and materials to stop smoking, including a behavioral health therapist, a dietician, and an exercise therapist. Due to limited funds though, we don't have a lot of medicine to provide to these patients to help with their process. But last year, we enrolled 378 people in our smoking cessation program, and 10 percent of them actually stopped smoking, 52 percent decreased the number of cigarettes that they smoke per day. This month at Charles Drew, among our employees we implemented a smoking cessation program because we've got about eight or ten employees that do smoke. And the value of this program is that we will decrease illness. We will increase productivity. We will save money as it relates to our now self-funded program. So LB807 I believe is a tremendous value to the state of Nebraska, the Medicaid program, in that it will decrease the number of visits to the doctor's office and hospital emergency rooms due to tobacco related illnesses. Equally important is that the bill will help save lives and improve health. Lastly, it is a way to help recipients of Medicaid to actually participate in self-management of their own illness and help control the health destiny of themselves, their children, and their families. And the economy of the state in general is tied directly to the health of its population. Nebraska needs all of its citizens to be healthy in order to compete successfully in the world marketplace. Therefore, I respectfully request that you support LB807. [LB807]

SENATOR STUTHMAN: Thank you, Richard. Any questions? Senator Erdman. [LB807]

SENATOR ERDMAN: Dr. Brown, go through the numbers again for me, the percentage of your patients that applied or went through the plan and what the success rate was again. [LB807]

RICHARD BROWN: Okay. We have 378 patients that went into the program. We had 10 percent that actually stopped quitting...that did stop smoking. So that's about 39 or so that actually stopped and 52 percent actually decreased the number of cigarettes

that they smoked per day. [LB807]

SENATOR ERDMAN: And that's based on a one-time...how does that program work? Are they eligible to repeat the program? [LB807]

RICHARD BROWN: Yes. They're eligible to repeat the program, but these are the statistics associated with a person going through the program only once. [LB807]

SENATOR ERDMAN: Okay. I was just trying to compare your situation with what the research that has been done on the success in Kansas, Oklahoma, and Wyoming. [LB807]

RICHARD BROWN: Well, let me make a distinction. Those success rates had to do with the combination of the counseling and the use of the medicine. As I mentioned in our program, we only had limited use of the medicine because we didn't have funds to purchase the medications to use with these individuals, but we did use some. But for the most part it was about education. It was about having someone to talk to. It was about group therapy. It was about having someone to rely upon and to call. And of course when they come back to the doctor's office, the physicians are able to ask them again if they've stopped or how are they doing. And of course our prevention program is focused on all of our patients for the most part having self-management goal. So every time they come in we ask them how they're doing in terms of them managing their own illness and disease. So I think with the use of medicines to go along with this to help with the addiction, I think the rate would significantly improve. [LB807]

SENATOR ERDMAN: And last question is a follow up. What percent roughly would you think the 397 people are as a total number of the people that you actually serve who smoke? [LB807]

RICHARD BROWN: It's hard to say. Now our total population that we serve is about 12,000. So I mean, it's a small number compared to the total number, 379. I don't know what the percentages are. [LB807]

SENATOR ERDMAN: Right. Okay. Thank you, sir. [LB807]

SENATOR STUTHMAN: Thank you. Any other questions? Seeing none, thank you, Dr. Brown. Any other testifiers in the proponent? [LB807]

MIKE WADUM: Good afternoon, senators. I also only brought one extra copy. I apologize. [LB807]

SENATOR STUTHMAN: Okay. That's perfectly okay. [LB807]

MIKE WADUM: (Exhibit 5) I'm blaming it on my wife, if that's okay. (Laughter) She printed it out this morning. Good afternoon, senators. My name is Mike Wadum, W-a-d-u-m. I'm the director of communications and advocacy in Nebraska for the American Lung Association. Thanks for this brief opportunity to talk about LB807. After analysis by both our Nebraska and our national office whom I just spoke with yesterday, the American Lung Association supports this bill. This bill would be good for health and also good for the financial business of the state. In the interest of the committee's time, I will not repeat the facts presented by Heidi, Dave, and Dr. Brown, except to say they absolutely know their stuff. They're absolutely correct and most particularly, our organizations concerns about asthma, emphysema, and chronic bronchitis. They're right on the money with what they've told you. I'm sure that it would be normal for you to be thinking thoughts such as yes, we know smoking is harmful to health, but that's an individual decision to smoke. Or that the Medicaid budget is strapped enough. Why should we take some of that money and divert it? Or even where's the proof, where's the documentation that his would help the problem we're talking about? Senators, those are very legitimate questions, absolutely legitimate questions and I will tell you the answers lie in the evidence provided by my colleagues, the evidence you have just heard. It's all there, senators. It's all there for the absorption. And again, my comments will be very brief. Having watched the work of this committee in the past few years on other bills, I've met with some of you personally and also testified in this committee. I have absolute confidence in your motives and judgment on this bill. And change is in the wind, senators, change for the better. I think you're a big part of that with your work the last two years in particular. So I'm asking you to please advance LB807. Thank you. [LB807]

SENATOR STUTHMAN: Thank you, Mike. Any questions from the committee? Seeing none, thank you. Next testifier. [LB807]

JUSTIN HARTMAN: Good afternoon. [LB807]

SENATOR STUTHMAN: Good afternoon. [LB807]

JUSTIN HARTMAN: Senator Stuthman, members of the committee, thank you for your time here today. My name is Justin Hartman. I am a business development coordinator for Saint Elizabeth Medical Regional Medical Center here in Lincoln, and I'm here on behalf of the Nebraska Hospital Association and its 85... [LB807]

SENATOR STUTHMAN: Would you spell your name, please? [LB807]

JUSTIN HARTMAN: Hartman, H-a-r-t-m-a-n. [LB807]

SENATOR STUTHMAN: Okay. Thank you. [LB807]

JUSTIN HARTMAN: Thank you. I am here on behalf of the Nebraska Hospital Association and its 85 members in support of LB807. Nebraska Hospitals have always been deeply concerned with the health of all Nebraskans and we encourage you to support LB807. In an effort to save time, I too will not re-testify on some of the statistics. But I would like to share with you what hospitals have done throughout the state with regards to smoking cessation and for our associates at our own hospitals. As always, it is the mission of Nebraska hospitals to help build healthcare communities and we feel it is critical to display this in our daily actions. Nebraska hospitals rarely take active participation in public health service. As such, 47 percent of member hospitals recently responded to an NHA survey indicated that they currently have smoke-free campus, 39 percent reporting having a completely tobacco free campus. There have been many wonderful things that have come of this. A lot of hospitals have increased their smoking cessation classes. They have offered one-on-one counseling for their associates and also community as well. Of the hospitals that currently do not have a tobacco-free campus, over 70 percent of them indicated that they would like to do this in the next 2 years. At Saint Elizabeth we, in cooperation with Bryan LGH and Madonna, became a smoke-free, tobacco-free campus January 1, 2008. You will recognize that a policy like this is really evident in the core mission and core values of all hospitals. We want to build healthier communities, be able to take care of our patients better, and it also helps us with our education for our patients that are currently battling this addiction. We also share the responsibility in our education efforts with this. At Saint Elizabeth, we have been offering tobacco cessation classes free to our community for the last two years. We partnered with Bryan LGH and Madonna to offer these services to their associates as well. We all know that tobacco has such a negative impact on healthcare costs throughout our country. We have had very positive feedback in our efforts from our associates, our patients, visitors, and volunteer staff, and also the physicians in our community by going tobacco free as of January. With the steady increase in Medicaid cost and tobacco being the number one cause of preventable death in the United States, we urge you to support LB807 and help us fund some of these cessation programs for our needing people. [LB807]

SENATOR STUTHMAN: Thank you. Are there any questions for Justin? Seeing none, thank you. [LB807]

JUSTIN HARTMAN: Thank you for your time. [LB807]

SENATOR STUTHMAN: (Exhibits 7-9) Any other testimony in the proponent? At this time, I would like to read into the record that we have letters of support for this bill from the Nebraska Academy of Family Physicians, the Nebraska Medical Association, and the Friends of Public Health in Nebraska, and those will be recorded in the minutes. Anyone in the opponent, in opposition of this bill? Yes, come forward, please. Welcome, Vivianne. [LB807]

VIVIANNE CHAUMONT: (Exhibit 10) Thank you. Good afternoon, Senator Stuthman and members of the Health and Human Services Committee. My name is Vivianne Chaumont, V-i-v-i-a-n-n-e C-h-a-u-m-o-n-t, from the director of the division of Medicaid and long-term care, Department of Health and Humans Services, here to testify in opposition of LB807. The sustainability of the Medicaid program is an issue of extreme importance in order to ensure that the most vulnerable Nebraska residents have essential coverage for necessary healthcare and related services. Publicly funded medical assistance cannot provide for all of the healthcare needs of all of Nebraska's low income residents. Medicaid coverage of tobacco cessation products and services constitutes an expansion of Medicaid services and would increase Medicaid expenditures by adding a new benefit. This is contrary to the direction that the Medicaid program has been taking since Medicaid reform efforts began in 2005. Additionally, the Medicaid reform efforts also sought to align Medicaid benefits with those of commercial insurance plans, particularly the state employees health plan. The latter plan provides no coverage for tobacco cessation products. Again, this bill is contrary to the direction taken by the Medicaid program. Thank you. I'd be happy to answer any questions. [LB807]

SENATOR STUTHMAN: Thank you, Vivianne. Does the committee have any questions? Senator Howard. [LB807]

SENATOR HOWARD: Thank you, Senator Stuthman. Vivianne, I'll have to be real honest with you. I'm very disappointed that the department comes in negative on this issue. I'm well aware and have gone to the meetings that have been conducted on the proposition to cut the benefits from Medicaid and to put caps on a number, a great number of the benefits. And here's an opportunity to be forward thinking and to say, how can we prevent these problems? How can we work on this at the beginning of these problems, rather than wait until they become very expensive at the other end. I don't see how we can agree to capping things when we know this is a problem, we know this contributes to it, when there's no spirit of let's work together to look at preventative measures. And I have a couple of questions if Senator Stuthman will allow me to ask these. [LB807]

SENATOR STUTHMAN: Yes. [LB807]

SENATOR HOWARD Didn't you recently come to us from Colorado, a state I notice here has a number of smoking cessation programs in effect? [LB807]

VIVIANNE CHAUMONT: They do have smoking. Some smoking pharmaceuticals and some smoking counseling, yes. [LB807]

SENATOR HOWARD: Were you working in Colorado at the time those were proposed and put into effect? [LB807]

VIVIANNE CHAUMONT: I don't know when they were added to the Colorado Medicaid program. So I don't know if I was there. [LB807]

SENATOR HOWARD: When did you come to Nebraska? [LB807]

VIVIANNE CHAUMONT: In May. [LB807]

SENATOR HOWARD: So recently? [LB807]

VIVIANNE CHAUMONT: Yeah. [LB807]

SENATOR HOWARD: Okay. Some of the things that I'm interested in, prenatal issues, children's issues, prevention of children's difficulties, and I'd like to know if you can tell me the answer to this. What percentage of births in Nebraska are paid for by Medicaid? [LB807]

VIVIANNE CHAUMONT: Forty-four percent. [LB807]

SENATOR HOWARD: Well of that, what percentage of our Medicaid population of women are childbearing age? [LB807]

VIVIANNE CHAUMONT: I don't know that. [LB807]

SENATOR HOWARD: If you could get me that information, I'd really appreciate it. And does the savings that you estimate, that you project include a decrease in the incidence of low birth rate babies and the problems associated with that? [LB807]

VIVIANNE CHAUMONT: As somebody testified earlier, a pregnant woman can't take the medication. So pregnant women would be able to do the smoking cessation only as far as the counseling services are concerned. And the quitline is and has been available to pregnant women at no cost to deal with that. So the addition of pharmaceuticals for pregnant women to battle the issue of low birth weight babies is not going to be remedied by the addition of pharmaceuticals to the Medicaid program. [LB807]

SENATOR HOWARD: I appreciate that answer. However, we need this piece of information. What percent of our Medicaid population are women of childbearing age and then factor in what percentage of that population are engaging in the habit of smoking. I think that would really give us some pretty concrete information. [LB807]

VIVIANNE CHAUMONT: I agree. I think that would be useful information and that's part of the whole issue. You know, you talk about Medicaid savings, you talk about Medicaid clients, but there have been no studies. We do not know, we have no way of looking at

our claims systems and determining what particular claims were as a result of, you know, cigarette, of smoking or anything. So all of the numbers that are being talked about are numbers that are extrapolated from national data by the Centers for Disease Control. But there are no specific numbers about...these are specific claims that were paid in the state of Nebraska that would be prevented by the smoking. And you know, another thing that I have to say that was some discussion about the fact that Medicare has smoking cessation as a benefit. Well, as you all know, once you go on Medicare, you're on Medicare. You're not going to ever be less than 65 years old. You're always going to be on Medicare. The Medicaid population is much more fluid than that. So to say that we pay for something today, the Medicaid program pays for something today and it will result in Medicaid savings 2 years down the line, 10 years down the line, 15 years down the line is not the same kind of direct extrapolation that you can make. In an insurance program such as Medicare where the recipients are much more, you know, they're not fluid like the Medicaid program is. [LB807]

SENATOR HOWARD: I think you'd agree that all evidence points to smoking being harmful to people's health. [LB807]

VIVIANNE CHAUMONT: Oh, absolutely. I would definite not argue with that. [LB807]

SENATOR HOWARD: Yeah, and you're in the business of paying the bill...we, as taxpayers are in the business of paying the bills for the effects of this. [LB807]

VIVIANNE CHAUMONT: The Medicaid program is in the business of paying Medicaid claims from Medicaid clients who have diseases and services covered by the Medicaid program. That's correct. [LB807]

SENATOR HOWARD: Well, I would say we're in a position to make a difference here, to really stop a train that's moving fast. And I'll look forward to the information from you. [LB807]

VIVIANNE CHAUMONT: Sure. [LB807]

SENATOR STUTHMAN: Any other questions? Senator Erdman. [LB807]

SENATOR ERDMAN: Vivianne, help me understand the numbers that the department comes up. As I understand the logic, and I think to some extent it's well founded, if individuals stop smoking there's a long-term benefit to them, potential savings to the healthcare industry as a whole. And in turn then that will be a savings to the Medicaid program because of the same reasons, and these are all theories that are being... [LB807]

VIVIANNE CHAUMONT: Correct. Assuming that the person stays on Medicaid. The

person could go on the smoking cessation today, quit smoking and be off of Medicaid tomorrow. So did Medicaid receive any cost benefit? They had the expenditure, they didn't have the gains. I mean, I'm only here talking about the Medicaid program and Medicaid expenditures. I'm not here talking about, you know, societal good or anything else. My job is to talk about Medicaid expenditures. So that's correct. [LB807]

SENATOR ERDMAN: But again, the reality is that an individual, all other things similar, who would stop smoking potentially has less health issues than someone who does smoke. So the theory is--regardless of who benefits--as a whole the healthcare industry or the cost of healthcare potentially is lessened. My interest is that it looks like we're going to spend on full utilization $1 million to save $88,000. And Ms. Buck or...sorry Margaret, I don't know your new last name, Senator Aguilar's staff (laugh)--I should have said that in the first place--mentioned that we have flexibility in how we determine this. And if you look in Iowa, there's a 12-week maximum over a certain timeframe. There's a limited number of times in other states that you can apply for the program. Do you have any...is there an opportunity for us to review what the parameters are? I read through the packet. I didn't see the specific guidelines from CMS as far as what we're eligible to do. But I would imagine that that would be a part of our waiver that we would apply for would be to outline those unless the statue would require them and then whether CMS would approve those. Do we have any idea of what the bookends are as far as the services that are being provided and what limitations are out there? [LB807]

VIVIANNE CHAUMONT: No. Our fiscal note was predicated on allowing cessation efforts twice a year. You could allow cessation efforts once a year, you could allow once in a lifetime cessation efforts there's any number of things to be done. [LB807]

SENATOR ERDMAN: Is there a way to work with the Medicaid directors or through CMS to get kind of the...the report that we got was limited as far as...I think they targeted Iowa and a couple of other states. We didn't get to see the true parameters. But you know, there's two questions here. One, should we do it and if we do it, what should it look like? And I think answering some of the questions you bring up are important to what we would do. I'm interested in kind of seeing what the options are and obviously much to the interest of all Nebraskans, I think they recognize that by doing nothing or expanding this program for other reasons as laudable as they are, leads us to a scenario say by 2025 where the state of Nebraska does two things. We provide state aid to schools and we pay for Medicaid. And that means that Senator Avery who's following won't have any money for his alma mater and that means that I won't have any money for roads in my district. I mean, I hope people understand what we're talking about here that we're not making things up. And to the extent that decisions are being made, it's to at least provide some opportunities for us to have decisions now before we don't have any options. And that's what we went through in the special sessions. I think people are aware of that. I just think most people don't understand the responsibility we have and the better that we can find alternatives and if this may be one of them, you

know, there may be an opportunity for savings. Again, I think you're right. It has to be returned to the program that pays for it. One of the examples that I pursued with the legal counsel is we spent $2.5 million a year from tobacco settlements for smoking cessation. If we want to truly see if it's effecting, we can use some of that funds. But you know, you could target those dollars for this program as a pilot project for other things to see if it would work. As I did last year, I'm not in favor of expanding Medicaid indefinitely just because somebody thinks it's a good idea and works. I'd like to see the results and unfortunately we didn't do that last year with LB482. So I'm interested in solving problems. I'm not opposed to any possible solutions. But I share some of the same philosophy as you do. We have to be able to prove that we're going to able to afford Medicaid, but all of the other things that Nebraskans expect reasonably that the state of Nebraska provide as well. And it's a monumental task and I'm grateful that we're having the discussions at least. But I would look forward to some information from you as far as what other states may do and some guidelines maybe from CMS as far as what they would consider if we would apply for this. [LB807]

VIVIANNE CHAUMONT: I'd be happy provide that information. [LB807]

SENATOR ERDMAN: Thank you. [LB807]

SENATOR STUTHMAN: Senator Hansen. [LB807]

SENATOR HANSEN: Mr. Chair. Was there a question there? (Laughter). [LB807]

SENATOR ERDMAN: There was two. It was actually asked twice. It was the same question. [LB807]

SENATOR HANSEN: Vivianne, it's good to see you here. I've got a question too about the quitline. The quitline, is it being funded now? [LB807]

VIVIANNE CHAUMONT: Yes. It's funded in the Division of Public Health. [LB807]

SENATOR HANSEN: And by what funds? [LB807]

VIVIANNE CHAUMONT: Not Medicaid, that's all I know. [LB807]

SENATOR HANSEN: Would it be a grant from the CDC? [LB807]

VIVIANNE CHAUMONT: I'm not sure. Is it a grant from the CDC? Okay. Sorry. [LB807]

SENATOR HANSEN: Part of it is. Okay. Well, that's partial funding. And I don't want to see the growth of Medicaid either, but this seems like a really good program. So if we can get it funded, can we have smoking cessation without starting a whole other branch

of Medicaid that continues to grow and grow and grow? If we get grant funding, if we get tobacco settlement funding without getting new dollars? [LB807]

VIVIANNE CHAUMONT: If you do a smoking cessation program with dollars outside of the Medicaid program for Medicaid clients, sure, you can do that. [LB807]

SENATOR HANSEN: That's what I'm asking. [LB807]

VIVIANNE CHAUMONT: Um-hum. If those dollars are out there without involving Medicaid dollars, sure. [LB807]

SENATOR HANSEN: Well, there's some dollars out there now for the quitline if those could be expanded. But you do agree that the smoking cessation idea is good? [LB807]

VIVIANNE CHAUMONT: I'm not going to tell you that smoking is good for you. [LB807]

SENATOR HANSEN: Okay. Thank you. [LB807]

VIVIANNE CHAUMONT: I'm not going to tell you that. I think that it would be silly to say that smoking cessation is a bad thing. Of course smoking cessation is a good thing. That's not the issue here. The issue is, is Medicaid going to be the vehicle for getting all of the good things in life done for people? That's the issue. And if the Medicaid program pays for this, is it...you know, what are exactly the statistics that we have that would show that the Medicaid program will get the benefit of that? [LB807]

SENATOR HANSEN: All right. Thank you. Appreciate that. [LB807]

SENATOR STUTHMAN: Thank you. Thank you for your testimony. Any other testimony in opposition? Any testimony in the neutral position? With that, that closes the hearing on LB807. At this time I would like to ask if Douglas Dilly is in attendance at this time? Would you come forward, please, on your confirmation? [LB807 CONFIRMATION]

DOUGLAS DILLY: Hello, committee. [CONFIRMATION]

SENATOR STUTHMAN: Welcome. We'll just wait a second until the room clears just a little bit. [CONFIRMATION]

SENATOR STUTHMAN: Sounds good. [CONFIRMATION]

SENATOR HANSEN: This is known as the shuffle. [CONFIRMATION]

SENATOR STUTHMAN: Welcome, Mr. Dilly. [CONFIRMATION]

DOUGLAS DILLY: Thank you. [CONFIRMATION]

SENATOR STUTHMAN: Would you tell us a little bit about yourself and the appointment? [CONFIRMATION]

DOUGLAS DILLY: I'm a family practice physician in Neligh, Nebraska, and I'm here just to answer any questions regarding my appointment to the Rural Health Committee by the Governor. My last name is spelled D-i-l-l-y and I was born outside of Hastings, Nebraska, raised in a rural community, and am now serving a rural community in family practice. [CONFIRMATION]

SENATOR STUTHMAN: Thank you, Dr. Dilly. Are there any questions? [CONFIRMATION]

SENATOR ERDMAN: Can you say that again, please? (Laugh). [CONFIRMATION]

DOUGLAS DILLY: Sure. [CONFIRMATION]

SENATOR ERDMAN: Not joking, but with all the noise I thought... [CONFIRMATION]

SENATOR STUTHMAN: I apologize for starting. I thought the noise was pretty well down, but it... [CONFIRMATION]

DOUGLAS DILLY: I'm just here to answer any questions regarding my appointment by the Governor the Rural Health Committee. My name is Dr. Doug Dilly. I was raised outside of Hastings, Nebraska, attended Hastings High, attended undergraduate Colorado, medical school at the University of Nebraska Medical Center. And did a rural training tract residency for three years, and then the last ten years I've been in Neligh, Nebraska, serving the community as a rural family practice physician and emergency room physician. [CONFIRMATION]

SENATOR STUTHMAN: Thank you, Dr. Dilly. Any other questions? Yes, Senator Erdman. [CONFIRMATION]

SENATOR ERDMAN: Thank you, Senator Stuthman. Doctor, talk to me about your practice, the type of issues that you confront? Obviously the Rural Health Advisory Commission has opportunities to be a part of a vital discussion. What do you see in your practice? What do you hear from your fellow practitioners in rural Nebraska, and what are some of the issues you would like to pursue through the commission? [CONFIRMATION]

DOUGLAS DILLY: We have an agenda put together now, but as far as my practice goes, I cover a rural hospital in Neligh. The nearest hospital to us is 35 miles away. We

cover the emergency room. I have a family practice where we see patients everyday and do hospital rounds and take care of inpatients. The concerns I have and the things that I think need work as far as rural medicine include being able to get an ambulance to someone when they need help. There's mental health issues of course. There's just serving the area and making sure that rural health doesn't disappear because of insurance reasons and things of that nature. I think it's important to keep it. You have to serve rural communities and anything I can do to serve or support rural medicine is why I'm happy to be on the committee. [CONFIRMATION]

SENATOR ERDMAN: In your hospital and in your area do you see or the EMTs and similar professionals utilized in the hospitals as well or do you have sufficient or are there willing individuals that currently fill that need because that was one of the things that I know we had worked on a few years ago is allowing that care to continue on and to also provide some additional training opportunities for those EMTs, especially in those rural settings. [CONFIRMATION]

DOUGLAS DILLY: The training has definitely improved. The quality of first responders over the last ten years is greatly improved. It's still difficult though as our communities all volunteer. Sometimes when someone is in the middle of shingling a roof to stop and go get someone that's nauseated at home. I mean, and then sometimes it's more than that. Sometimes it's just difficult at 2:00 in the morning to transfer a nursing home patient to the hospital. We do rely on like Norfolk's aid EMTs a lot. Unfortunately we have to rely on them a lot when it's too difficult for our volunteers we immediately go within. So it's difficult sometimes. [CONFIRMATION]

SENATOR ERDMAN: Thank you, sir. [CONFIRMATION]

SENATOR STUTHMAN: Thank you, Dr. Dilly. First of all, I just want to thank you for coming down here today and also I want to thank you for serving on the Rural Health Committee. I think that's very important that we get people from out in the rural areas that are willing to take the time and serve on these committees. And I really appreciate that and furthermore, I really appreciate that you did take the time to come down here today only for a few minutes to meet us so that we can put a name with a face and hopefully support this and we will truly do that. [CONFIRMATION]

DOUGLAS DILLY: Thank you. [CONFIRMATION]

SENATOR STUTHMAN: Thank you very much. [CONFIRMATION]

DOUGLAS DILLY: Thank you. [CONFIRMATION]

SENATOR STUTHMAN: We will now open the hearing on LB818. []

_____: He went across the hall to close on a bill. []

SENATOR STUTHMAN: Okay. We will stand at ease for just a few minutes. []

EASE: []

SENATOR STUTHMAN: Senator Avery. [LB818]

SENATOR AVERY: Thank you, Senator Stuthman. Sorry I was a little bit late, but I...across the hall. [LB818]

SENATOR STUTHMAN: No. That's okay. [LB818]

SENATOR AVERY: Good afternoon, senators. My name is Bill Avery, spelled A-v-e-r-y. I represent District 28. I am here to introduce...what am I introducing? (Laughter). [LB818]

SENATOR STUTHMAN: LB818. [LB818]

SENATOR AVERY: Thank you. [LB818]

SENATOR STUTHMAN: And you're in the Health and Human Services. [LB818]

SENATOR AVERY: ...LB818. Next week is going to be worse; I have seven. A little background, the State Children's Health Insurance Program, which is known as SCHIP, is specifically to designed to help children who are without health insurance. It provides assistance for families who earn too much to qualify for Medicaid, but earn too little to afford health insurance for their children. The presumption of this federal law, which was passed in 1997 was that states would set eligibility requirements at 200 percent of the Federal Poverty Level, which today the Federal Poverty Level is $21,200, and 200 percent of that would be $42,400. But when the law was passed in 1997, states were allowed to set the qualifying rate at 185 percent of the Federal Poverty Level. And Nebraska choose to take the lower percentage and has not raised that amount in the ten years that we have been in the program. LB818 proposes two changes to Nebraska's current SCHIP program. One, it increases the qualifying threshold for SCHIP from 185 percent of the Federal Poverty Level to 200 percent. The second change is the requirement for reapplication. Right now, families that qualify for SCHIP are required to reapply every 6 months and this bill would change that to every 12 months. Let me explain why I'm doing this. I think we have an obligation to help families provide children with basic healthcare. Research shows that without insurance, children are less likely to receive health services in a timely manner, and that their health and long-term development can be compromised. Research also shows that children's health insurance can be an important part of a broad strategy toward child development

aimed at helping children stay healthy, eager to learn, prepared to succeed, keeping them out of the hospital and out of emergency rooms. Increasing the threshold to 200 percent of the Federal Poverty Level would bring Nebraska in line with all of our neighboring states, with the exception of Missouri which currently sets its rate at 300 percent. The Nebraska Health and Human Services Department estimates that there are currently 131,000 children enrolled in our program and that's good. But only 25,000 quality for SCHIP. Then when I say our program, I'm referring to Kids Connection. Today, about 32,000 children in low income families in Nebraska under the 200 percent level are uninsured, about 32,000. And what's important I think is that these are families of four, working families earning $41,000 a year or less. This is exactly the population this program was intended to reach and we're not reaching, in my opinion, enough of them. Increasing the threshold from 185 percent to 200 percent would likely mean an enrollment increase of about 5,400 additional children that currently do not qualify. Requiring reapplication every 12 months, the second feature of this bill, instead of 6 will not only reduce the cost of accepting and reviewing these documents to the HHS, but it would take pressure off the families trying to get by who find themselves jumping through bureaucratic hoops and cutting through governmental red tape just to remain eligible. That would relieve some of the burden on those families. Finally, 97 percent of Nebraska businesses are small businesses, employing just a few people. Two-thirds of these businesses do not...(cough)...excuse me. I don't have a cold. I don't know what that is. Maybe it's this room, Senator. [LB818]

SENATOR STUTHMAN: It could be. [LB818]

SENATOR AVERY: Allergens. Let me go back to that. Ninety-seven percent of the businesses in Nebraska are small businesses, two-thirds of which do not offer healthcare. The one-third that do provide coverage, many do not offer dependent coverage. So we've got a problem there. I've had some constituents in my office complaining about their inability to provide health insurance for their employees. Many of them, they used to provide it, but can't do it anymore. This legislation is needed for the well-being of our children. We need to put our children first. The number of uninsured kids in this state is rising and we cannot and must not wait to act. I would point out that this Legislature rightly so provided record-level tax breaks last year. I voted for those. We have passed expensive business incentive legislation, which I support. Are children less important? I don't think so. I urge you to advance this bill to General File and to get me a glass of water, please. (Laugh). [LB818]

SENATOR STUTHMAN: Thank you, Senator Avery. Any questions from the committee? Senator Erdman. [LB818]

SENATOR AVERY: (Exhibit 1) I do have a handout here, sir, that I forgot to mention. [LB818]

SENATOR STUTHMAN: Okay. [LB818]

SENATOR ERDMAN: Senator Avery, I think we can support your motion for a glass of water (laugh). One of the comments you made was that there would be a reduction in staff at the department. If you actually read the fiscal note, it doesn't say that because you're actually going to be adding more individuals to the SCHIP program, as well as Medicaid and child care there would be an additional staff required to handle those eligible. So that may be one thing we have to consider in this. I guess the question that I'll ask, not to be the mean person in the room. But if we pass LB818, would you be willing to request an equivalent offset in some other state program, whether it's K-12... [LB818]

SENATOR AVERY: Do you have something in your district I could target? [LB818]

SENATOR ERDMAN: Actually I don't, Senator Avery. It's kind of nice (laugh). The nice thing about economic development in my district is it can't be taken way when the Legislature meets, and so therefore it's true economic development. My question is, is that if we would offset K-12 spending or funding for the University of Nebraska or funding for roads or something by the same amount, would you support that as a contingent of this bill? [LB818]

SENATOR AVERY: Not those two. I am really not prepared to make that choice at this point. [LB818]

SENATOR ERDMAN: But would you be prepared to do that? [LB818]

SENATOR AVERY: I'm prepared to consider reductions elsewhere. And let me just answer your first point because there is in this last paragraph it does say that there would be a decrease in eligibility technicians by eliminating the monthly review eligibility. [LB818]

SENATOR ERDMAN: And if you read the next sentence, it says additional staff would be needed to handle the increased number of eligible. [LB818]

SENATOR AVERY: Yeah. [LB818]

SENATOR ERDMAN: So it may be wash. [LB818]

SENATOR AVERY: I just thought I'd emphasize the good part. [LB818]

SENATOR ERDMAN: I read it all. I try to read top to bottom, left to right to get a full sense of what's there. But just so that I'm clear, you would be interested or you would consider replacing the exact dollar amount that this would propose to cost the General

Fund in some other program. So therefore, we're not increasing the obligation of the state long term in another area. So that way this could be revenue neutral, if you will. [LB818]

SENATOR AVERY: Well, I don't know if it could be revenue neutral. I think what I might be willing to do is look at some cost savings in other programs. [LB818]

SENATOR ERDMAN: Like eliminating all the other programs and taking the cost savings because we're talking about $8.5 million. [LB818]

SENATOR AVERY: No, no. [LB818]

SENATOR ERDMAN: And then $14.9 million in the first year of the next biennium. [LB818]

SENATOR AVERY: $14.9 million from the General Fund up to that. [LB818]

SENATOR ERDMAN: Right. [LB818]

SENATOR AVERY: It could be less, could be $12.7 million. [LB818]

SENATOR ERDMAN: It could be. That would be great. [LB818]

SENATOR AVERY: I know it's significant money. It's a significant problem and every state sets priorities. We decide what's important and that's what we fund. [LB818]

SENATOR ERDMAN: I agree, and that's what I'm asking you is... [LB818]

SENATOR AVERY: And I know the best way to answer your question is go after the things you know I support. Are you willing to give those up in order to get this? [LB818]

SENATOR ERDMAN: Um-hum. [LB818]

SENATOR AVERY: And I'm not willing to give those up to get this. [LB818]

SENATOR ERDMAN: Okay. Then let me ask you it this way: Are you willing to allow the state of Nebraska to continue on the path that we're on so there's no funding for higher education? [LB818]

SENATOR AVERY: Absolutely not. [LB818]

SENATOR ERDMAN: Okay. So by answering it that way you've also answered the first question because as you know as I have shared with you and as is public record, the

projections that we're using over the next 20 years show that the state of Nebraska will do 2 things. We will fund K-12 education, the state aid part of that, and we will fund Medicaid. And there remains no money and in fact within the next four budgets, all of the new revenue that comes into the state of Nebraska will be required to meet the growth in Medicaid and state aid to schools, just those two programs. So that means there's no additional funds available for anything else. I'm not saying we shouldn't do what you're doing, Senator Avery. I'm just saying I'm not going to be here, you are. Is it in your best interests to expand a program that we know is not sustainable at this point or not because people of District 28 will probably reelect you. You'll be here for another six years. You're going to be in the middle of that debate before you know it. And I'm just...I guess my wisdom from being here all these many years is just to ask you to consider ways that we can afford to do the things that you think are the priorities of the state of Nebraska. And I think that's a great discussion because I don't think we've ever had that conversation as a state. [LB818]

SENATOR AVERY: I'm really sorry about this. [LB818]

SENATOR ERDMAN: I was trying to give you a chance to drink some more water. [LB818]

SENATOR AVERY: I don't want to have to face that question, frankly. [LB818]

SENATOR ERDMAN: I don't think anybody does. [LB818]

SENATOR AVERY: And I know what you're saying, it has some truth to it. But I think that as we move down the road, we're going to have to get more creative. [LB818]

SENATOR ERDMAN: I agree. [LB818]

SENATOR AVERY: And I hope that I can be a part of that and contribute to it. But I do believe that we should not be put in a position where you have to choose between this good program and that good program and that's the only choice you have. [LB818]

SENATOR ERDMAN: That would be the only choice we have, Senator Avery. [LB818]

SENATOR AVERY: It may not be. Ah, thank you. [LB818]

SENATOR ERDMAN: If you keep supporting tax relief and programs that bring businesses in the state of Nebraska, it may be an easier decision to make in my philosophical and economic opinion. But having said that, the reason you support tax cuts isn't to get reelected, it's to spur on the economy. [LB818]

SENATOR AVERY: But there are studies that show that some of these tax incentive

programs that we pass don't do what we expect them to do. [LB818]

SENATOR ERDMAN: Fair enough, and that's part of the get creative but... [LB818]

SENATOR AVERY: And maybe that's some of the stuff we have to revisit. [LB818]

SENATOR ERDMAN: But as we've talked this morning on the floor, you and I off the mike, the biggest reason why companies and people don't come to Nebraska isn't because we don't have tax incentives; it's because of our tax policy. And the reason why young people in Nebraska don't stay here is because of a number of reasons. And one of them is the fact, at least in my district, that they can go to Wyoming and Colorado and their tax base is substantially better. They have a better opportunity to make a living and in fact, there are people that make less money that actually have more disposable income because their friends in the elected bodies aren't stealing more of it. This is all part of the bigger picture. You're talking about being creative. I don't want to get to a point, Senator Avery, where we're discussing between two good programs which one is better. But I will tell you that if we don't begin to think that way or to be able to find alternatives to that discussion now, that will be the decision that you and others will have to make, and ultimately we as a state will be forced to make. [LB818]

SENATOR AVERY: I know that. But I am still concerned that we have 32,000 kids that are not covered. [LB818]

SENATOR ERDMAN: Absolutely. Absolutely. [LB818]

SENATOR AVERY: And there's another problem with this program. And that is a lot of people who are eligible for it don't even know about it and they're not enrolled. [LB818]

SENATOR ERDMAN: Or they don't participate for other reasons. [LB818]

SENATOR AVERY: Yeah, and I have an idea that I'll probably bring to this committee maybe next year on how we can get more people enrolled. It will cost money. Yeah. But understand that when you look at the fiscal note and when you look at...go up to 2009-2010 you're talking about a minimum estimate, if fiscal notes are estimates, of $12.7 million. But looking at the increase in federal contribution, that's $15.5, I've rounded up to $15.6, that's at minimum. [LB818]

SENATOR ERDMAN: And you're also aware that the funding for certain programs are not necessarily dollar for dollar, but they're block funding. In other words, there are certain programs that we offer services for that once we get to a certain allotment, we don't get more. It becomes 100 percent of the state's obligation and we pay no more... [LB818]

SENATOR AVERY: This is not one of them. [LB818]

SENATOR ERDMAN: ...we pay no more than that match. [LB818]

SENATOR AVERY: Yeah. [LB818]

SENATOR ERDMAN: But we pay 100 percent of the cost once we get over our allotment for that block of money that's authorized under Congress. [LB818]

SENATOR AVERY: But you would admit this is not one of them. [LB818]

SENATOR ERDMAN: Well, if you read the fiscal note, there may be some different interpretations as well. But there's a lot of factors that play into this and I don't want to keep you here because there are talented individuals here to testify as well. [LB818]

SENATOR AVERY: And they know more about this than I do and my cough is under control now, so fire away. [LB818]

SENATOR STUTHMAN: Thank you, Senator Erdman. [LB818]

SENATOR AVERY: I'm sorry about that. I haven't been coughing all day. [LB818]

SENATOR STUTHMAN: Senator Hansen, you had a question? [LB818]

SENATOR HANSEN: No, no. Fine. I think that Senator Erdman and Senator Avery had got the highlights of it. [LB818]

SENATOR STUTHMAN: Okay. Thank you, Senator Avery. [LB818]

SENATOR AVERY: I do have...did I get that passed out, the handout? [LB818]

SENATOR HANSEN: Yes. [LB818]

SENATOR STUTHMAN: Yes. [LB818]

SENATOR AVERY: It shows where we are with the surrounding states and it shows that we are among a minority of states that are at least of 200 percent. [LB818]

SENATOR STUTHMAN: Yes, Senator Hansen. [LB818]

SENATOR HANSEN: I do have a question. Senator Avery, is the Federal Poverty Level, does it change from state to state or is there one Federal Poverty Level? [LB818]

SENATOR AVERY: One. It's one Federal Poverty Level that's established for the 48 states and the District of Columbia. Then you have different Federal Poverty Levels for Hawaii and Alaska. And they are significantly higher for Alaska and somewhat higher for Hawaii. [LB818]

SENATOR HANSEN: Is there a cost of living index, cost for living? [LB818]

SENATOR AVERY: You mean a consumer price index for different states? [LB818]

SENATOR HANSEN: Yeah. That's probably what it would be, yes. [LB818]

SENATOR AVERY: I think usually that's a nationwide estimate or index. [LB818]

SENATOR HANSEN: So is it cheaper to live in Nebraska than it is in New York? [LB818]

SENATOR AVERY: Oh yeah. [LB818]

SENATOR HANSEN: Cheaper to live in Nebraska than Alaska or Hawaii evidently because they're separated off. Is it cheaper to live in Nebraska than Colorado? [LB818]

SENATOR AVERY: I don't know. [LB818]

SENATOR HANSEN: Yes. [LB818]

SENATOR AVERY: Wouldn't Colorado have a lighter tax burden? [LB818]

SENATOR ERDMAN: They would, but the cost of living potentially is greater, Senator Avery. But thanks for that observation. [LB818]

SENATOR HANSEN: Thank you, Senator. [LB818]

SENATOR STUTHMAN: Okay. Thank you. Senator Erdman. [LB818]

SENATOR ERDMAN: Senator Avery, just so I'm clear. You mentioned earlier that you didn't believe that the program that you were expanding is subject to limited funding and that we would receive the match. If you read the second page of the fiscal note... [LB818]

SENATOR AVERY: The second paragraph? [LB818]

SENATOR ERDMAN: Second page, third paragraph, it refers to the SCHIP program, Children's Health Insurance Program, that... [LB818]

SENATOR AVERY: I don't have a second page, Senator. [LB818]

SENATOR ERDMAN: We can get that for you if you don't have it. That children made eligible...the federal funding for SCHIP is currently legislated at current enrollment levels through March 31, '09. Obviously if our friends in Congress can figure out how to pass legislation, it would help too. Especially the increase necessary to at least meet the needs of those that are currently eligible. But it says that LB818 would be federally funded through a certain rate. And then it goes through and explains how it may have some additional obligations based on current enrollment levels versus current need. [LB818]

SENATOR AVERY: It does affect other parts of...I realize that, transitional care program, for example. [LB818]

SENATOR ERDMAN: Okay. That's all I got. [LB818]

SENATOR AVERY: And pregnant women. That adds some cost, I admit that. [LB818]

SENATOR ERDMAN: Okay. [LB818]

SENATOR AVERY: But I'm not sure if those are capped, where at some point we'd pick up 100 percent above a certain level. [LB818]

SENATOR ERDMAN: I'm sure there's people here that can explain it to us. [LB818]

SENATOR AVERY: Yeah, probably so. [LB818]

SENATOR STUTHMAN: Okay. Thank you, Senator Avery. [LB818]

SENATOR AVERY: Thank you, Senator Stuthman. [LB818]

SENATOR STUTHMAN: Will you be around for a closing? [LB818]

SENATOR AVERY: Well, I don't know. I'm in another committee and one of my bills is up, so I'll have to reserve. So if I disappear, just carry on. Thank you. [LB818]

SENATOR STUTHMAN: Okay. Thank you. Okay. At this time, how many proponents for this bill? Two, four, six, seven, eight, nine. How many opponents? Okay. We will have the first proponent. And what I'd like to also mention that I think there are about nine or ten of them. So if you can keep your comments down to five minutes, we'd appreciate it, and if there's anything repetitious, please keep those comments to a minimum. Thank you. Welcome. [LB818]

JO KINBERG: (Exhibit 2) Okay. Welcome. Thank you. I'm Dr. Jo, J-o, Kinberg, K-i-n-b-e-r-g. I'm currently the president of the Nebraska Chapter of the American Academy of Pediatrics. At this time, there are 239 pediatricians in our state chapter. And I would like to thank the committee for allowing me to represent those pediatricians in favor of testimony of LB818. We want to talk to you today about why children need access to healthcare. What happens if they don't? Let me tell you about a patient of mine. We will call her Sadie. Sadie is a six-year-old I first met while I was a pediatrician on call for Saint Elizabeth hospital. Just to let you know what "on call" means, each physician with admitting privileges to that hospital rotates with other physicians of your specialty to see patients who come to the ER, newborns or patients needing to be admitted who do not have a regular physician or "medical home" as we call it. Sadie came to the emergency room having an asthma attack and was having a lot of distress with her breathing. She was breathing so fast, sucking in her abdomen with each breath, unable to complete a sentence and was pale. Her big brown eyes looked up at me with that look of "please help me." Her father told me she had a medicine to help her with her breathing, but she was out of her medicine. We put her in the hospital and she was improved to a point where we could send her home on her daily asthma medications and medicines to help prevent her attacks. I saw her later for a follow-up visit and she was doing well with her preventative medicine. After a few months passed by, she again presented to the emergency room at Saint Elizabeth with another asthma attack. Again, she was having the same scary difficulty with her breathing. I found out that she wasn't taking any of her asthma medicines, even though I knew they had a prescription with quantity enough if filled to take them. We again admitted her, improved her breathing to the point where she could go home. You might ask why wasn't she taking her medicines. Why was she going to the emergency room? The emergency room is certainly more expensive than going to my office or taking her medicines. The answer lies in the fact that her family was making just a little bit more than what would qualify them for Kids Connection. They therefore could not afford regular office visits. They couldn't afford to pay for her asthma medications. These costs would have averaged $150 to $200 a month. So they had no choice but to go to the emergency room when she was having such difficulty with her breathing. While in the hospital, I asked her how is school going? The tears welled up in her eyes. Because of her frequent problems with asthma, she was missing a lot of school, and she wasn't able to read like the other children in her class. Her parents were in jeopardy of losing their jobs because of Sadie's frequent illnesses and staying home with her. Who paid for her emergency room doctor and hospital bills? All of you did. Everyone in this room did. I did. These costs are all passed on to everybody. Wouldn't it have been more economical to pay for her medicine and doctors visits than all of us to pay for the tens of thousands of dollars for her as a result other hospitalizations, ER visits, the parents economic impact of losing their jobs, the bills for the paraeducator who has to be hired to help her catch up in school? Currently in Nebraska, we have about half a million children. Thirty percent of these children are covered by Kids Connection, but they only

use 27 percent of the total costs of the program. That means without Kids Connection, 30 percent of our Nebraska children would have no healthcare coverage. We have in Nebraska 32,000 children who are uninsured, as Senator Avery said. They're under 200 percent of the Federal Poverty Level. Senator Avery's bill would allow us to increase the qualification from 185 percent to 200 percent of the Federal Poverty Level. That means 32,000 Sadie's would have a chance at healthcare. In closing, we as Nebraskans need to realize our children are our hope and promise for tomorrow and put them first, recognizing that they are our best investment and will bring us many lifetimes of returns. Thank you. [LB818]

SENATOR STUTHMAN: Thank you, Doctor. Any questions from the committee? Seeing none, thank you for your testimony. Next testifier. Welcome. [LB818]

STACIE BLEICHER: (Exhibit 3) Good afternoon, Senator Stuthman, committee members. My name is Dr. Stacie Bleicher, it's B-l-e-i-c-h-e-r, and I will keep my comments short. I have brought a copy of my statement also to add some additional information as a practicing pediatrician and also having testifying to this committee in the past. I felt there were some additional points as a pediatrician that I wanted to bring up. I think medical homes for children is very important. We have potential to offer cost effective care, preventative services, and impact the long-term health of the kids we care for. I see more and more in my practice, which is 25 years old now, that I have increasing numbers of families and their children that are losing their health insurance coverage and they verbalize that to me. It's either an issue of employers cutting back to only covering the worker, no dependent care or the copays being so high now, the shared premium the parents cannot afford to include the family in the coverage. We do see a significant decrease in preventative office visits when the families do not have coverage for those services. And it really can affect long-term outcomes. We don't care for acute illnesses in early stages when they may need care and oftentimes do end up with hospitalizations instead of something that might be dealt with in the office. We also see a significant delay in diagnosing chronic conditions. A child will end up hospitalized in diabetic ketoacidosis instead of being identified early and being able to be managed at earlier stages of disease and being handled in a less expensive method. And the loss of the health insurance occurs in many ways. Yes, I do have some parents that opt to just go uncovered. It's not they just think it's too expensive, I don't want to do it. They usually learn within a year that oh, yeah, they fell out of a tree, broke their arm. Those x-rays cost a lot, it would have paid for our health insurance. That's the minority of my families that are losing coverage. More of them are because of the economic costs. They may have catastrophic insurance only, nothing that covers well care. Some families get covered for vaccines and for no well visits so they go and get their shots at county health departments or other facilities. But they don't get any of the preventative counseling and ongoing care that we offer in addition to giving shots to kids. I've had...the other major concern that I have is that when a child is diagnosed with a medical condition, it is very difficult for those families to get health insurance for their

children if they're not in a large group coverage like a work plan. I see insurance companies cherry picking like crazy. I had a family that had the misfortune a few years ago of having a son have a very unusual, but definite vaccine-related illness. He developed very low platelets, risk of serious bleeding had to be hospitalized and treated for that. His father's company very shortly went out of business. They lost their family health insurance. Both parents had been working. He was out looking for new jobs. They could not get health insurance for their family as a unit. They could for their daughter and the parents. The insurance companies would not even consider covering the son. And that was with statement from me and a pediatric blood specialist indicating this problem was related to the vaccine. He's at no greater risk of developing the problem again compared to anybody else in the population. He could not get any insurance coverage except for Kids Connection for three years after that incident. And that was even after his dad had stable employment and open enrollment health insurance available to him again. So we have some real issues with our private industry, the fact that they don't want kids with chronic conditions. They totally turn them down or they exclude it from coverage if the families have to seek independent coverage. There are COBRA protections, but the premiums for COBRA have no price guarantees and they're frequently very excessive, very hard for the families to maintain previously existing coverage for that year that they're allowed. And even the SCHIP plan, our state comprehensive plan, that's there for backup is, again, exceedingly expensive, very difficult when a family might have to pay a premium for one family member that's equivalent to their entire cost for the rest of the family's health insurance coverage on a monthly basis. So those really have to be considered. I think that Kids Connection offers a great option for these families. I don't see people abusing it when they're able to move on and get private coverage. Living at 200 percent of the poverty level is not a state of luxury for these families. They have very limited abilities to offer any extras for their kids. And I do feel we have community obligations to be sure that our children are raised in a health state, that they have basic opportunities, and I do consider preventative services and counseling as being a basic that every child should be entitled to. So my question is how can we not afford to offer this to these 32,000 kids that are uninsured? We need to do that. The long-term hopefully would be that we do indeed see cost savings. They're very hard to quantitate. But in my opinion that type of expansion should result in long-term improvement in costs because we're taking care of things in a preventative up front way. Thank you for allowing me to testify and I'd be happy to answer questions. [LB818]

SENATOR STUTHMAN: Thank you, Dr. Bleicher. Any questions from the committee? Seeing none, thank you. [LB818]

STACIE BLEICHER: Thank you. [LB818]

SENATOR STUTHMAN: Next testifier as a proponent. Welcome. [LB818]

LYNNE ANDERSON: (Exhibit 4) Acting Chairman Stuthman and committee, thank you very much. My name is Lynne, L-y-n-n-e, last name Anderson, A-n-d-e-r-s-o-n. I'm a registered nurse, have a master's degree in maternal child health nursing, and have worked 30 years as an advanced practice nurse. I am here today, and I do have copies, I am here today to testify in support of LB818. I come here representing Nebraska Nurses Association, which represents 20,000 registered nurses here in the state of Nebraska. As an advanced practice nurse over my career, I have seen firsthand the financial medical and emotional difficulties that individuals and families encountered as they've sought health. For those without health insurance, those difficulties were multiplied and healthcare deferred until an emergency occurred. SCHIP, the State Children's Health Insurance Program, is a program known as Kids Connection here in Nebraska, which you all know. SCHIP is a federal state program initiated in 1997 with bipartisan support that provides access to health insurance for the children of the working poor. Those who earn too much to qualify for Medicaid but do not have access to or cannot afford health insurance. Federal money provides 70 cents on the dollar and the state provides 30 cents on the dollar. Of utmost importance, however, the state does set the guidelines within certain federal constraints and I am aware that there are a lot of controversies and efforts to change those constraints within our Congress in Washington. For the administration of this program, however, the state does set its program. Not to contradict Senator Avery, but to go back in history a little bit, in 2007 is when the guidelines were changed from 200 percent of Federal Poverty Level to 185 percent, as well as the guidelines that instead of yearly review, it would go to every six months. As all of you in this room probably recall, that was the time of deep economic recession, whether or not that was related to the 9/11 tragedy or not. But anyway, 2002 was not a good year for Nebraska nor for the United States. At that time, because of the financial crisis, the guidelines were changed to 185 percent from 200 percent, and from yearly renewal to every six month renewal. For the every six month renewal...in my long experience working as a nurse, much of that time, actually all of that time with very ill people, I can tell you that unlike those of us who are lucky enough to work in a profession where if we need time off to go take care of paperwork, we can take time off, usually paid time. For those individuals who work in a lot our industry here in Nebraska, particularly those individuals who would qualify only because they are on the lower socioeconomic class, if they take time off from work they're either not paid or may in fact lose their job. So it's not easy the way it was easy for me when I was bringing up my children to say I need to take two hours off and go to the doctor, do whatever and still have a job and a salary waiting for me. At the time in 2002 when these guidelines were changed, 15,000 children were taken off the roles. So yes, it did save the state money. By any health outcome measure, people who have health insurance have better outcomes than those who are uninsured. It is projected that the reverting to the pre-2002 guidelines, apparently one half--and you've heard these statistics--of the currently uninsured children in Nebraska could become insured through this program. Children who lack insurance, as you have heard, are more likely to receive their healthcare in an emergency room a less desirable and more expensive alternative to a

primary healthcare provider. That can cause the taxpayer and other consumers more in the overall picture and may have a worse outcome, as you heard from our doctor colleagues here. It makes sense that Nebraska citizens benefit from the federal tax dollars to which we have contributed in order to provide the health insurance through SCHIP that our working families so desperately need. NNA encourages you to advance LB818 from committee. It's the right thing to do for our working families. We need to keep them working. We don't want them to slip down to the poverty level so then they can apply for Medicaid. Thank you for your time and I would encourage questions, comments at this point. Thank you all very much. [LB818]

SENATOR STUTHMAN: Thank you, Ms. Anderson. Any questions from the committee? Seeing none, thank you. [LB818]

LYNNE ANDERSON: Thank you. [LB818]

SENATOR STUTHMAN: Welcome. [LB818]

JIM CUNNINGHAM: Good afternoon, senators. My name is Jim Cunningham, that's spelled C-u-n-n-i-n-g-h-a-m. I'm the executive director of the Nebraska Catholic Bishops Conference and I am testifying is support of LB818. Guided by Catholic social teaching we assert that access to adequate healthcare is a basic human right necessary for the development and maintenance of life and for the ability of human beings to realize the fullness of their dignity. A just society protects and promotes human dignity and basic human rights, including a right to safe and adequate healthcare, especially for children and the vulnerable. Public policy should not be content to allow children to be deprived of regular, primary and preventative healthcare because their parents are less successful economically. The compelling reason why this bill warrants your support and advancement to General File is that it ensures access to healthcare and better health outcomes for more economically disadvantaged children in Nebraska. Raising a healthy generation of Nebraskans and benefiting the state as whole and in the long-term. Thank you. [LB818]

SENATOR STUTHMAN: Thank you, Mr. Cunningham. [LB818]

SENATOR STUTHMAN: Any questions from the committee? Seeing none, thank you. [LB818]

JIM CUNNINGHAM: Thank you. [LB818]

SENATOR STUTHMAN: Any other testifiers in the proponent? Welcome. [LB818]

ANDREW HICKMAN: Good afternoon. My name is Andrew Hickman, that's H-i-c-k-m-a-n. I represent a fledgling grassroots group in Omaha called Citizens for

National Healthcare and I've prepared a short personal statement. I'm a resident of Omaha and a father of four young children, all of whom have their healthcare provided by the state of Nebraska. Were it not for the state provided health insurance, I would not be able to afford healthcare for my children and this is a chilling thought for any parent. Living a life without healthcare coverage for my children would be living a life of constant anxiety. I wholeheartedly support any and all increase in the maximum income for families to get state health insurance for their children. I'm a student and will soon be graduating from Creighton University. To be honest, I am deeply afraid of someday having to make the switch to private health insurance. I'm increasingly aware that especially in today's economy I will not be jumping into high-paying job. The day is quickly approaching where what limited income we live on now will be stretched even further out of necessity. Especially because I have two children who have severe and life threatening food allergies, as well as immune system problems. I am terrified at the prospect of them being rejected for insurance on the basis of preexisting conditions. I am terrified of the prospect of taking them to a hospital only to be denied service because my insurance won't cover that hospital. I am terrified at the prospect that a doctor won't do everything he/she can for my children because insurance companies have given him/her the incentive not to. I'm here today because these are fears that not only I face, but countless others. These are fears that I hope my children never have to live with when they have children of their own. As Americans, I fail to understand why so many like myself live in this kind of fear. I fail to understand why we as a country cannot have what so many other countries have, a life without being afraid of the healthcare systems. Countries like Australia, Belgium, Bosnia, Bulgaria, Croatia, Czech Republic, Denmark, Finland, Estonia, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Malta, the Netherlands, Norway, Lichtenstein, Luxembourg, Poland, Portugal, Romania, Russia, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, and the United Kingdom, and last but certainly not least Iraq and Afghanistan. The later two paid for by the U.S. government. Can we not enjoy the same freedom from fear that they do? Even Mexico is currently attempting to implement a state run healthcare system that has no maximum income eligibility. So while Mexicans cross our borders to look for work, will we be crossing their borders to look for healthcare? Some day I hope to see a legislative bill that proposes to remove the maximum income eligibility so that all people are entitled to healthcare. When that day comes, you will not just see me, but my wife and children standing before you as well with nothing more to say than thank you. [LB818]

SENATOR STUTHMAN: Thank you, Andrew. Are there any questions from the committee? Again, I want to thank you for your testimony. That means a lot when we have an individual come that is experiencing the need for the healthcare. Thank you, again. [LB818]

ANDREW HICKMAN: Thank you very much. [LB818]

SENATOR STUTHMAN: You bet. Any other testifiers in the proponent? Good afternoon. [LB818]

CARLY RUNESTAD: (Exhibit 5) Good afternoon, Senator Stuthman, members of the committee. My name is Carly Runestad, it's C-a-r-l-y, last name is R-u-n-e-s-t-a-d, and I am the director of health policy at the Nebraska Hospital Association. And today we are here on behalf of our 85-member hospitals to ask you to support and advance LB818. We actually had someone lined up today from children's hospital who was going to come and give you probably a much better perspective as to how this expansion would impact the patients that they are privileged to serve everyday. Unfortunately, he had an emergency and he had to leave about an hour ago. But he had asked that I come on record and let them know that children's hospital definitely supports this and that they will be sending you a letter within the next week. I will be extremely brief. I think that the previous testifiers have done a wonderful job of outlining the statistics and the data. I would just draw you attention to that second page of my testimony. And that is that the lack of health insurance leads to a poorer quality health status, and the lack of health coverage and care limit a child's ability to grow, thrive, and engage in society in a productive manner. For example, uninsured children are seven times more likely to go without needed medical care than children who have health insurance. A recent study showed that one in five parents of uninsured children has delayed or skipped needed medical care for their child because they did not know how to pay for it. Some others include uninsured children are more than twice as likely to go without care for reoccurring ear infections, which if untreated can lead to permanent hearing loss. Uninsured children are four times more likely to end up in the ER with conditions that could have been avoided with preventive care. Uninsured children are 25 percent more likely to miss school than insured children. Too many Nebraska Children do not have access to healthcare services in the state. Kids Connection provides critical healthcare to our low-income and all Nebraska children should have a healthy start in life. Investing in preventive and primary care for kids will produce a healthier, stronger future for your state and cost savings for our healthcare system. I thank you for your consideration. I thank Senator Avery for bringing this forward and I would welcome any questions. [LB818]

SENATOR STUTHMAN: Thank you, Carly. Any questions from the committee? Seeing none, thank you. Any other testifiers? Welcome. [LB818]

SARAH ANN LEWIS: (Exhibit 6) Good afternoon, Senator Stuthman, members of the committee. My name is Sarah Ann Lewis, L-e-w-i-s, and I am the policy coordinator and registered lobbyist for Voices for Children in Nebraska. I'm here today in strong support of LB818 and I'd like to express my sincere appreciation to Senator Avery for introducing this bill. You have my longer, written, and detailed testimony in front of you. And in the interest of time, I'd just like to share that after many months of lobbying at the federal level for SCHIP reauthorization, which has yet to pass, we support improving our

program at the state level to position us to receive more federal dollars to support Kids Connection. If we strengthen our Kids Connection program by passing LB818, we would be squarely inline with the directives of the opposition to the recent attempts at federal SCHIP reauthorization. We would be covering low income children. We would not be covering adults, with the exception of pregnant women, and we would not be covering middle income families. Furthermore, we would ensure a better continuity of care through 12 months continuous coverage. Thus we would urge you to advance LB818 and I thank you for your time. [LB818]

SENATOR STUTHMAN: Thank you, Sarah Ann. Any questions from the committee? Seeing none, thank you. Any other testifiers in the proponent? [LB818]

TEJA TAYLOR: Good afternoon, Senator Stuthman and senators. My name is Teja Taylor, first name is T-e-j-a, last name Taylor, T-a-y-l-o-r, and I am here because I am a mother and I'm the voice for my children as well as voices for other low income families and children as in need. As Senator Avery has mentioned other of proponents, children have many difficult life-threatening diseases ranging from small to large, some can be cured, some can't. With children, things pop up such as colds or diseases or flus or...I mean cancers, anything with children. And I think that is an important that these children are insured, and the reason why is because imagine being a father, a mother and you know you're both working and you have a child who is suffering, you know, from a disease. And the first six months you go in to your caseworker and you're submitting all your documents, you're approved for your, you know, medical insurance. And then when you have to go in for the next portion of the six months of the year, you're not approved. How do you tell your child or your husband or wife or the doctors, I can't bring my child to you because we don't have insurance or the job that I'm working for does not cover my dependents? As a mother I have an eight-month-old baby who suffers from seizures. How do I explain to him that I can't take him to get his medicine or take him to a neurologist for him to be seen to be looked at so we can fix his problem? As everybody has said, children who are not covered, who are not seen, who are not improved with their health issues, nothing is gained, nothing positive is gained from this. As a representative for low income families I think that it is an award to be told that you don't have to struggle, you don't have to worry about losing your job taking off time or watching your child suffer, getting that bill in the mail from the emergency room. How are you going to pay for that if you can't take your child to a regular doctor's office? Thank you. [LB818]

SENATOR STUTHMAN: Thank you, Ms. Taylor. Any questions from the committee? Seeing none, but I do want to thank you for coming and testifying as an individual. That means a lot to me and the committee. [LB818]

TEJA TAYLOR: It means a lot me to be here. [LB818]

SENATOR STUTHMAN: Okay. Thank you very much. You did a good job. [LB818]

TEJA TAYLOR: Thank you. [LB818]

SENATOR STUTHMAN: Any other testifiers in the proponent? Good afternoon. [LB818]

TIFFANY SEIBERT: (Exhibit 7) Good afternoon. My name is Tiffany Seibert, that's S-e-i-b-e-r-t, and I am here to testify in support of LB818. On behalf of the policy working group of the Opportunity @ Work Coalition. Opportunity @ Work is a newly announced statewide coalition bringing together the business community, nonprofit organizations, and human service providing agencies to work together to promote financial stability for all working Nebraskans. I've submitted my written testimony. So I just want to ensure that a couple of points are made today, particularly about the children that will benefit from the passage of this bill, those children who fall between 185 percent and 200 percent of the Federal Poverty Level. These children are all in working families. We know in Nebraska that 88 percent of low income children have at least one working parent. Despite that strong work ethic and a relatively full employment economy, we have seen the number of uninsured children in Nebraska rise from 5.2 percent in 2002 to 10.1 percent in 2006. We know that this increase can be attributed largely to a decline in employer-sponsored coverage. The Mercer Health and Benefit study released in 2006 found that the cost to employers of providing health insurance to employees increased by 10.9 percent in that year. We also know, as it's been mentioned, that the majority of Nebraska employers are small businesses and it's become prohibitively costly to offer insurance to their employers. There's also an economic stimulative effect to increasing the number of insured children in our state. More insured creates increasing demand for healthcare, thus more need for healthcare jobs. So we have to keep that in mind, as well as the benefits of having our children insured. And then finally, I think it's important that we recognize that the problem of uninsured children isn't going away and it may quite feasibly get worse as we look at this upcoming recession that we're dealing with. By extending Kids Connection to 200 percent of Federal Poverty Level, Nebraska can say that at the very least, we are taking care to ensure that all of our low income children have access to consistent and quality medical care. Thank you. [LB818]

SENATOR STUTHMAN: Thank you, Tiffany. Are there any questions from the committee? Seeing none, thank you. Any other testifiers in the proponent? Good afternoon. [LB818]

JENNIFER CARTER: (Exhibit 8) Good afternoon. Good afternoon, Senator Stuthman and committee members. My name is Jennifer Carter, C-a-r-t-e-r, and I'm the director of the Healthcare Access Program at Nebraska Appleseed and their registered lobbyist. There's been a lot of good testimony on this already. So we're here obviously in support of LB818 and we would echo everything that has been said about the national

conversation that's been going on on children's healthcare over the last year. And the real consensus that children need to be covered, and I think importantly, a consensus that children up to 200 percent of the Federal Poverty Level are the low income children that were targeted under this program. So this would, I think, really bring us up to where the nation really thinks that we should be. I handed out testimony, so I won't go through it all. But I just wanted to highlight two other things, which is there a long-term benefits in savings that I think have been discussed and I think are probably in a lot of the written testimony to the children obviously. But I also think this is extremely important to working families moving to self-sufficiency and to more economic stability when they have programs like this to bolster them as they get their educations or their improving in their jobs and making more money. And just having just even a little bit more room to get your economic footing before you may lose some of these public benefits that help you out, really helps those families because we see often what we end up referring to as a cliff effect when families lose some of those public benefits when they have to pay for child care and healthcare. In the private market, it's so expensive that they end up not being able to meet their basic needs while they're paying for their health insurance. And we get this crazy situation where the family is almost better off making $7 an hour instead of $15 an hour and really moving ahead. And so we'd love to see this happen also to help those families. A couple of clarifications, on the fiscal note--which I forgot to bring up with me, but I've read--I know that we're going to hear about the cost of the program and that's real. And the question of fiscal sustainability of the Medicaid program is a real question and we share that concern because we obviously really believe in this program and think it is really important to our citizens. And if it goes away because there's no money left for it, that's a really bad thing. But two things, my understanding was that a lot of the discussion that--and I'm sorry Senator Erdman is not here--about this eating up our entire budget in the next few years was based on 12 percent growth and my understanding is Medicaid has not been growing even close to that. It's between 3 and 4 percent right now. It's a really efficient program and that also at some point we have to balance. And I know we've had...this committee has said this, that, you know, you need to balance the fiscal sustainability with making sure that people are still getting the services under the program. And I just want to make sure that that really is in the forefront when we're looking at these issues, and that the fiscal sustainability argument isn't there really as a way for shrinking benefits for maybe no other reason. You know, maybe there isn't really the fiscal concern at all times because ultimately we just have to make a choice as a community. Are we going to cover our kids? Are we going to put our resources into this program, which is efficient, runs well, kids don't cost a lot of money in the Medicaid program. And it's just, we do need...I agree with Senator Erdman, we need to have a bigger discussion about where are we putting our resources as a whole as a state. I would ask though that when we're having that conversation, we not just look at expenditures, we not just say what else can we cut? But where are revenues and what are we cutting on our revenue side and should we make different choices there also? And so I just wanted to point that out as well and hope that we make certain choices as a community to cover our kids for I think real

long-term benefits, and real fiscal benefits down the road when you have healthier kids who aren't costing the system as a whole, especially until we fix our broader healthcare system. And one question also on the funding. The way the Kids Connection program works, our SCHIP allotment is a block grant, but we then fall back on a Medicaid match for those kids when we do run out our SCHIP dollars. So at the very least we're getting I think it's 57-point-something percent for the kids on the program, even after we run out of our larger SCHIP funding. And on the federal level, we hopefully have filled our shortfall that was our projected shortfall. That's what Congress based their allotments off of through March of '09. So happy to take any questions and we really, really would encourage the committee to advance this to General File. [LB818]

SENATOR STUTHMAN: Thank you, Jennifer. Any questions from the committee? Seeing none, thank you very much. [LB818]

JENNIFER CARTER: Thank you very much. [LB818]

SENATOR STUTHMAN: (Exhibits 9-12) Any other testifiers in the proponent? At this time, I would like to read into the record that we have letters of support from Keith Allen, from the Iowa/Nebraska Primary Care Association, also from Tom Tonniges, from the Center for People in Need, and Friends of Public Health in Nebraska. At this time we will have the opponents on this bill. Welcome. [LB818]

VIVIANNE CHAUMONT: (Exhibit 14) Thank you. Good afternoon, Senator Stuthman and members of the Health and Human Services Committee. My name is still Vivianne Chaumont and I'm still the director for the Department of Health and Human Services, and it's V-i-v-i-a-n-n-e C-h-a-u-m-o-n-t, director of the division of Medicaid and Long-Term Care. I'm here to testify in opposition to LB818. The department's primary concern is that of sustaining the Medicaid program for the persons currently eligible for services. LB818 would expand the Nebraska Medicaid program by raising the eligibility cutoff from 185 to 200 percent of the Federal Poverty Level for the Children's Health Insurance Program know as SCHIP, for pregnant women, and for transitional healthcare coverage for persons moving off of Aid to Families with Dependent Children cash assistance. LB818 also expands Medicaid coverage by increasing the initial period of continuous eligibility for all Kids Connection enrollees from 6 months to 12 months. Further, LB818 raises income eligibility for transitional childcare assistance from 185 to 200 percent of the Federal Poverty Level. Federal funding for SCHIP is currently frozen through March 31, 2009, at existing enrollment levels. Therefore, services for children made eligible by LB818 would be supported during most of the fiscal year '08-09 with the regular federal Medicaid share of approximately 60 percent of expenditures, rather than the estimated SCHIP enhanced federal share of approximately 72 percent. If the income cutoff is raise to 200 percent Federal Poverty Level, enrollment is estimated to increase by 5,400 children, at an average annual expenditure per enrollee estimated at $2,470. Total cost to Medicaid program for FY '08-09 and FY '09-10 is estimated at

$21.4 million. In addition, LB818 would expand Medicaid to pregnant women for pregnancy-related services by raising the upper income limit from 185 to 200 of the Federal Poverty Level. If the FPL is raised to 200 percent, an estimated additional 830 pregnant women would be made eligible at an annual cost estimated at $4,280 per person. The total estimated cost for FY '08-09 and FY '09-10 is $5.7 million. Since the 185 percent eligibility cutoff for pregnant women is established in the Social Security Act, the department would have to obtain federal approval of a waiver in order to claim federal funding for this expansion. If a waiver is not approved to allow coverage to the 200 percent of the Federal Poverty Limit, there would be no federal financial participation in the new expense. Another cost to the Medicaid budget is transitional health care, also known as transitional Medicaid. Transition Medicaid is allowed for 12 months after termination of Aid to Dependent Children benefits. The first six months are allowed regardless of income, and eligibility for the second six months is limited to 185 percent of FPL. Expanding eligibility would add estimated costs of about $36,000 for the biennium. Again, approval of a waiver would be required to assure federal financial participation in the additional expense. LB818 would also expand Medicaid by increasing the initial period of continuous eligibility for all Kids Connection enrollees from 6 months to 12 months. Twelve months of continuous initial eligibility will extend Medicaid coverage of children whose families income increases between the 6th and 12th month after initial application. Under existing rules, coverage would be terminated. This means under this bill that eligibility would continue for six months for children whose families no longer meet the eligibility criteria. The six months of additional guaranteed eligibility is estimated to add 118,846 additional months of eligibility at $100 per month for a biennial cost increase of $19.1 million. Eligibility for transitional child care benefits available to families after termination of ADC benefits doesn't impact Medicaid expenditures, but will have a similar impact on the children and family division within the department. In addition, each of the proposed areas of eligibility expansion has as associated impact on department's administrative work to determine eligibility, process payments, and coordinate changes with appropriate federal agencies. In conclusion, we oppose LB818 because of its far-reaching impact on department expenditures for Medicaid payments, child care payments, and administration. This legislation significantly expands Medicaid and SCHIP eligibility, contrary to the Medicaid reform directive to contain Medicaid spending and create a fiscally sustainable program. I would be happy to answer any questions. I'd also like, just because of the issues that we have with the fiscal sustainability, I would just like to mention my experience. The last two years before I came to Nebraska, I worked in Arizona and the contract that I ran was a Medicaid contract for behavioral health. During that time I became friends with a Arizona Medicaid director and I recently met him in Washington, D.C. When I moved to Arizona in May of '05, Arizona could not figure out how to spend the money that it was getting in from taxes fast enough; it's a low tax state too. Trust me, I really can tell the difference after moving here. They really could not spend the money fast enough and they have a very limited and very tight Medicaid program. When I talked to Tony (phonetic) a couple of months ago, Arizona is currently struggling in its legislative

session right now with a $1 billion deficit and the Medicaid program has been asked to take $65 million in cuts. This is in the second fastest growing state in the country. So I don't think that we're crying fire when we say the fiscal sustainability of this program is key in that we need to be very careful about how we spend the money to ensure that we have it here for the people that need it. If you have any questions... [LB818]

SENATOR STUTHMAN: Thank you, Vivianne. Does the committee have any questions? Senator Howard. [LB818]

SENATOR HOWARD: Thank you, Senator Stuthman. Vivianne, do you feel that it's important for pregnant women to receive prenatal care? [LB818]

VIVIANNE CHAUMONT: Yes. [LB818]

SENATOR HOWARD: Do you think that if they don't receive prenatal care there can be some detrimental outcomes to the baby? [LB818]

VIVIANNE CHAUMONT: I think that there's studies that show that in some cases that's true. [LB818]

SENATOR HOWARD: And what I've read, and you can correct me if I'm wrong, that prenatal care for an infant with a very serious birth defect due to a mother not receiving care prior to birth can be very expensive. [LB818]

VIVIANNE CHAUMONT: That's true. [LB818]

SENATOR HOWARD: So doesn't it behoove us to look at this issue of providing care to these individuals in order to prevent the possible negative outcomes that we're well aware can occur? [LB818]

VIVIANNE CHAUMONT: I think that's true. But you know also from my experience in Colorado I can tell you that we did a statistical analysis, a data analysis at some point talking about the prenatal when we were looking at presumptive eligibility and other issues with prenatal care. And we found that this particular population tended to come in for prenatal care in the seventh and eighth month. And I'm sure that you know that the studies show that by the time somebody comes in in the seventh and eighth and ninth month, the harm that could have been prevented by prenatal care has happened because that harm comes in from having prenatal care very early in the pregnancy as opposed to very late in the pregnancy. [LB818]

SENATOR HOWARD: I don't give you any argument with that. My point being that I think we have an obligation to provide to offer to make this prenatal care available to these women who have the potential of delivering babies that really are going to be very

costly infants and we're all going to pay for it. Thank you. [LB818]

VIVIANNE CHAUMONT: Um-hum. [LB818]

SENATOR STUTHMAN: Thank you. Any other questions for Vivianne? [LB818]

SENATOR PANKONIN: Senator Stuthman. [LB818]

SENATOR STUTHMAN: Yes, Senator Pankonin. [LB818]

SENATOR PANKONIN: Vivianne, thanks for coming today and I missed some of the earlier part of the hearings, so maybe some of this would be covered. Can you tell me what the 200 percent level in approximate, let's say, in a family of 4 in Nebraska? Do you know what we're talking for income? [LB818]

VIVIANNE CHAUMONT: You know, it's $40-something thousand dollars. The new Federal Poverty Levels just came out and I don't have those numbers, but I would be happy to provide those to the committee. [LB818]

SENATOR PANKONIN: Okay. I think somewhere along that line might be helpful in the continuing discussions. That was a point I made last year. Sometimes in Nebraska...and you go out in the smaller communities, that 200 percent level is actually a pretty average income for some folks. But I know it's different in the cities and realize that as well. But I think it would be helpful to have that number. The second thing, if things are stymied in Washington right now on SCHIP, how does this all...obviuosly it would be speculation to know what's going to happen there. Does that have any bearing on this discussion, do you think? [LB818]

VIVIANNE CHAUMONT: Well, this bill is about expanding what we already have. The issues in Washington are effecting payment for what we already cover and Congress has been stymied. There's been a lot of press on the struggles between Congress and the President on the SCHIP issue. What is the current situation is that SCHIP has been reauthorized, I think it was through March of '09 but at the current levels. So Nebraska has sufficient money to get through the fiscal year with the allotment that we have from the federal government based on the current enrollment that we have at 72 percent. So we get 72 percent federal money for SCHIP, 28 percent state dollars. Because Nebraska has a Medicaid expansion, if we run out of that allotment, unlike other states such as Colorado, which has a standalone SCHIP program that the program can terminate, cannot...you know, has much more flexibility, Nebraska would continue to pay for any SCHIP children, SCHIP clients at the Medicaid reimbursement level, which is about 60 percent federal, as opposed to 72 percent federal. So that would be additional money that the state would be having to come up with. [LB818]

SENATOR PANKONIN: Thank you. [LB818]

SENATOR STUTHMAN: Any other questions? Thank you, Vivianne. [LB818]

VIVIANNE CHAUMONT: Thank you. [LB818]

SENATOR STUTHMAN: (Exhibit 15) I would also like to mention for the record that LB1248 in 2006 that was passed, the department required to develop alternatives to child health insurance program and the committee has been provided with that information of those alternatives. Also, is there any other one in the opposition, opponents? Anyone in the neutral? I do have a letter of support from the Nebraska Chapter of National Association of Social Workers, and we will enter that also into the record. So with that, Senator Avery, you're welcome to close. [LB818]

SENATOR AVERY: Mr. Chair, I apologize for leaving briefly, but I had other business across the hall, so I missed some of the testimony. But I do want to address some of the points that I did hear. The last witness was concerned about sustaining current coverage of Medicaid patients or recipients. And I guess my question is, is this really the choice? Are we talking about if we expand SCHIP that somehow you're going to take money away from other needy recipients of Medicaid? I don't think that's really the choice we're being asked to make. Senator Erdman raised the question of whether we can do this without eliminating funding for the university and K-12 schools. I want to know this, why is it that every time we propose more spending to meet human needs--I mean, I'm talking about needs that we all recognize are there--we hear the same thing, we can't afford this. And when we consider tax cuts and incentives, no one that I recall raises the question of affordability, and I'm not arguing against those programs. The long-term cost of not acting to help those who are most in need might be higher than the cost of acting now. Back to the issue of affordability, maybe the time has arrived for us to ask the question about the long-term sustainability of programs that continue to shrink our tax base. Perhaps we need a discussion of how the tax base can be expanded. Many services are not now taxed. We don't tax legal fees. Why not? They're not lawyers here so that makes it an easier statement to make (laugh). The fact is that this is an important issue. I know it's not easy and I know that we have to make hard choices and I believe that we in the Legislature are going have some really tough decisions to make down the road, picking and choosing and trying to figure out how we can afford to do the things we must do. This is one of those things. I don't think this is a luxury. I really don't. I think it's really a need. So I urge you to pass this onto General File and if it gets there and it gets on the agenda, I will make sure I have cough drops for the debate (laugh). [LB818]

SENATOR STUTHMAN: Okay. Thank you. Are there any questions for Senator Avery? Senator Howard. [LB818]

SENATOR HOWARD: Thank you, Senator Stuthman. Senator Avery, I want to thank you for bringing this in. All the years I worked in Health and Human Services as a case manager, I saw these infants struggle for life, these babies whose mothers had not had the opportunity for prenatal care to really prevent problems that really limited these babies ability to survive frankly. And I think this is an important issue that we look at and we determine who we are and what quality of life we want in the state. [LB818]

SENATOR AVERY: And the long-term costs really are impacted by what we do now. [LB818]

SENATOR HOWARD: Thank you. [LB818]

SENATOR AVERY: Kids that don't develop because they haven't had adequate healthcare or they get illnesses that could have been prevented, that costs society. [LB818]

SENATOR STUTHMAN: Thank you, Senator Howard and Senator Avery. Any other questions? Senator Erdman. [LB818]

SENATOR ERDMAN: I don't know. Maybe you want to go first, Dave. [LB818]

SENATOR PANKONIN: Go ahead. I'm writing my notes yet. [LB818]

SENATOR ERDMAN: Senator Avery, I don't know that it's accurate to say no one is making the argument that we can't afford tax cuts and incentives because last I checked, Senator Chambers is still a member of the Legislature (laugh). And he makes that argument every time. [LB818]

SENATOR AVERY: He does. [LB818]

SENATOR ERDMAN: And there are others that make the argument on incentives, and there were others last year that made the argument on tax cuts and there are others making the argument on cash reserve this year. My question to you, when you did your opening wasn't we couldn't do this. But you admitted in your closing that we're going to have to make difficult decisions down the road. Make the difficult decision today. What would it look like? That's all I'm saying. I'm not saying no because always the debate has been we need to do this to add to what we're doing. If you're interested in priorities and I've been interested in setting priorities since I've been a member of the Legislature and my voting record reflects that, then let's sit down and decide what is the priorities of the state of Nebraska because if we don't do it today, you will have no choice. [LB818]

SENATOR AVERY: You're right. I'd be happy to join that... [LB818]

SENATOR ERDMAN: You will choose between Medicaid and state aid to schools. So I'm simply saying again... [LB818]

SENATOR AVERY: I will be happy to join that discussion. [LB818]

SENATOR ERDMAN: Great. But you have to join that discussion before we pass LB818 because by passing LB818, you contribute to that long-term problem. The plan in place now is a reflection of the fact that there was no planning in place, that there were no alternatives thought of, and when we were forced with a difficult decision, we made the decision. And the decision isn't that you have to reapply from SCHIP every six months, that's not what the program is. You have six months continuous eligibility, then you get analyzed month by month. And the idea is, is that we want to take the dollars that we have an ensure the people who are being covered are the people who fit the qualifications. That's how you utilize the resources to meet the criteria without trying to provide an undue burden. That's all of this discussion and it has to carryover to state aid to schools, to everything else that we do and you're on the Education Committee. You're looking at what's going on in Omaha, the millions and millions of new dollars that we injected into that. You're looking at what we're going to do for the 17 and 14 percent increases in spending in that program for this year of the biennium and over the next biennium. Those things are growing at a rate that may not be sustainable. But if we don't sit down and honestly ask ourselves, which I think you're asking us to do, what are the priorities of the state? We'll do two things and when I'm at the ripe age of 42...carry the five, excuse me, 47 I will say I'm a resident of the state of Nebraska and the state of Nebraska does two things on behalf of all residents. That's not the Nebraska that I want to live in because I don't think that's the Nebraska that people would want to live in. From the standpoint of what you're asking us, you're got it right on. Question all these things? You bet. I mentioned to you earlier, we don't vote for tax cuts to get reelected. If you believe as I do that they help stimulate the economy, then you vote for them. If you don't, then don't. But the fact is that we can't continue to discuss your proposal or a similar proposals in a vacuum from all other proposals. And I don't plan to vote for LB235 because if I'm being asked whether or not we want to spend $5 million to recruit people to make films in Nebraska or whether your proposal has more merit, it's a pretty easy decision for me. That's the type of discussion that we as lawmakers have to have. [LB818]

SENATOR AVERY: I agree, I agree. Let me make one comment about the six month... [LB818]

SENATOR ERDMAN: Let me ask you a question. Senator Avery, what do you think? [LB818]

SENATOR AVERY: I just assumed that there was an implied question. [LB818]

SENATOR ERDMAN: There is. I just let you freewill. [LB818]

SENATOR AVERY: Yeah. you mentioned going from six months to seven months for reapplication. It's my understanding...I might be wrong because I wasn't here when this happened, but a few years ago when we had a fiscal crisis it was changed from 12 to 6 months. [LB818]

SENATOR ERDMAN: Right. [LB818]

SENATOR AVERY: And the purpose of that was to capture some cost savings. [LB818]

SENATOR ERDMAN: Correct. [LB818]

SENATOR AVERY: Okay. This is not a radical proposal to go back to what we were doing prior to that. [LB818]

SENATOR ERDMAN: But would you not agree that there will be people during that course of time who will exceed the guidelines that will still be receiving benefits which were not intended under the passage of the law? In other words, if it's only a 12 month... [LB818]

SENATOR AVERY: I don't know that. [LB818]

SENATOR ERDMAN: Okay. Let me give you a scenario, Senator Avery. I make X. Seven months from now I make X plus 20 percent. I am now over the guidelines, but under a 12 month period, I am actually, should I apply at that seven month period, exceeding the guidelines and would be denied. But for the remaining five months after that time, I still get benefits. Does that not...and you're right, we're not talking about taking money away at this point, but we will at some point if we don't make some rational decisions. Are we not providing a benefit to somebody that the law didn't intend to because we don't have the administrative option in place to ensure that we're providing the money for the most number of people because if you're talking about putting more people on Medicaid who are not currently using it, that does increase the cost. But if the goal is to serve that population who qualifies, then shouldn't we have a responsibility to ensure that the people who are qualified are receiving those services and that they should be able to afford that and the state should be able to sustain that? [LB818]

SENATOR AVERY: Yeah, I do. But I think that your example is probably a bit far fetched because I can't imagine somebody that's barely at the poverty level is going to be getting a 20 percent increase in pay. I mean, that just doesn't seem to make sense in a six-month period. [LB818]

SENATOR ERDMAN: Pick a number. Pick the number, Senator Avery. It doesn't matter. We heard about...Jo was up here talking about Sadie and how her family is just above the income thresholds and so they don't qualify, they end up at the ER as opposed to going to her doctor's office, which would be more economical for them and it would be a better lifestyle for their child and they would have probably the opportunities they need. That's the rationale behind raising this up. It doesn't matter whether it's 20 percent or 1 percent over. The fact is that if we're going to set a guideline, then set a guideline. If you want to provide universal healthcare for people, then say everybody under the age of ten will get healthcare. [LB818]

SENATOR AVERY: Well, let's take your point to its logical conclusion. Why have any time limit at all on the reapplication? Why not have everybody reapply every month? [LB818]

SENATOR ERDMAN: Well, one is administrative cost because you have to be efficient in the application. [LB818]

SENATOR AVERY: Yeah. [LB818]

SENATOR ERDMAN: And two is political is to ensure... [LB818]

SENATOR AVERY: It's unrealistic. [LB818]

SENATOR ERDMAN: Two is to ensure, the second part of that is to ensure that it's fair. Is it fair to ask people to reapply? No. But what's going on is not that they have to reapply, but they're reevaluated by the department on a monthly basis. No one is reapplying every month or every six months to stay on Medicaid. That's a complete fabrication of the process. Read the law and talk to the department. Are there people who go off because they don't reach the requirements and then come back on. They do, and when they come back on, they get six continuous months. The reason why we set it at that level was one, for cost savings, but two, to ensure fairness in the plan that the people who are receiving the benefits get them. [LB818]

SENATOR AVERY: I don't know what other states do in this, but it wouldn't surprise me if most of them are at 12 months. Why did we have it at 12 months in the beginning if you are even...if it's so superior? [LB818]

SENATOR ERDMAN: Because we could afford it. [LB818]

SENATOR AVERY: Because we could afford it. [LB818]

SENATOR ERDMAN: Absolutely. [LB818]

SENATOR AVERY: Well, let me raise another issue. Right now... [LB818]

SENATOR ERDMAN: I actually enjoy this conversation, so if the other members would like to take a break (laughter) we'll be here when you get back. [LB818]

SENATOR AVERY: Right now we have...in order to qualify, you have to be at 58 percent of the Federal Poverty Level. That's the beginning qualification and you can go up to 185 percent. Why not lower that so that you really capture some people who may be in great need. [LB818]

SENATOR ERDMAN: And you're talking about Medicaid or Kids Connection? [LB818]

SENATOR AVERY: I'm talking about the SCHIP. [LB818]

SENATOR ERDMAN: SCHIP because Medicaid covers people below that. [LB818]

SENATOR AVERY: Is it covered, everybody, below 58 percent of the Federal Poverty Level covered by Medicaid? [LB818]

SENATOR ERDMAN: Senator Avery, the purpose of SCHIP was to target middle to low income families who didn't have health insurance... [LB818]

SENATOR AVERY: I know the purpose. I know the purpose. I know the purpose. [LB818]

SENATOR ERDMAN: ...and other provisions and programs are in place to help those that generally are in need. [LB818]

SENATOR AVERY: So you know that to be true that people who are 58 percent or below the Federal Poverty Level now are covered by Medicaid? [LB818]

SENATOR ERDMAN: I don't know the details, but I will tell you that there are probably reasons or scenarios where there may be people who don't. But again, it comes back to my comment to you. If you want to make sure that everybody under the age of 10 has health insurance, than just say that, just write it in the bill and then send it to us as a state. [LB818]

SENATOR AVERY: That's not the intent. [LB818]

SENATOR ERDMAN: But I'm just saying, if you want to ensure that everybody has the healthcare that they need, then let's do that. If you want a reasonable plan that can be administered and afforded by the citizens who are paying for it, then there's going to be some tradeoffs in the proposal of administration and other things. So again, whether or

not you're setting the numbers A, B, or C, if you're goal is ultimately that everybody should have care, then you have to talk about completely different dynamic. If you want to fix this, if you think that this is the solution, then let's go at it. But my offer to you is, again, if we want to do this, let's come up with a $6 or $7 million that it's going to cost for this year, and the potentially $15 million for the next biennium. And probably the next $18 or $20 million the years after that that continues to add to the cost of the program, and say that if this continues to exceed where the levels are in 2007, we will reduce...I don't care what the program is, K-12, higher education, public safety, law enforcement, roads funding, by that same percent so that we're not contributing to the problem long term of an imbalance of programming that is exceeding the resources of the state. [LB818]

SENATOR AVERY: You're right. This does require a much broader look at how we use our resources and where we get our resources. But you and I had this conversation before. But I suspect you may not even support the program itself. I'm not asking you to answer that question. [LB818]

SENATOR ERDMAN: Senator Avery, I'm offended by that and I will tell you, I will tell you, I will tell you unequivocally we would not be having a discussion about how this state intends to provide any Medicaid coverage for any of its residents, long term if it wasn't for the legislation that I worked with Senator Jensen and others to ensure that we had people thinking about it. And if you're going to sit here and tell me today that I don't support Medicaid or I don't think that there are people in our society that we as government should help, you obviously don't know me. And we're going to go down a path, Senator Avery...Senator Avery, let me finish. [LB818]

SENATOR AVERY: Well, I suspect that because you've used words to me before to accuse me of supporting socialized medicine... [LB818]

SENATOR ERDMAN: It's a question. [LB818]

SENATOR AVERY: ...because of this piece of legislation... [LB818]

SENATOR ERDMAN: This is not socialized medicine yet, but if you go to a proposal that says we're going to cover all ten-year-olds regardless of wealth... [LB818]

SENATOR AVERY: I'm not suggesting that. [LB818]

SENATOR ERDMAN: That was my question...then you are going down that path. Again, if you're going to accuse me of saying I don't support Medicaid, you don't know me, and we can have all kinds of conversations before the Legislature. What you can't accuse me of is ensuring that the people that I think and the state of Nebraska as a whole generally think need to have this program, that it's sustainable. You can accuse

me of that because when we get into times of shortfall and you're going to be sitting in this Legislature and trying to determine where you cut, you're not going to have many options because it wouldn't have been for the planning that's being done and the hard work of individuals like Jeff Santema and Dick Nelson who worked through the Medicaid reform process and continue to work on our behalf to help make sure that we know what the options are, that we pursue those and consider them. Then your option will be no different than the one that we had in 2002, and that will be to arbitrarily kick people off of a program to get to a number because of our requirement to balance a budget. And I will let you say whatever you would like to say because candidly I don't know that we should continue. [LB818]

SENATOR AVERY: The sky is falling, the sky is falling. You hear this all the time when people come with a proposal you don't want to see passed. [LB818]

SENATOR STUTHMAN: At this time, are there any other questions or concerns? (Laugh) Senator Pankonin. [LB818]

SENATOR PANKONIN: This won't be as long, I promise. [LB818]

SENATOR STUTHMAN: I hope not. [LB818]

SENATOR PANKONIN: Thank you, Senator Stuthman. Senator Avery, just one perspective and it is a question, in that as you know, I'm a small businessperson. I've got like, besides myself, 14 employees in a farm equipment dealership. I pay 100 percent of the premium of the health insurance, but over the years, in a ten-year period, that's gone from $40,000 to $120,000. And that check is $10,230 and change every month, and along that path our employees...we've had higher deductibles, higher copays, and these are hard-working folks that go to work everyday who are above that--and I asked that question earlier--above that 200 percent. But these folks are having to pay more for their own care, and myself as a businessperson is paying triple what it was ten years ago. And so when you talk about unsustainability and some of those comments, I mean, I'm living it. And I'm...that plan renews on April 1, and the question is, what do you say to the small businesspeople that are trying to keep their employees insured and trying to make...and times are good in our business right now, so I'm not poor-mouthing, but I mean, there's been times...and I'm still worried about April 1, because I want to provide that benefit. I don't know if it's going to 10 percent, 20 percent. I've had increases of 35 percent in the past; obviously, to triple in ten years, that's how that happens. But what do you say to folks like that in the state that, we're trying to expand coverage here when a lot of people are seeing that they're above that 200 percent, but they're seeing their costs going up to provide it. The young man earlier talked about--you were gone, I think, at the time--about he hated to get off public insurance, because private insurance isn't near as good, and it isn't. So we've got a whole problem...this whole health insurance area is, as you well know, is a problem in

our entire country, but the question is, what do you say to people like myself and my employees, the people I work with who, we're trying to keep our head above water in the private system? And you know, it's just tough to see folks that probably have better insurance, quite frankly, expand that, you know, when we're trying to so hard. [LB818]

SENATOR AVERY: I applaud you for what you do in your business, and I'm glad you're able to do that and willing to do it. I had a small business owner in my office the other day, who used to provide health insurance for his employees. He has about 20 people, and he said, you know, it got to where I couldn't afford that, so I started just giving them a stipend, you know, an extra $200 or $300 a month to help them buy their own insurance; then it got so expensive I couldn't do that. And he said, what I was providing them didn't help them enough so that they could go out and buy insurance. He said, so now I'm out of the...the limited purchasing pool he had in his shop, and he's buying his own insurance now, for him and his family, and it's costing him over $2,000 a month. It's unsustainable. This is a huge problem, but you were, I think, out of the room when I gave my testimony. Ninety-seven percent of Nebraska businesses today are small businesses. Two-thirds do not offer healthcare to their employees, and the one-third that do provide coverage many times don't offer dependent coverage. So I think this is needed legislation, in part because of small businesses that can't afford to cover their employees, and I applaud you, Senator Pankonin. And I'm not surprised that you do that. [LB818]

SENATOR PANKONIN: Well, I'm not looking for applause. I'm just saying it's hard. [LB818]

SENATOR AVERY: I am not at all surprised that you do that. I know. [LB818]

SENATOR PANKONIN: And I worry about that April 1...that April 1 date is huge, because it does make a difference in... [LB818]

SENATOR AVERY: We need to find some way to help small businesses cover health insurance for their employees. Perhaps one way to do that might be to allow small businesses to participate in the statewide program and join a larger purchasing pool. Now I don't... [LB818]

SENATOR PANKONIN: That has some potential, but you know, there's cost to all these things, and we're not going to belabor it any more... [LB818]

SENATOR AVERY: Yeah. [LB818]

SENATOR PANKONIN: ...but thanks for coming, and I know it's the same for Senator Erdman. We're all concerned about folks, that's why I do provide it in my business, because it is important. I mean, it's essential, and so it's not like that we're hardhearted,

but it's just trying to figure it all out. [LB818]

SENATOR AVERY: Yeah. [LB818]

SENATOR PANKONIN: So thanks for coming. [LB818]

SENATOR AVERY: Yeah, it's not easy. [LB818]

SENATOR STUTHMAN: Okay, thank you, Senator Avery. At this time we will open the hearing on LB753. Senator Synowiecki. [LB753]

SENATOR SYNOWIECKI: (Exhibit 1) Thank you, Senator Stuthman, members of the committee. Good afternoon. I'm John Synowiecki. I represent District 7 in the Legislature, and I'm introducing today LB753. It's a bill that would allow nurse practitioners to practice without an integrated practice agreement if he/she has practiced in accordance with an integrated practice agreement for five years with no disciplinary action taken against his/her license. As you know, members, nurse practitioners are highly qualified healthcare professionals. They must meet the requirement of a licensed registered nurse in the state. They must complete an approved nationally accredited master's or doctoral program in the clinical specialty area of a nurse practitioner practice. In addition, they must obtain 30 contact hours of education relating to the use of drugs to treat diseases and pass a board-approved examination pertaining to their specific nurse practitioner role in nursing. Before nurse practitioners can enter a practice agreement with a physician, they must complete 2,000 hours of practice under the supervision of a physician. All nurse practitioners must meet requirements for continuing competency, as well. I want to hand out to you an integrated practice agreement in our state that is commonly used between a nurse practitioner and a physician. You can see that within the nurse practitioner agreement, Senator Stuthman, that this is really not a supervisor-type role for the physician. The physician does not assume the role of a supervisor unless the nurse practitioner does not hold a master's or doctor's degree or the nurse practitioner cannot demonstrate adequate level of coursework. I truly believe that the training and education that these individuals receive should allow them to practice free of the collaborative agreement, particularly after five years of practice in good standing. You might note that as of January of this year, that 24 states, the District of Columbia, and U.S. Virgin Islands, do not require the nurse practitioner to have a practice agreement with a physician. There will be others testifying behind me that can provide much better and further insights into this issue for the committee. And I do want to emphasize, members of the committee, that this bill does not involve anything relative to the scope of practice of a nurse practitioner. [LB753]

SENATOR STUTHMAN: Thank you, Senator Synowiecki. Are there any questions from the committee? Senator Erdman. [LB753]

SENATOR ERDMAN: Senator Synowiecki, did you receive a copy of the letter from the Department of Health and Human Services? (See Exhibit 2) [LB753]

SENATOR SYNOWIECKI: I did, Senator. [LB753]

SENATOR ERDMAN: Do you have any comments on...their opposition appears to be one, to the actual proposal, and two, as to whether or not there should be a distinguishing...we should distinguish between nurse practitioners who practice without protocols versus those who do? [LB753]

SENATOR SYNOWIECKI: You know, Senator, I received this this afternoon, and I would characterize this as very soft opposition, and what I was going to suggest--I was going to do it in my closing, but I'll just do it now, and my staff will get this together with Mr. Santema--is an amendment that kind of appeases their concern relative to this protocol/nonprotocol. I'm sure the nurse practitioners would accept that amendment, that after five years of practice and no blemishes on the record and completion of the specific issues raised by the department, that they can practice without an agreement. I would very much like to endeavor with the committee and work on something like that. [LB753]

SENATOR ERDMAN: Okay. Thank you, sir. [LB753]

SENATOR STUTHMAN: Any other questions for Senator Synowiecki? Seeing none, thank you. [LB753]

SENATOR SYNOWIECKI: Thank you. [LB753]

SENATOR STUTHMAN: I would like to see a show of hands first, of how many are in the proponent for this bill. We have several. Any opponents? Okay, thank you. We will start with the proponents. [LB753]

JOYCE SASSE: Senator Stuthman, honored members of the committee, my name is Joyce Sasse, J-o-y-c-e S-a-s-s-e. I'm a psychiatric nurse practitioner. I've been in practice for six years now. I would like to let you know a little bit about my history. As a psychiatric nurse practitioner, I had some difficulty finding a physician to work with me. One physician informed me that he would work with me, but only if I would be under his...work in his office. He told me specifically that he would not supervise anyone that did not work specifically for him. Another physician, a psychiatrist, said that he was concerned because it would raise the cost of his malpractice insurance if he supervised me. Another nurse practitioner that I know said that a psychiatrist told her that he was uncomfortable supervising her, not because of her record--she had a spotless record--but he was just uncomfortable supervising someone. Another psychiatrist who is

now my supervising and collaborative partner would have been glad to supervise me at no cost at all, but he informed me that the organization that he worked for required that he charge me a fee of $200 an hour for every hour of supervision. This is not an unheard-of fee. Some charge more, some charge less. So we're in a situation where the collaborative agreement is not just a collaborative agreement. It's not easy to find someone, especially in my field, where there are few psychiatrists and few psychiatric nurse practitioners, but where there's also a fee involved. The second part of this is, having the collaborative agreement I think is important for the first five years. We learn a lot when we get out of our practice. We don't learn everything in school. We learn a lot, and we've also been nurses. In my case I was nurse for many years in psychiatry before I became a psychiatric nurse, so I had a lot going into my practice. But I still had protocols that I followed with my physicians for my 2,000 hours. I completed those. I came out of my protocols, and I'm still under a collaborative agreement, because that's what the law is. We do have a provision in the law that states that if we're in a rural area or an area where there's few physicians, there may be a case where we do not have to have a collaborative physician. And I have known nurses that had to work under that at times. In the state of Iowa, they do not have to have a collaborative physician. They have very few problems with their nurse practitioners. It might interest you to know that since 1990, there have only been two nurse practitioners in the state of Nebraska who have had their licenses suspended. That is 18 years--2 nurse practitioners. We have over 700 nurse practitioners. We have a shortage of nursing crisis. Nurse practitioners are the wave of the future for nursing. We are a low-cost alternative that provide care for people with common problems across the spectrum of medicine. We will be out in the rural areas. We can be in the small towns. But we have to have the freedom to practice there. We can be your answer, a low-cost answer, to the healthcare crisis. Magellan, who answers for and covers psychiatric care for the state of Nebraska's Medicaid, pays us a lower rate. We can cover those cares. We can have patients come in to us a lot quicker than we can to other psychiatrists, because the few psychiatrists we have are full. The universities here in...that graduate medical students are graduating far less psychiatrists and general practitioners than ever before. Nurse practitioners can fill some of that gap and refer on to physicians those patients that are beyond our scope of practice. But we can fill those gaps at a low cost. We're talking today about the women who need early pregnancy care, and we have lots of problems in those early pregnancy months. That's where nurse practitioners can be. We can do a lot of these things and be a very important part of the healthcare continuum, but we have to have the freedom to practice. We're here offering ourselves for the people of the state of Nebraska in the rural areas, taking the patients that other practitioners don't want to see, because we offer ourselves at a much lower cost. We're here for you all. Please help us with this bill. Help the people of Nebraska. I mean, we're a win-win proposition. You're talking about looking at ways to be creative with finances? We're your women and men. We're here for you. We want to help. Please let us. Thank you so much. Any questions that I can answer? [LB753]

SENATOR STUTHMAN: Thank you, Joyce. Any questions from the committee? Senator Howard. [LB753]

JOYCE SASSE: Yes, Ma'am. [LB753]

SENATOR HOWARD: Thank you, Senator Stuthman. Thank you. Just for my information, for my education, in your realm of practice, in your expertise, do you diagnosis or do you write prescriptions? [LB753]

JOYCE SASSE: Absolutely. [LB753]

SENATOR HOWARD: To both of those? [LB753]

JOYCE SASSE: Yes, I do. I am a psychiatric nurse practitioner and a clinical nurse specialist. I'm board certified to do therapy, to diagnose, treat, assess, and handle basic psychiatric problems. A patient can come in to me, and I can do a psychiatric assessment on them, diagnose them, and treat them. If it's something beyond my specialty area...like I am not a specialist in eating disorders. I may be able to diagnose that it's an eating disorder, but then I would send them to someone who is a specialist in that area. If it's a patient who needs to go into the hospital, I'm going to refer them to someone who can admit them to the hospital. [LB753]

SENATOR HOWARD: Okay. Thank you. [LB753]

SENATOR STUTHMAN: Thank you. Senator Hansen. [LB753]

SENATOR HANSEN: Thank you, Senator Stuthman. Glad to have you here today. [LB753]

JOYCE SASSE: Thank you. [LB753]

SENATOR HANSEN: As a psych nurse... [LB753]

JOYCE SASSE: Nurse practitioner. [LB753]

SENATOR HANSEN: Nurse practitioner, I'm sorry. [LB753]

JOYCE SASSE: That's okay. [LB753]

SENATOR HANSEN: Nurse practitioner, I'm sorry. [LB753]

JOYCE SASSE: I worked really hard for that. (Laughter) [LB753]

SENATOR HANSEN: Should know by now, the term. [LB753]

JOYCE SASSE: Yeah. [LB753]

SENATOR HANSEN: What do you do in a case without an agreement such as this? What do you do when you find someone beyond your scope of practice? You said, for the common diseases, for the common diagnosis, that you can do the job for a lower price and all that. But what do you do when you find someone that is beyond your scope of practice, if you don't have an integrated management plan? Who do you call? [LB753]

JOYCE SASSE: Well, the same thing I would do under any other circumstances. If I have a patient who comes in to me and they appear to have a medical problem, I'm going to be calling their medical doctor. If they don't have a medical doctor, then I'm going to be calling someone that I can send them to. If they don't have a physician, I'm going to be calling a hospital that I know, one of the psychiatric hospitals, and saying this is a patient I have; I need to send them in. I will be calling 911 if they need to have the assistance of the police to get them there, if they're out of control. I would be calling a family member to transport them, if I had to. You know, I'm going to be looking for different ways to get them where they need to go, and then the hospital...is there at the hospital, whether it's, say, University or if it is at...which any of the psychiatric hospitals that have openings in Omaha. It just would depend. But I have relationships built up over the years where I could call their emergency room and make sure that that patient got to a safe placement. [LB753]

SENATOR HANSEN: Okay, that helps. Thank you. [LB753]

SENATOR STUTHMAN: Thank you. Any other questions? Seeing none, thank you, Joyce. [LB753]

JOYCE SASSE: You're welcome. [LB753]

SENATOR STUTHMAN: Next testifier? Good afternoon. [LB753]

MARY SCHERLING: (Exhibit 3) Good afternoon, Senator Stuthman, and others of the committee. My name is Mary Scherling, that is M-a-r-y S-c-h-e-r-l-i-n-g. I am from Beatrice, and I'm here today representing the Nebraska Nurses Association and as an individual family and family psych mental health nurse practitioner, speaking in support of LB753. I'd like to tell you just a little bit about myself. I've been an RN since 1977, and I've practiced in many different roles. In 2004 I enrolled in a program at UNMC to obtain my post-master's certificate. I was one of five students and in one of the first-in-the-country programs that enables me to work both with patients with mental health issues as well as physical health issues. As part of that program, I performed

1,000 hours of clinical practice. I am also one of five certified developmental disability nurses in the state of Nebraska. When I speak in support of LB753, I would just like to highlight the credentials of a nurse practitioner, the role of the nurse practitioners, a general description of the patients we serve, and the problems with this integrated practice agreement in access to care. As far as credentials, the Senator earlier mentioned the master's and doctoral levels for entry-level practice, so I won't go over that again, but I do want to mention that our education provides a holistic, community-based perspective and that we are regulated, like many other healthcare professionals. We have the education, we have testing of competencies, standards, and licensing requirements, and there is professional oversight. Our role--and I'm sorry. I have handouts. (Laugh) The role of the nurse practitioner: We provide a wide variety of services. As you asked in your questions, we do order and perform tests, such as x-rays and laboratory tests. We do diagnose and treat acute and chronic conditions, and as a family nurse practitioner, I can, you know, look at diabetes, high blood pressure. But also as a psychiatric nurse practitioner, I can diagnose and treat the psychiatric disorders. We can prescribe medications and treatments, and we can also manage our patients' care. Nurse practitioners collaborate with many healthcare professionals, and collaboration works, it affects patient care, and it is a core competency of advanced practice nursing. Nurse practitioners and physicians share a common goal--good patient care. And collaboration will occur, whether or not we have that integrated practice agreement. We strongly believe that the integrated practice agreement is not necessary at all. However, LB753 has the assurance mechanism with five years of practice with an integrated practice agreement. As far as the patients we serve, I just gave you an example of one of the patients I saw today, and in light of time you can read that, but I just want to highlight, as a nurse practitioner, how I make it accessible for patients. I had a very distraught lady come in. Her car broke down, her daughter had died, her son had brain surgery, and she was out of her medications for her bipolar disease and anxiety. And within two hours, I sat down with her, had her preauthorization done, could see her for that 60-minute evaluation, and then ordered the medications that she needed. And I'll be seeing her again on Monday, so we are available. That might have taken three months to get in to see a psychiatrist, if she wanted to make an appointment. Problems with the integrated practice agreement and access to care: It's been a struggle for me as a nurse practitioner in Nebraska for many reasons, but today I'm going to focus on my personal problems with the integrated practice agreement. I wanted to work with a well-known psychiatrist who would sign my integrated practice agreement, and he would collaborate with me. He was going to charge $320 an hour, but then I found out he was not a Medicaid provider and I was unable to work with him, because I want to take care of patients on Medicaid and I'm not alone. There's other nurses in the rural areas that have paid thousands of dollars to have a collaborating physician, and they've never met face to face for that collaboration. The company I work for hired a psychiatrist, but this physician won't sign my integrated practice agreement, because I practice in southeast Nebraska, not Omaha, and I travel to many areas--Omaha, Columbus, Seward, and Beatrice in southeast Nebraska--and it's very difficult to find

physicians that are willing to sign my integrated practice agreement. Because I am dual certified, I have to have a physician in family practice and a physician that is a psychiatrist, so I have to have two different integrated practice agreements. By being certified in both of the areas, family practice and psych mental health, I strive to fill the gaps of Nebraska's health professional shortage, especially for those who cannot easily access mental health services, including those in the rural areas and urban underserved. We nurse practitioners are valuable resources in Nebraska, where 75 percent of the rural counties are federally designated mental health professional shortage areas, and 36 percent of the rural counties are federally designated primary healthcare professional shortage areas. An examination of the IOM, the Institute of Medicine, report on the future of healthcare in the 21st century reveals many gaps in the healthcare delivery system, and one of the gaps is patient safety. Lawsuits against nurse practitioners are rare. The rate of lawsuits per 1,000 nurse practitioners is 0.6 compared with the rate of physicians for 38. In the state of Nebraska, I think they had mentioned earlier there is a provision, if you're in a rural area and you can't find someone to sign that, that there is a waiver process, and we have had some nurses in the past practice under that waiver without any disciplinary action. Shortages in providers for healthcare in rural areas are driven in part by rigid practice models. Researchers are also noticing a trend that nurse practitioners are migrating to states that have enacted laws allowing the nurse practitioner to practice without the integrated practice agreement. We respectively ask you to advance this bill out of committee. Passage of LB753 will provide efficiency of care, access to care, and quality of care, along with a significantly improved delivery model. And thank you very much for your time on this very important bill affecting nurse practitioners in the state of Nebraska. [LB753]

SENATOR STUTHMAN: Thank you, Mary. Any questions from the committee? Seeing none, thank you for your testimony. [LB753]

MARY SCHERLING: Um-hum. Okay. [LB753]

SENATOR STUTHMAN: Good afternoon. [LB753]

KATHY MURPHY BUSCHKOETTER: (Exhibit 4) Good afternoon. My name is Kathy Murphy Buschkoetter, M-u-r-p-h-y B-u-s-c-h-k-o-e-t-t-e-r. Thank you, members of the committee, for allowing us to testify today. I'm an advanced registered nurse practitioner, and I am employed in a critical access hospital and rural health clinics as a family nurse practitioner in Franklin and Red Cloud. I am currently the president of the Nebraska Nurse Practitioners and today, as a representative of the Nebraska Nurse Practitioners, I would like to voice our support of LB753. My practice began in 1994 when I graduated from UNMC's College of Nursing's first family nurse practitioner program in the state. And with that, I don't want to give you the impression that nurse practitioners just started in 1994, because before that there were nurse practitioners

practicing in the state, but they had been educated in another state. I've been caring for patients in Franklin and Webster County for the past 14 years. Our critical access hospital and rural health clinics employ three nurse practitioners. As you are aware or as you might not be aware, rural health clinics are required to employ nurse practitioners or physician's assistants. We operate three outreach clinics that are staffed by those nurse practitioners, and we provide high quality care for our patients and give them access to care that otherwise would not be available. As the previous testimony went through...I won't read through all of this, you can read that easily. But our current integrated practice agreements, I just want to give you an example. I work in a rural health clinic in Red Cloud, Nebraska. When I am there, I am there by myself with no other physician, nurse practitioner or PA. I have an LPN or medical assistant, and a receptionist. And so I'm just going to give you an example of what happened the other day. A patient came in, shortness of breath, complaining of some chest pain. My practice agreement is with a physician that is employed by our hospital, but I didn't even utilize...I mean, I didn't need that physician. He was a family physician. I needed a cardiologist, because after I had done the EKG, I found an arrhythmia and you know, you need to get them out of there quickly. And so to give you an example of the fact that the integrated practice agreement isn't always necessary for us to develop relationships with other physicians or specialists, that's the kind of relationship I have. I've been practicing for a long time, so all I had to do was make one call, cardiologist, gave him the rundown on the situation. He said he would accept the care. I had to arrange for an ambulance to come and get the patient and take them to Hastings to where the cardiologist was. But there was no need for me to even be involved with my family practice physician who I have my integrated practice agreement with. And I think originally when we started as nurse practitioners here in the state, physicians were worried that maybe, you know, you'd have a nurse practitioner that wouldn't be able to find somebody to refer on to. But with all of us that have practiced all these years, none of us have ever had where we made a call and somebody refused to accept our patient. We may have had to make several calls to find an opening, especially with the psych mental health nurse practitioners. They have a much more challenging position than I do. So in closing, I just want to say that the removal of the integrated practice agreement will not change the relationships that have proven to be crucial networks that the NPs utilize everyday, and the Nebraska Nurse Practitioners ask that you support LB753 and vote it out of committee. Thank you. [LB753]

SENATOR STUTHMAN: Thank you, Kathy. Any questions from the committee? Seeing none, thank you. [LB753]

KATHY MURPHY BUSCHKOETTER: Thank you. [LB753]

SENATOR STUTHMAN: Next testifier? [LB753]

SANDRA BORDEN: Good afternoon. [LB753]

SENATOR STUTHMAN: Good afternoon. [LB753]

SANDRA BORDEN: (Exhibit 5) My name is Sandra Borden. I am a family nurse practitioner. It's a pleasure to be here today, and I appreciate the opportunity to speak in support of LB753. A lot of what I was going to say has already been talked about. I too am a family nurse practitioner. I too work in a rural area. You can read all of my comments here. Twelve years ago, the Nebraska physicians argued successfully that there was a requirement for integrated practice agreements. They established a collaborative arrangement with physicians, and physicians guaranteed to us that it would do nothing to inhibit nurse practitioner practice, but instead, it would assure quality of care and professional oversight. Instead, it has turned into something different, especially for those of us who practice in a rural community. In some instances nurse practitioners are unable to open clinics or to move to areas where they would like to, because they are unable to find a collaborating physician. I currently work in Prompt Care in Grand Island. It's an ambulatory care clinic. It's staffed with one very part-time physician and a number of nurse practitioners. There's only one of us on at a time. We're open from 9:00 in the morning to 9:00 at night. We see an average of 280 patients a day, well over 14,000 patients per year. About 25 percent of our patients are Hispanic. A substantial number of them have no medical insurance. Most of the children we see are on Medicaid, and many of my patients have no other regular medical provider. The physician who signs my collaborative arrangement is a kind and competent practitioner, but I've only met him once, for less than two minutes. He signed my collaborative agreement over a year ago, and it was part of his contract with the clinic. When I am confronted by a patient who exceeds my skills, I call for the advice or refer the patient to anyone of a large number of other medical specialists with whom I maintain professional relationships. I have never called nor had access to what is technically called my collaborating physician. The previous physician contracting for collaboration has always lived over 200 miles away in Omaha. I've met him once briefly. He was forced to end his collaborative agreement with our clinic because of his fellow physicians who told him that he could no longer be collaborating with nurse practitioners in another setting. We did find a physician locally who was willing to sign the agreement, but only if it be kept a secret from the rest of her medical colleagues, if there were no actual consultations, no involvement with clinic operations, no medical services, and if we paid her fee of $36,000 a year. If you think this is an exception, if you think this is not the norm, please know St. Francis Community Hospital of Grand Island currently pays $84,000 a year to a local family practice group to oversee 2 nurse practitioners who run their rural healthcare clinics. Make no mistake--this is the reality of collaborative agreement. I have another story about the limits of collaboration. I live in Gibbon, it's a town of 1,500 people. Our physician retired and moved away ten years ago. Our pharmacy closed its doors when an overpass was put in. We have no medical community. We have no medical services. Two years ago, I tried to open a clinic in Gibbon. I found a suitable building, I developed plans needed for renovations, I made

arrangements with a nearby pharmacy to deliver prescriptions on a daily basis, I arranged for laboratory pickups of samples. My husband and I were ready to invest $100,000 to renovate, staff, and equip a clinic. We knew there wouldn't be much return, but we were willing to do it. It's my town. The project came to an end when I was unable to find a physician anywhere who would sign a collaborative arrangement. I contacted every primary care physician in a 75-mile radius and was refused by all. To this day, Gibbon has no regular medical provider. The provision that was allowed in the original bill only grants us a one-year collaborative arrangement, and I'll be real honest--I wasn't to invest $100,000 on a yearly renewable contract. The problem of access to our medical care in our rural communities, particularly the Third District where I reside is not going to solve itself. As our population ages, the demand for primary services is expected to increase substantially. The trend is already being felt. According to the Centers for Disease Control, from 1993 to 2005 the number of office visits for medical providers in the U.S. increased from 717 million to 963 million. That's an increase of 34 percent. It is exactly consistent with the increased number of Americans aged 45 or older in the same period. The Baby Boom generation is just now poised on the edge of retirement. Senators, we are about to experience a veritable tsunami in demand for medical services, and Nebraska's medical infrastructure needs to adjust accordingly. I hope that you will support and pass out of committee this bill. It would allow nurse practitioners to move to counties that are underserved and would help serve the people of Nebraska in a more reasonable manner. Thank you. Do you have any questions? [LB753]

SENATOR STUTHMAN: Thank you. Are there any questions? Senator Erdman. [LB753]

SENATOR ERDMAN: Well, it sounds like we legalized extortion. That's fantastic. (Laughter) [LB753]

SANDRA BORDEN: It kind of sounds like that to me, too. [LB753]

SENATOR ERDMAN: It reminds me of my professional experiences of trying to find an appraiser to supervise my work. But fortunately, so far, they're not charging me for the opportunity to get all the fees that I generate. Aside from the potential payment for their evident "nonservices" in your oversight, are there other benefits that go to that collaborating physician? You know, the example that you gave of the $36,000 for the one family doc to oversee the clinic. Are there billing benefits? I mean, do they get a percentage? Explain to me kind of how that works. Or is it just simply the fact... [LB753]

SANDRA BORDEN: Currently. Historically, most nurse practitioners work in physicians' office. They are salaried employees. They are not partnerships, and so they practice as a whole is allowed to bill more, therefore generating additional income. Nurse practitioners generally work a fixed salary. It doesn't matter how much income we

generate. It's a fixed salary. In terms of what is in it for the collaborating physician, nothing. [LB753]

SENATOR ERDMAN: If they can get you to pay... [LB753]

SANDRA BORDEN: But since they provide no service, why should we pay them anyway? [LB753]

SENATOR ERDMAN: Generally, is there a...I mean, you've done a decent job, and I'm assuming this was orchestrated to see a cross-section of individuals who are nurse practitioners. Greater need in certain areas than others or is it depending upon the location? I would imagine why there's no collaborative agreement in Gibbon is so everybody will go to Kearney to get their healthcare. I mean, I can... [LB753]

SANDRA BORDEN: Um-hum. People to go to Kearney, yes. [LB753]

SENATOR ERDMAN: ...understand that. But I mean, do we see a greater need in certain areas than others? Do we...as far as the type of care, because obviously you're providing...nurse practitioners aren't simply providing all the same types of services. There are different types of nurse specialists. [LB753]

SANDRA BORDEN: We have specialties just like physicians have specialties. Several of us are family nurse practitioners. We provide family care services, just like a family physician does. Some of us are psych mental health nurses, nurse practitioners, and they specialize in psych mental health, just as psychiatrists do. Is one portion of care more important than others? [LB753]

SENATOR ERDMAN: That's not my question. My question is do we generally see the same shortages for medical providers on the nurse practitioners' side as we would, say, on the doc side of the agreement? In other words, are we short of family nurse practitioners as we would be family docs? Do those two coincide or are there more nurses that fill those roles? [LB753]

SANDRA BORDEN: I don't think I can give you numbers, and so I am not sure how accurate my impressions are. I would say that there are more family nurse practitioners than other kinds of specialties. It's sort of a self-selection process. I think the two large portions of interest for nurse practitioner students in specialty is adult nurse practitioner and family nurse practitioner. There are also geriatric nurse practitioners who specialize in elder care, and a variety of other subspecialties that attract a smaller percentage of the students. I think that nurse practitioners are willing to settle in rural areas for the same reasons that sometimes physicians will. But we have a smaller cost of our education; therefore, we have smaller bills to pay. And some of us are older and have money and can invest it and don't have to worry about that as much. [LB753]

SENATOR ERDMAN: Okay. I appreciate you being here. [LB753]

SENATOR STUTHMAN: Any other questions from the committee? If none, thank you very much, Sandra. Any other testimony as proponents? Are there any more in the proponent testimony? Okay. Welcome. [LB753]

RUBY HOUCK: (Exhibit 6) Hi. Thank you. Good afternoon, Senator Stuthman, members of the committee. My name is Ruby Houck and it's R-u-b-y H-o-u-c-k. He's going to pass out packets, and in these packets I have letters of support from some of my patients. They were very generous, and I appreciate that; also from a contract. I do some contract healthcare. I have been a nurse practitioner since 1998. I worked for a clinic and then I thought, in my hometown, which is 750 people, there was no healthcare. And I thought, oh, this would be perfect for a nurse practitioner. So I opened my own clinic August 1, 2000. However, before I could open this clinic--I had the building, I had renovated it--I had to find a physician that would be my collaborating physician. And I asked every physician that lived in my county, which seemed like that would be an ideal situation, because I would refer patients directly to that person. I asked eight different physicians, but none of them would agree to sign on. The doctors didn't see a need for another healthcare facility in the county, although my hometown is 17 miles from the major community in our county. And then finally a physician in the clinic where I was temporarily covering for another nurse practitioner heard of my plight and he said, yeah, I'll do that for you. I was just thrilled. I thought God had answered my prayers. So I opened my clinic and people didn't know what a nurse practitioner was, and so they kind of drifted in slowly, which was okay, because the people that came to me were seeking a different kind of healthcare or maybe just healthcare at all, because some of them couldn't...they couldn't drive out of town or they had no car, no money for gas. And my practice grew every single week, and things were going great until my collaborating physician decided he couldn't be my collaborating physician anymore, so on 9-15-04, I received a letter telling me that he didn't want to collaborate anymore, and I was given one month's notice to find another collaborating physician, in order to continue providing healthcare to my patients. Well, I knew it was going to be a struggle, because I had worked so hard before my clinic opened, and I couldn't imagine what was going to happen. And so I contacted nine different clinics with multiple physicians and then five other individual physicians, requesting just an interview to talk with them about collaborating with me so that my clinic could continue to operate. All of them declined due to various reasons--lack of interest, they were too busy or their employer had restrictions on what they could do...could contract with. So then I wrote the state Board of Nursing to request a waiver, because I knew that was available, so I tried that. But the request was denied, and I came down and testified before the nurse practitioner board, and it was denied because I didn't have a formal referral system. No one, no nurse practitioner, has a formal referral system, and I didn't think that was quite fair, that because I wanted a waiver I had to have one, and because I see clients with a broad

spectrum of needs. They had said if I only saw one type of client, like say, oh, kidney patients or you know if I was a specialist or orthopedic, you know, then they would consider it a little more. And they weren't comfortable with me owning my own clinic. They said that I had a saleable property and maybe I'd like to sell it, and then they'd consider giving me a waiver. And also they reminded me that the waiver is only temporary and only for maybe six months. Okay, so I couldn't find a collaborating physician. The state board said, okay, you can't practice anymore, and I got that notice on a Thursday afternoon. So then for the next four business days I was limited to assessing my patients, giving them advice, and explaining why I couldn't write prescriptions that I'd been writing for them for four years. And the way I covered it was, I would call physicians that were friends of mine or that I'd referred to before or that the patients had seen previously and explain to them. And they were all very generous and they all covered my prescriptions that my patients needed. And then thankfully Dr. Byron Barksdale, who is a pathologist with the lab that my clinic uses, offered to be my collaborating physician. So the state Board of Nursing agreed that I could resume my practice with this collaborative agreement. So Dr. Barksdale signed the agreement on 11/24/04. So that's a couple of months after I got the notice that my collaborating physician had resigned. And this was new--I didn't know this was in the rules, but they said no, you have to have a collaborating physician in your same specialty. Well, Dr. Barksdale is a pathologist, and so then once again, I was in danger of having to close my practice. Well, Dr. Barksdale, who knows lots of physicians across the state, talked to his friends and Dr. Christopher Costa from Gothenburg graciously agreed to be my collaborating physician. And he signed his agreement with me on 2/3/05, and truly, he's never been to my clinic. I haven't ever had a physician, except Dr. Barksdale, a pathologist, walk through my doors. And I do refer to Dr. Costa occasionally, but mostly, like Kathy had said that if we need to refer, you know, usually I refer to a specialist--a cardiologist, an orthopedist, a nephrologist--and Dr. Costa, the...what I pay him is much less than a lot of people do, but I pay extra malpractice insurance, which is $200 to $400 a year, and that's the way I pay him. And I call him two to three times a month, to as much as maybe one to two times a week, so not very much. And once a year I meet with him to review my charts, like seven charts out of the year that I've talked to him about, and that's the extent of his actually overseeing my practice. The patients that come to my clinic range from upper middle class to the very poor. They have all the different kinds of healthcare. They're not necessarily always able to pay for their healthcare, and a lot of them don't have insurance. But because I own my own clinic, I can do this--I work out payment arrangements with them. Oh, different things, and it sounds silly and it sounds real old time, but sometimes we exchange services, and it works really well for us. And my...we don't have a pharmacy in town, and so my clinic, because I offered it at first as a...just kind of as a draw to patients, we bring medication back from Holdrege, which is 17 miles away, once a day. So if I order medicine, the patients don't have to...well, now they have to drive to Holdrege anyway, so we bring that back to town for them, and I make home visits sometimes. My patients, they tell me how grateful they are that there's a clinic in town. I don't hardly have long waiting times.

I really try to schedule my patients so that they're in and out, and many of them claim that they receive a lot better healthcare. I spend a lot of time with my patients, that normally they don't get. And now, in the back of my mind is always the worry that my current collaborating physician will have a change of heart as my first collaborator did, and then I wonder what will happen to my clinic and to my patients if I'm unable to find another collaborating physician. And I'm constantly praying that God will protect my clinic and help me to provide excellent care to my patients. But with or without a formal collaborative agreement, I will continue to consult with other providers to provide the best care I can to my patients. I don't feel that any healthcare provider, whether you're a physician or nurse practitioner or PA, practices on an island; hopefully, that there is a true concept of healthcare team, and no individual can be an expert in every field. I'm very passionate that every person deserves to have excellent healthcare, regardless of where they live, who they know or how much money they have. Thank you. Do you have any questions? [LB753]

SENATOR STUTHMAN: Thank you. Thank you, Ruby. Any questions from the committee? Senator Hansen. [LB753]

SENATOR HANSEN: I have one, thank you. Ruby, earlier today we okayed Dr. Douglas Dilly on the Nebraska Rural Health Advisory Commission. [LB753]

RUBY HOUCK: Um-hum. [LB753]

SENATOR HANSEN: Do you and other nurse practitioners work through that commission to find doctors to help... [LB753]

RUBY HOUCK: Well, I did look into being a rural health clinic, which has a little different regulations. However, because Holdrege is in my county, I am...or my clinic is in Bertrand, which is two miles inside the county limits, Gosper County, which is the next is a healthcare shortage area, but Phelps is not. So I, yeah, I did look into that when I first was looking for a collaborating physician. [LB753]

SENATOR HANSEN: Okay. And it didn't help? [LB753]

RUBY HOUCK: It was very frustrating. [LB753]

SENATOR HANSEN: Okay. Thank you. [LB753]

SENATOR STUTHMAN: Thank you again, and I would like to comment: All of you that have testified this afternoon on this bill, it's heartwarming to me to hear the testimony of the people that are actually affected by a bill like this. Any other testimony in the proponent? Welcome, Brendon. [LB753]

BRENDON POLT: (Exhibit 7) Good afternoon, Senator Stuthman. I'll submit my written testimony, and I won't read from it. And I also won't repeat many of the points made earlier. For the record, I'm Brendon Polt, and it's P-o-l-t, with the Nebraska Health Care Association. That's an association of long-term care providers--assisted living and nursing homes, both proprietary and nonproprietary. For many of the reasons that have been stated by the testifiers, the nurse practitioners before me, they're the very reasons why our membership would like to bring on staff such a provider. We don't believe that there is any risk to our residents from using a nurse practitioner without the collaborating physician. We believe there's a large cost savings in an already strapped area of the healthcare continuum, and so I would urge your support. I'm happy to answer any specific questions about the types of services that could be performed by such a nurse practitioner in a long-term care facility. I'm not sure at this late hour that's the type of questions you would have, so I'll leave it at that. I'll submit my testimony, and I'm available for questions. [LB753]

SENATOR STUTHMAN: Thank you, Mr. Polt. Any questions from the committee? Seeing none, thank you. Any other testifiers in the proponent? Any testifiers in the opposition? How many do we have in the opposition? Thank you. Welcome. [LB753]

DAVID BUNTAIN: Thank you, Senator Stuthman. Do I get as much time as the proponents? [LB753]

_____: Nope. [LB753]

SENATOR STUTHMAN: No. (Laughter) [LB753]

DAVID BUNTAIN: That's good. I don't need it. [LB753]

SENATOR STUTHMAN: You will get a maximum of 4.5 minutes. [LB753]

DAVID BUNTAIN: Four and a half minutes? (Laughter) [LB753]

SENATOR ERDMAN: It started when you sat down. [LB753]

DAVID BUNTAIN: (Exhibit 8) I hope there are lots of questions. I'm David Buntain, B-u-n-t-a-i-n. I am the registered lobbyist and attorney for the Nebraska Medical Association. I do have two items that can be handed out to the committee. The Nebraska Medical Association opposes LB753. One of the items I'm handing out is a letter from Dr. Dale Michels, who's a family physician who wanted to be here but was unable to, and it presents his testimony. I want to talk about what the reasons are that we oppose this bill, and I want to do it giving you a perspective of having been involved with this issue since the Nurse Practitioner Act was passed in 1984. I remember that year well because that was the first year that I was lobbying for the Nebraska Medical

Association, and I had to get up to speak very quickly on a number of issues, including the Nurse Practitioner Act that was pending that year. At that time when the nurse practitioner bill was passed, it was a negotiated bill between the nursing profession and the medical association, and at that time we required nurse practitioners to have a practice agreement which provided for supervision by physicians, and that was what the law was until about ten years later, when the nursing profession came to the Legislature and said, we want to eliminate the requirement of supervision, and we want to eliminate practice agreements. And we went through about a two-year process. Senator Rasmussen was very involved in it; Senator Wesley, who was the Chair of this committee; Senator Withem was involved in it; and again, it was a protracted negotiation which resulted in essentially the current version of the nurse practitioner law, which has been in effect since 1994. I have handed out as one of the handouts an item that I prepared which basically includes what I think are the three key sections for this discussion, and I want to start with the third section, which is the requirements that nurse practitioners must meet in order to practice. They have to meet educational requirements, they have to have 2,000 hours of practice under the supervision of a physician, they have to furnish proof of professional liability insurance, and they're required to submit an integrated practice agreement. That's where the requirement comes in. They are to have an integrated practice agreement with a collaborating physician. As a part of the negotiation, because of the concern that there might be situations where it would be difficult for nurse practitioners to get collaborating physicians, paragraph three was put into Section 38-2322, and this is the provision that provides for a waiver. And it says that if after a diligent effort to obtain an integrated practice agreement a nurse practitioner is unable to obtain an integrated practice agreement with one physician, the board may waive the requirement of the agreement upon a showing--and it explains what the showing is, part of which is that they've made a diligent effort to obtain an integrated practice agreement, and that they want to practice in a geographic area where there's a shortage of healthcare services. You've heard discussion about this waiver and how people have had trouble meeting that waiver. I want to point out that that waiver is administered through the nursing profession. It's administered under the Uniform Credentialing Act. It's administered by the Board of Advanced Practice Nurses. There's nothing in this that says that a waiver is limited to a year or less. There's nothing that says it's limited; you can't own your own building. There's nothing that says that you have to only see a certain kind of patients. It says that if you can show that you made a diligent effort to get an integrated practice agreement and have been unable to, then you can have a waiver. So these requirements are not requirements, as far as a waiver is concerned, that the medical profession is insisting on. Those are requirements that apparently are being imposed by the nursing profession and by the board that administers this law. At the time that this was passed, the medical profession said to the advanced practice nurses, if you are having problems getting collaborative agreements, if there are obstacles that you are encountering, come to the medical profession and...because we want to help you. We want this to succeed. And to my knowledge, this is the first notice that we've had of

many of the problems that have been portrayed today. I was not aware of any problems that had been brought to the medical association with the way this was administered, and the medical association is willing to work with the nurse practitioners and the nursing profession if there are obstacles to getting collaborative agreements. We think that the policy decision that your predecessors made in 1994 to require an integrated practice agreement still makes sense today. As I think each of the proponents has conceded, it is important that all of our healthcare practitioners, including nurse practitioners, practice within collaborative relationships with many healthcare providers, and there is a whole continuum of care that must be available in order to provide medical care...the kind of excellent medical care that people expect, and the requirement of an integrated practice agreement is one component of that. I think people expect that if they are seeing a practitioner for diagnosis and treatment and prescription, that there is a relationship with a physician, at least that physician is available to consult with or collaborate with that practitioner. And what this does is encourage that. It does not require that you refer to that collaborating physician; in fact, often that's not the thing to do. But we want to encourage this interaction, and in defining what's in the integrative practice agreement, that's where the first section on the first page comes in. Basically, what this agreement requires is that nurse practitioners and the collaborating physician practice collaboratively within their respective scope of practice. It does not require direct supervision. The supervision requirement was taken out, and so this again was a compromise. Hours, I would say, tens if not hundreds of hours went into working out the relationship as it currently exists. Finally, one of the things that I think is of concern about the bill that has been proposed is that it really sets an arbitrary standard for when an integrative practice agreement is required or is not required. Clearly, not being subject to discipline by HHS is significant, but that is not the only measure of the quality of the care and the kind of practice that a practitioner in any profession is providing to the patients that he/she serves, and it seems to me that this is...it's really kind of...it's an elusory protection to tie it to whether or not someone has been disciplined or not. The other thing I would point out is, I think that this section amends the wrong section. This really goes to the issue of whether you need a practice agreement, which is covered by 38-2322, rather than the scope of practice section, which is 32-2315, which is where this amendment would be placed. But we would urge the committee not to advance LB753 and to encourage the nursing profession and the physicians to continue to look at issues, if there are issues, relating to the opportunity for nurse practitioners to have collaborative relationships. So with that, I would respond to any questions. Was that 4.5 minutes? (Laugh) [LB753]

SENATOR STUTHMAN: It was exactly five minutes more than four and a half. Mr. Buntain...first of all, does the committee have any questions? Senator Erdman. [LB753]

SENATOR ERDMAN: You can ask first, if you'd like. [LB753]

SENATOR STUTHMAN: No, I will be last because it may take me awhile. [LB753]

SENATOR ERDMAN: Doctor, how are you? [LB753]

DAVID BUNTAIN: (Laugh) I'm not a physician. [LB753]

SENATOR ERDMAN: I know. (Laughter) [LB753]

DAVID BUNTAIN: I'm a jurist doctor. [LB753]

SENATOR ERDMAN: I know. Help me with the comment that you made before I asked my question. The statutes that you gave us are the current statutes for nurse practitioners and integrated practice agreements... [LB753]

DAVID BUNTAIN: That's correct. [LB753]

SENATOR ERDMAN: ...Section 38-2310, 2315, and 2322. You said that supervision had been removed. Can you read what subsection (b) is on 38-2310? [LB753]

DAVID BUNTAIN: Yeah. It says, supervision means the ready availability. This is...the word "supervision" was retained, but if you read through the whole definition of what is in an integrated practice agreement, it really requires collaboration. [LB753]

SENATOR ERDMAN: Which they're technically required to have, regardless of whether they have an agreement with somebody, because the statute in 2315 says that it's the responsibility...that a nurse practitioner shall function by establishing a collaborative, consultive, and referral network as appropriate with other specialists. [LB753]

DAVID BUNTAIN: That's correct. Yes, they are required to collaborate. That would be beyond... [LB753]

SENATOR ERDMAN: So regardless of whether they have an agreement--and it sounds, from some of the testimony today, that the agreements that they have are an opportunity for extortion, which I'd like your comments on. What is...I don't know the word to use, but it's an illusion, essentially, that not having anything against them in the last five years, is...somehow make them better qualified to practice independently. It's also just as much an illusion that these individuals have an agreement with somebody that doesn't do anything with their practice. [LB753]

DAVID BUNTAIN: And I would not disagree with you. And I am not familiar with any of the specific instances that were discussed today. Obviously, if there are problems in individual situations, we would want to deal with that. One of the things that the leadership of the Medical Association has been working on is to improve the awareness of physicians as to what their responsibilities are, both as to nurse practitioners and also

physician assistants, whose relationship is similar. And there are...but the physician assistant model is somewhat different than the nurse practitioner model, and they still are under a supervision requirement. So anyway, I can't defend individual cases. I don't know enough about them. But you know, if there are situations such as have been described, I think those, you know, those should certainly be looked at. [LB753]

SENATOR ERDMAN: So what's the remedy? What's the remedy for a nurse practitioner who...a physician says, if you pay me $36,000, I'll sign your agreement. What's the remedy, then? Is that an ethical issue or is that perfectly fine? [LB753]

DAVID BUNTAIN: I don't know that I have enough facts to comment one way or the other. It would... [LB753]

SENATOR ERDMAN: I wish you were a doctor. [LB753]

DAVID BUNTAIN: It would strike me as being... [LB753]

SENATOR ERDMAN: I wish you were a doctor, not a lawyer, because then you could answer the question. [LB753]

DAVID BUNTAIN: Right. Clearly, if that were the situation, and depending on where they're located and what other efforts they've made to find a collaborating physician, they may well fit within the waiver provision. I mean... [LB753]

SENATOR ERDMAN: So if an individual would submit to the board, and board isn't defined here, but you're saying it's the board of nursing, if they would submit to the board that I have a physician who's interested in serving as my collaborating physician if I pay them $36,000, you would consider that to be acceptable for the waiver? [LB753]

DAVID BUNTAIN: I think that would be...yes, I think that would be...if...I don't know if making contact with one physician would be sufficient. But if you made contact with, you know, the physicians in the immediate area and were unable to find someone to do it, except for one who said you have to pay me $36,000 to do it, I think that would be...I would regard that, if I were on the nursing board, as a diligent effort. [LB753]

SENATOR ERDMAN: I appreciate your testimony, and obviously there's two side to any issue. It just strikes me as maybe oversimplification of the issue to say that this is something that the nursing...the board of nursing can handle, because I'm imagining that as members that are credentialed under the board, that they would probably know that and they wouldn't be here talking to us, if they knew they could go talk to their board. But I'm...you know, I'm interested. The observation that I shared with Senator Pankonin was the physician assistants and how we treat them regarding their abilities, and I don't know enough about it, but appreciate your testimony. And I recognize that...

[LB753]

DAVID BUNTAIN: The PAs are required to have a practice agreement, and it does provide for supervision. [LB753]

SENATOR ERDMAN: All right, and I understand there's differences. Thank you, Doctor. [LB753]

SENATOR STUTHMAN: Any other questions from the Committee? I have one concern, and I really respected the testimony that was given of the proponents, of the individual that came as individuals in a practicing nurse setting. I think there's one thing that always concerns me is, you know, the state of Nebraska is two different situations. We've got the east part, where the population is, and we've got the situation out west, where it's very densely (sic) populated, and those people deserve to have someone be able to take care of them. And it seems like we can't get the doctors to come out to that area, and we have nurse practitioners that are willing to take that on, and I think we've got to work real hard to try to establish something so that it isn't a real burden or some law that prevents them from doing some of the practices that are needed in those rural areas. [LB753]

DAVID BUNTAIN: And Senator, I could not agree with you more, and frankly, that's part of the reason that that waiver provision is in there, was that same sentiment was there, and this is an opportunity to deal with that situation. We always have a concern about having people out who are essentially practicing by themselves. I mean, I think that would even be true to an extent with physicians, as well. Your role as the Legislature, the state's role, is to protect the public. The role of licensure is not to benefit the licensees; it's to protect the public and be sure that the persons that you're going in to see for primary care, regardless of what kind of credential they have, are able and qualified to deal with that. And that's why we encourage the kind of collaboration that I think is in the integrative practice agreement. [LB753]

SENATOR STUTHMAN: But in the testimony this afternoon, I am not sure--maybe I didn't listen close enough, as, you know, to waive the requirements. The board may waive the requirements. Has that ever taken place? [LB753]

DAVID BUNTAIN: As I understand their testimony, the...I'm not sure what the current term...what it's called, but it will be the Board of Advanced Practice Nursing under the Uniform Credentialing Act. That board makes the decision. My understanding from the testimony is that they have granted waivers. Some of the testimony about conditions that have been raised for granting that waiver I think go way beyond what was intended by the waiver section when it was put in 12 years ago. [LB753]

SENATOR STUTHMAN: Mr. Buntain, in the directions of the head movement of the

nurse practitioners, they weren't really thinking that there had been very many waivers. [LB753]

DAVID BUNTAIN: I can't see for...well, I don't know. I mean, someone knows the answer to that. I am under the impression that there have been some waivers, but I don't know how many. [LB753]

SENATOR STUTHMAN: Yeah, and I think if there's a problem with that, we need to try to address that. So... [LB753]

DAVID BUNTAIN: And I agree. [LB753]

SENATOR STUTHMAN: Senator Pankonin. [LB753]

SENATOR PANKONIN: Senator Stuthman, thank you. As I heard the testimony I thought of a couple of questions. One of them, David is you're right. From a public policy standpoint, we have to be careful that the care is more than adequate and whatever. But I think what Senator Stuthman is getting at, when the choice is no care, when people literally have to drive 80, 100 miles, 40 miles, whatever it is, and these folks can provide a level of care for many ailments, many things, at least get them to some point down the road, that we've got to also balance these two things, because no care is not a good public policy, either. [LB753]

DAVID BUNTAIN: Right. [LB753]

SENATOR PANKONIN: As I know you agree. So I think we have to work hard on this, like we've all said. I think this testimony today from the nurse practitioners has been effective. But I guess, what's the assurance we have? Obviously, if we don't pass this bill on, if we wait a year, some will be gone, like Senator Erdman. But I will be hopefully back here in this committee, is that we do have progress in this next year, that the doctors, that the nursing board, that whatever it takes to...you know, I think there's been more questions actually come up than answers during this hearing. [LB753]

DAVID BUNTAIN: Right. Well, I mean, I'm not sure...the assurance I can give you is that if the nurse practitioners want to talk with the medical association about some of the practical problems they're experiencing, we're available to do that. We have had several rounds of those conversations with the physician assistants over the years about these same issues, not same issues, similar issues. And a lot of these things can be worked out without having to come in and have the Legislature fix it, and that's...you know, I think this fits...really, I think that's where it should go first before coming to you and saying, well, the law needs to be changed. [LB753]

SENATOR PANKONIN: Thank you. [LB753]

SENATOR STUTHMAN: Thank you. Thank you for your testimony. [LB753]

DAVID BUNTAIN: Thank you. [LB753]

SENATOR STUTHMAN: Any other testifiers in the opponent? Any testifiers in the neutral? Seeing none, Senator Synowiecki, would you like to close? [LB753]

SENATOR SYNOWIECKI: Thank you, Senator Stuthman. I really wasn't planning on closing, but one thing I'll agree. I found the testimony today particularly compelling, and as the introducer of the bill I didn't know that the problems were to the degree and the depth that the testimony showed. A couple things I think the committee needs to know, that the Advanced Practice Nurse Board has physicians on that board. You need to know that. Physicians, nurses, and consumers, as well as the pharmacists. It's not all nurses on that board, as one may be led to believe, that it was all nurses. Secondly, I just want to reiterate: The letter from the department affirms that nurse practitioners are increasingly having difficulty arriving at collaborative agreements. It affirms that. And secondly, the letter from the affirms that physicians are charging fees for these collaborative agreements. I don't know where that's actually coming from. And lastly, I want to again extend to the committee counsel--and we'll get together with my staff--the department's letter relative to those practicing with protocols and those practicing without protocols. I'll be more than happy to offer to the committee an amendment that would specify that those practicing with protocols would have to be under a collaborative agreement. So that's it. (See also Exhibit 9.) [LB753]

SENATOR STUTHMAN: Thank you, Senator Synowiecki. Any questions or comments? If not, thank you and that closes the hearing, and that closes the hearings for today. Thank you. [LB753]

Disposition of Bills:

LB753 - Held in committee.
LB807 - Held in committee.
LB818 - Indefinitely postponed.
LB835 - Indefinitely postponed.

Chairperson

Committee Clerk