[LB149 LB378 LB493]

The Committee on Banking, Commerce and Insurance met at 1:30 p.m. on Tuesday, February 17, 2009, in Room 1507 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB149, LB378, and LB493. Senators present: Rich Pahls, Chairperson; Pete Pirsch, Vice Chairperson; Mark Christensen; Mike Gloor; Chris Langemeier; Beau McCoy; Dave Pankonin; and Dennis Utter. Senators absent: None. []

SENATOR PAHLS: Good afternoon. I want to welcome you to the Banking, Commerce and Insurance Committee. My name is Rich Pahls. I represent District 31 in the Legislature which is actually the Millard of Omaha. I have the pleasure to serve as the chair of this committee. The committee will take up the bills as posted. LB149, Senator Pankonin; LB378, Senator Gloor; and LB493, Senator Karpisek. As many of you know, this is your opportunity to provide input into our hearings today, and to better facilitate our hearings, I'm having you take a look at the small chart over to my right, your left. Simply, the rules are basically pretty simple. We're asking you to turn your cell phones off, and to move to the reserved chairs we have in front, so that gives us a feel of the number of people who will be speaking. Our testimony will be as the introducer which will be the senator; then we have the proponents, opponents, neutral, and then the closing. And we're asking the testifiers to sign in and put your information sheet up there. Also, for each bill, for those people who do not want to speak, but want to have their position registered, there's a form over there. We're going to do that for each of the bills, just sign your name. This is for those who do not want to come up and testify, but do want to make sure their feelings are noted, so we're asking you to take a look at that. Another thing too, since it does look like we have a more diverse group today, please, we ask you to spell your name, because we have somebody up there who is taking down all of our words of wisdom, and it makes it easier for them if they have a name to go along with the testimony. Again, after you listen to several people speak, we're asking you to try to be concise and to help move the meeting along. Now, if you have information that you want to hand out, we need at least ten copies because we hand them out to the members of the committee. And if you do not have ten copies, if you hold your hand up, one of our pages will run and have some copies made for you. But we do at least need ten. Just to begin with, right to my side here is Bill Marienau. He is very involved in the committee and all the way over there is Jan Foster who can push a button and just shuts us all down, so we have to be really nice to her. I'm going to have the senators introduce themselves today, and I'll slow it down so Senator Langemeier has a chance to sit down. We'll start over here. []

SENATOR UTTER: I'm Dennis Utter from District 33, Hastings and the surrounding area. []

SENATOR PANKONIN: I'm Dave Pankonin, District 2, I live in Louisville. []

SENATOR LANGEMEIER: I'm Chris Langemeier, District 23, Schuyler. []

SENATOR PIRSCH: Pete Pirsch, Legislative District 4, west central Omaha. []

SENATOR McCOY: Beau McCoy, District 39, Omaha. []

SENATOR GLOOR: Mike Gloor, District 35, Grand Island. []

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

SENATOR PAHLS: (Exhibits 1, 2, and 3) I want to thank you, and Jared Weikum is usually here. I guess we must have him busy, and other page who actually is from the Millard area. She's a graduate of the Millard school since we do have a former superintendent sitting in our office, I thought I'd let him know that--Rebecca Armstrong. So I think we are ready, Senator Pankonin. And as he proceeds and gets ready for, we do have three letters I'm going to read into the record; two from the Andersen family, one from Jensen in support of this bill, and all of the senators do have this. Thank you. And Senator, just before...just so I can get a feel of it, how many proponents just...this will give us a feel of...I see okay, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19--looks like we have around 20, so that should tell us something. Okay. How many opponents? We have 1, 2, 3, 4, 5, 6, 7 opponents. Now, I'm just trying to get approximate numbers so everybody feels this. And how many in the neutral? We have no one in the neutral, okay? []

SENATOR PANKONIN: Senator, I wonder if they're all going to speak, though. That might be... []

SENATOR PAHLS: That's--okay. That's a good question. []

SENATOR PANKONIN: Yeah. []

SENATOR PAHLS: I think I got a feel of it. That at least lets people know. Okay, thank you. []

SENATOR PANKONIN: (Exhibits 4 and 5) Good afternoon, Chairman Pahls and members of the Banking, Commerce and Insurance Committee. I am Dave, D-a-v-e Pankonin, P-a-n-k-o-n-i-n, and I represent the 2nd Legislative District. I'm here to introduce LB149 on behalf of the Amputee Coalition of Nebraska. LB149 would require that the most appropriate prosthetic deemed medically necessary by a treating physician be covered by insurance plans in the state of Nebraska at a minimum equal to coverage provided in the Federal Medicare Program. Medicare establishes a cost for each type of prosthesis. Medicare then pays 80 percent of the cost, and the patient

pays 20 percent. LB149 would not prevent application of deductibles or copayment provisions contained in the insurance plan or require coverage to be extended to any other procedures. Copayments would not be allowed to exceed those imposed under Part B of the Medicare Fee-for-Service program. For purposes of this bill, prosthetics are defined as artificial legs and arms and associated components. The lifetime for a prosthetic limb depends on many factors including the individual's age, activity level, and overall health status. For example, adults can typically use a prosthetic limb for three to five years, but growing children may require a new device every six to nine months. The costs for prosthetic limbs vary greatly, and no one would suggest that they are inexpensive. However, appropriate coverage for prosthetic care would ultimately result in a cost savings for Nebraska. Individuals who receive proper prosthetic care can be productive citizens and avoid the need to depend on assistance from the state Medicaid program. The Medicare and Medicaid programs and federal employees' health insurance plans all cover prosthetic devices without caps or other restrictions. The Veterans Administration and the National Guard plans both provide prosthetic coverage without caps or limitations if the limb was lost during active service. This is not to say such coverage is unlimited. Medicare coverage is provided to only those who qualify for it. What is covered is dependent upon a medical necessity as determined by the treating physician. Such coverage is also determined by the functional level of amputee capabilities which is set by Medicare. Currently, insurance companies doing business in Nebraska have various forms of caps, although it seems that the trend in the past couple of years has been to modify policies to include caps for prosthetic coverage. Private citizens in Nebraska who pay health insurance premiums should be afforded prosthetic coverage that is at least equal to the coverage provided in the federal Medicare program. The Amputee Coalition commissioned a study to try to determine the cost impact to policyholders in Nebraska as a result of including prosthetic coverage. The study results indicated that minimal increases have been found in other states. The average cost impact on premiums would be .03 percent to .06 percent for commercial insurance policyholders in Nebraska. The impact on any particular individual's premium could range from zero to as much as 41 cents per member per month. As many of you know, I am one of those small business employers who provides health insurance. I have studied these numbers, and personally think the minimal potential cost for my business and for me is worth it to provide a higher quality of life to those who need this coverage. Eleven states have already passed legislation that is similar to LB149. I have provided copies to the committee of a letter of support from Louisiana representative Charles Kleckley. Representative Kleckley introduced and helped to ensure passage of similar legislation in his state. Twenty-seven additional states are currently developing legislation. With the introduction of LB149, Nebraska could be added to this later group, and with support from this committee and the full Legislature, Nebraska would require insurance coverage deemed necessary by a treating physician for individuals who need to have prosthetic limbs. Representatives from the Amputee Coalition of Nebraska and other experts on the subject of prosthetics are here to provide more information about the provisions of LB149. Thank you. [LB149]

SENATOR PAHLS: Do we have any questions for Senator Pankonin? Senator, let me just bring this up since it won't...it's not directed to anyone. But the question I've had in the past, at least until you reach a certain age, as a Shriner, one of our obligations is to provide this service at no cost to a family. The cost would be going to Minneapolis; it's my understanding there's even a transportation fund. So that's...I'm just being upfront with you that for...at a certain age level, I know they will later on. [LB149]

SENATOR PANKONIN: Right, right. Well, Senator Pahls, I think you're absolutely true. That's a tremendous organization who I tremendously admire for their efforts--their time, their resources, the commitment to that, and it has done wonderful things. But as you have said, at a certain age, that doesn't work. People our age don't go to the Shriners Hospital in Minneapolis for prosthetic limbs. And we'll hear more about it as testifiers come forward about the impact of that, but you're absolutely right on that statement. [LB149]

SENATOR PAHLS: Okay. I see no more questions. [LB149]

SENATOR PANKONIN: Thank you. [LB149]

SENATOR PAHLS: And I'm assuming you will close? [LB149]

SENATOR PANKONIN: Yes. [LB149]

SENATOR PAHLS: Okay. We are now ready for the proponents, and just to clarify, those proponents who plan to speak, if I could just see your hands. That may reduce the numbers a little bit. Okay, about half a dozen. Good afternoon. [LB149]

STEVE HUGGENBERGER: (Exhibit 7) Good afternoon, Senator, and good afternoon, committee members. I'm Steve Huggenberger, S-t-e-v-e H-u-g-g-e-n-b-e-r-g-e-r. I'm the chair of the Amputee Coalition of Nebraska. The Amputee Coalition is made up of amputees, of limbless people, of families of amputees, doctors, prosthetic providers. And we are trying to ensure that amputees have an adequate insurance coverage for prosthetic benefits. I've been an amputee since 1971 since an accident on our family farm. I'm currently working as an assistant city attorney with the city of Lincoln, and as I look back, I can assure you that I couldn't be where I'm at today and couldn't have accomplished the things I've accomplished without adequate prosthetic care. In my early years of being an amputee, our family had no insurance to cover these costs. We relied on Easter Seals, and we relied on state assistance. And I would characterize the prosthetic care I had early on as not very good, but I didn't know anything else. It was all I had, and that's what I went with. After becoming employed, my group insurance always provided coverage for prosthetics, and I was able to see that prosthetic care could be much different, and that was a difference between night and day. In 2003 or

2004, I'm a little bit fuzzy on exactly which year it was, the prosthetic coverage in my employer's plan changed without my notice. That's a little bit why I'm fuzzy; it was without my notice. A $2,500 annual cap was placed on the prosthetic coverage at that time, and that was with United Healthcare. When the city of Lincoln changed providers to Coventry, that same cap continued with Coventry. My prosthetics have been costing between $15,000 and $20,000 each time, so I quickly...once I became aware of the cap, I knew I had some issues ahead of me. I as well as others were very concerned with the changes that we were seeing in our group insurance plans. The coverages for prosthetic benefits were being capped in different ways, and that was something that was new. That hadn't been done before the early 2000s. The insurance limitations were either in the form of caps of $2,500 or $3,500 or $5,000 or there was...sometimes there was a lifetime cap of $50,000. Sometimes we would see a limitation of we'll provide the first prosthetic, but none after that. We who are in this coalition realized that most of us could not afford the prosthetic care that we'd had in the past if we were to have these kinds of limitations, and this is prosthetic care that we needed for the future. We've sent information to all of your offices about what prosthetic costs are today. I have attached a one-page fact sheet to this testimony as well. A below-the-knee prosthetic can easily cost up to $25,000. Above the knee and up to the hip is much more expensive. Arm prosthetics are very expensive as well. The information that we've provided you is in ranges of costs and in generalities, and there are many examples that we can point to that go above those ranges and above those generalities. Some of the amputees are double amputees, so their costs are twice as high. Two things are certain about prosthetics. One thing is that prosthetics are like every other piece of equipment. They will wear out depending on how much you use them, and depending on how old they are. The second thing that's a certainty is that an amputee stump will change shape over time regardless of all other factors. When you get to a point of equipment not fitting properly or being worn out, a change has to be made. Many of us have had a prosthesis for a long time in this coalition. Many of us know what it's like to wear a prosthesis that doesn't fit well, and we know what kind of problems come with that. I can't impress on you how significant the technology is today, the way things can be today and how significant that can change a person's life. You know, we've estimated that a prosthetic would need to be replaced every three to five years, and much more often for a growing child. With a $2,500 cap, most families couldn't take a financial hit like that every year or every three years. They will either deplete whatever assets they have or they will seek government assistance as I had to do when I first became an amputee. Some in our group have suggested, well, what they'll do is they'll go back to crutches or they'll go to a wheelchair. That's really a horrible choice to force them to make. The more sedentary a person gets, the more other health issues will arise. If amputees are prevented from accessing prosthetic care, this increases the other healthcare costs that are due to complications, knee problems, shoulder problems, back problems, muscle loss. And I can't overemphasize this one--depression all occur, along with nursing home costs and homecare costs. Some of these costs far exceed the costs of providing prosthetic care. The majority of amputations in the U.S. are due to vascular or circulatory diseases.

Diabetes is what we're talking about mainly. And the incidents of those diseases is on the rise, and this is truly becoming more and more of an issue of need. Nobody chooses to become an amputee. You know, a person becomes limbless because of an accident or a disease or a birth defect. No one misuses the benefits that we're talking about in this legislation. Nevertheless, caps exist in Nebraska. We have caps under Coventry, under UnitedHealthcare, under Mutual of Omaha, some under BlueCross/BlueShield. There have been questions about what is the impact of this kind of legislation here in Nebraska, and for that reason, a legislative study was embarked on this summer. And the insurance companies were asked to participate in that. The Amputee Coalition provided the funding for an actuary to produce that study to answer some of these questions. While BlueCross/BlueShield provided some information on approximately 15 patients, the rest of the insurance companies argued that it asked for proprietary information and would not participate. These studies have been done in other states, and we've provided the committee last year with all of the studies that were done in other states. You know, this lack of cooperation made the effort more difficult, but we decided to go forward anyway. We've estimated that there are several thousand amputees in Nebraska. The cost of the coverage of this kind of legislation has been in the 12 cents to 35 cent range in other states. The conclusion of a study we did for Nebraska was similar, and Senator Pankonin indicated what those costs were, a cost impact of .03 to .06 percent. You know, the range of individual premium increases, our consultant indicated, would be between 0 and 41 cents per month. Because we couldn't get specific information from very many insurance companies, actually only BlueCross and a limited amount of information, we don't know how many policies would be at zero and how many policies would be at 41. You know, most people don't have any idea what the prosthetic coverage in their health insurance policy is, and they couldn't tell you the difference between a BK or an AK. That's below-the-knee prosthesis and above-the-knee prosthesis, and they wouldn't have a clue about what those things costs, but the public expects to be covered if they lose a limb through an accident or a trauma. We have significant support from a number of groups across Nebraska--American Cancer Society, the Nebraska Medical Association, a number of veterans. Consumers expect to be covered for catastrophic illness and injury, and they expect that their monthly premiums will provide them with the most basic of care. Prosthetic coverage is basic medical care, and it's being made unaffordable by some of the insurance limitations, but the general public expects that basic care to be covered. Prosthetic bills like LB149 ensures that it be treated as basic care. Reconstructive surgery as a result of breast cancer is something that's generally covered. A prosthetic limb should be covered. You know, if a knee or a hip needs to be replaced, it's covered. A prosthetic limb should be covered. You would not tell someone that they can only have one heart attack per year, or you would not tell them that they're limited at $2,500 worth of stroke care every three years. Legislation like LB149 requires that prosthetics are treated the same as other basic essential care in these insurance plans. There are many individual stories that we could bring before you this afternoon; we don't intend to do that. There are victims of farm accidents, car accidents, work accidents, and there

are those who have suffered through cancer and diabetes. There are children who need their prosthetics replaced every year. Thank God for the Shriners and their help in that matter. All of those stories involve difficult recoveries and some level of discouragement or depression about the limitations that are now part of those people's daily lives. And when you add being unable to afford prosthetic care to the mix, the whole thing becomes overwhelming. Eleven states have passed this type of legislation. Another 20-some states are taking the issue up again this year, and we urge you to pass this legislation this year. The longer we wait is the more people that begin to cut back on the prosthetic care that they need. Thank you. If I can answer any questions? [LB149]

SENATOR PAHLS: Steve, I have a couple of questions. It is my understanding, you're saying that in the past the major insurance companies covered. [LB149]

STEVE HUGGENBERGER: I believe the correct information is before 2000, there was no policy that didn't cover it. [LB149]

SENATOR PAHLS: Okay, and currently, the majority of them have caps except for BlueCross and BlueShield, they have caps on certain aspects of it. [LB149]

STEVE HUGGENBERGER: BlueCross/BlueShield has one, and I'm sure they can speak for themselves, has one policy, I believe they call it Blue Pride, which has caps on the prosthetic care. I believe their other policies do not. [LB149]

SENATOR PAHLS: Okay. Senator Gloor. [LB149]

SENATOR GLOOR: Chairman Pahls. Thank you, Mr.--excuse me, make sure I get the name right. Huggenberger. Thank you, Mr. Huggenberger... [LB149]

STEVE HUGGENBERGER: I'll answer to almost anything (laughter). [LB149]

SENATOR GLOOR: So do I (laughter), but I'm getting used to answering to senator. That's a new one for me. A couple of questions. It's my understanding that we have the benefit of some nice technology that has improved the ability of people who wear prosthetics to engage in a lot more activities--running, biking. I don't know how common that is, but would there be an expectation that those items would be covered in a limitless capacity? I mean, I don't know to what extent the prosthetics are changed. I'm sure they get different levels of articulation, depending upon the activity level, but are we talking about any bounds on the levels of prosthetics that could be purchased? [LB149]

STEVE HUGGENBERGER: What the legislation provides for, and let me suggest, too, Dr. John Rush, who will be testifying as part of our group, can answer this question better than I. This is not limitless. This is not boundless. What the suggestion is, that the

provision be the same as what Medicare provides. Medicare does not provide limitless benefits. It depends on the patient and what they're capable of doing. Not all amputees are adequate subjects for any kind of prosthetic. I don't know how to answer it better than that. [LB149]

SENATOR GLOOR: That's fine. Thank you. [LB149]

SENATOR PAHLS: Senator Utter. [LB149]

SENATOR UTTER: Thank you, Chairman Pahls. Can you give me any kind of...how often does a prosthetic, just on the average, need to be changed? [LB149]

STEVE HUGGENBERGER: Replaced? [LB149]

SENATOR UTTER: Replaced, yes. [LB149]

STEVE HUGGENBERGER: Well, I can speak for myself. The longest that I've ever stretched a prosthesis was a little over five years. I've also had prostheses only last less than three years, at times. It totally depends on your activity level. When I was a young man involved in many things, not a fat bald man like I am now, I could wear those out pretty fast. But I wasn't near as active as all those people around me. It totally depends on your activity level. I believe some of the prosthetists will say the legs are good for about a million steps, and then things break down and wear out. [LB149]

SENATOR UTTER: Can you...I noticed that in looking at this, that there is no fiscal note to this bill as far as cost to the state is concerned. But I'm wondering if it should not have some type of a fiscal note, that if this is going to raise health insurance premiums and the state of Nebraska, for example, provides to its employees a health insurance plan that's a participatory plan, as I understand it, it seems to me like there's going to be some increased cost to the state from this. Would you agree or not? [LB149]

STEVE HUGGENBERGER: No...well, not in the manner that you're suggesting. My understanding of the state employees' health insurance program is it already provides prosthetic benefits. I think there may be increases in cost to the states where we're talking about cost shifting, whatever private insurance doesn't cover, and these people have to go to state assistance. That certainly is going to be shifted to the state. And as we look forward in time, we're talking about diabetes that's on an upward incline. Well, we do have a fiscal note that's with the bill (laughter). Want me to read it? [LB149]

SENATOR PAHLS: No, we can...we can get that straightened out. Seeing no more...Senator. [LB149]

SENATOR CHRISTENSEN: Thank you, Chairman Pahls, thank you Mr. Huggenberger.

You listed two states here, Colorado 12 cents per person per month; Massachusetts 28 to 35 cents per month. You said there's 11 states or maybe Senator Pankonin did that have passed this. Can you get us a copy what the other states have cost? [LB149]

STEVE HUGGENBERGER: I believe there are five or six studies that have occurred in the other states. We provided those studies to you last year. We can get you the copies of those again. [LB149]

SENATOR CHRISTENSEN: Okay. I appreciate that. [LB149]

SENATOR PAHLS: Yeah, thank you. Seeing more, thank you. Next proponent. [LB149]

SEAN McGARRY: (Exhibit 12) Good afternoon, Chairman, fellow senators. My name is Sean McGarry, S-e-a-n M-c-G-a-r-r-y. I'm an orthopedic oncologist at the University of Nebraska Medical Center in Omaha. As a disclosure, my testimony today does represent my thoughts and opinions, and is not intended to represent the opinions of the University of Nebraska Medical Center or the University of Nebraska Medical Center Physicians Group. My training includes medical school at Creighton University, a five-year orthopedic residency at the University of Colorado Health Sciences Center in Denver, Colorado, and a two-year fellowship in orthopedic oncology at the University of Florida in Gainesville, Florida. I specialize in the treatment of patients with benign and malignant tumors of the skeletal system, primarily arms and legs. The vast majority of the time I'm able to remove a tumor and salvage the arm or leg. Unfortunately, some of the time I'm forced to perform an amputation in order to treat a cancer. I also occasionally perform amputations for trauma, uncontrolled infections or circulatory problems. I perform about 10 to 15 amputations a year. UNMC physicians performed 42 amputations in this past calendar year. Of the last ten amputations that I've performed, five were for infection, five were for cancer. The ages of the patients ranged from 15 years of age to 92. Six of the patients were 50 years of age or younger. Seven of these ten patients have been placed into prostheses. The remaining three were nonambulatory prior to their surgery, and will not be fitted with prostheses. Six of the ten patients who were gainfully employed prior to their amputation have all returned to work. For those who can use prostheses, it is an absolute medical necessity. Not only does it aid in the emotional healing for these patients, but it does allow the vast majority of them to return to function at or near the level they were prior to surgery. An appropriate prosthesis and its maintenance is also an investment in the future health of the patient. Remaining active, slows or halts the onset of other medical conditions including diabetes, high blood pressure, complex wound issues, and obesity, all of which, obviously, add a tremendous burden to the cost of healthcare. There has been some concern that support for this bill would be abused by patients. I would again remind you that this bill supports requiring coverage at the same level as Medicare. As you can tell from the numbers that I gave you for just the Nebraska Medical Center, the number of patients who will be affected by this bill is not tremendous, but it will have a tremendous

effect on those who are. It is for these reasons that I ask you to support LB149. Thank you, and I'd be happy to take any questions. [LB149]

SENATOR PAHLS: Senator Langemeier. [LB149]

SENATOR LANGEMEIER: Thank you, Chairman Pahls. Dr. McGarry, thank you for your testimony. Here's my question. What is...you talked about six out of ten were fitted for prostheses. [LB149]

SEAN McGARRY: Seven...seven out of ten, actually. [LB149]

SENATOR LANGEMEIER: Seven? Seven out of ten? What is your role in determining the seven that should, and those that shouldn't. Is that strictly a patient...the patient wants to do it or doesn't want to do it? [LB149]

SEAN McGARRY: That's partially a discussion with the patient. Doing what I do, I guess, to give you a little bit of an example. Of those 42 amputations that were done, at the medical center, 20 of those were below-knee amputations. There's very rare instances where someone who would require a below-knee amputation wouldn't get one. Because of the nature of what I do, I'm doing a lot higher amputations, entire leg, or entire leg and half of pelvis, and sometimes older people...typically, older people don't do well with a prosthesis for that. It's more of a cosmetic thing, and they end up carrying around dead weight, basically. And they typically will refuse a prosthesis. I have one of the ten that I spoke of was a patient who is bedridden for other reasons, and so she was not fitted for a prosthesis either. [LB149]

SENATOR LANGEMEIER: Okay, thank you. [LB149]

SENATOR McGARRY: Um-hum. [LB149]

SENATOR PAHLS: Seeing no more questions, thank you. Next proponent? Good afternoon. [LB149]

NANCY McCABE: (Exhibit 8) Good afternoon. Thank you, Senator Pahls. My name is Nancy, N-a-n-c-y McCabe, M-c-C-a-b-e. I am from Omaha, Nebraska. I am the mother of an amputee. My daughter, Melissa McCabe, who was unable to be here today, had her right leg amputated 15 years ago when she was 11 years old and diagnosed with cancer. Since her amputation, Melissa has had many prosthetic legs. During the first few years when she was growing, and her stump was changing, she went through several new legs a year. And as a very active teenager, Melissa was known to break a prosthesis or two. But because she had a prosthetic leg, she was able to ride a bike, play softball and basketball, march in the band, rollerblade, and her favorite, continue her ballet and jazz lessons. She was a normal teenager enjoying what normal

teenagers do. Melissa was covered under my health insurance, and after the normal deductible and copay, the insurance paid the balance of the many prosthetic legs that she went through. It wasn't until a few years ago, around the year 2000, when she was in college and getting a new prosthesis, that the insurance company started talking about a yearly cap. I talked to my insurance company and my insurance specialist at the company, and she said that the prosthesis had a wrong insurance code, that there was just a mistake, there would be no cap, and they paid for the prosthesis after the deductible and copay. Melissa was thrilled when she got her first job after graduating from college in 2004. She had insurance in her own name and was no longer a dependent of her mom. After visiting her orthopedic doctor for a bi-yearly checkup, he felt it was time for a new prosthesis. She had literally worn this leg to pieces, and it was duct taped together. As with all prosthetic devices, the doctor wrote a prescription, and Melissa went to her provider for a new leg. While they were in the process of making the new prosthesis, Melissa's provider called Coventry Health Care to check whether a preapproval was necessary which it wasn't. After completing the leg, they submitted the necessary insurance forms and learned that there was going to be a cap. This prosthesis cost over $14,000, and that didn't even include the skin covering because the insurance company called that cosmetic. Coventry paid $2,500. So along with rent, utilities, a car payment, groceries, a student loan, Melissa now has a payment to her prosthetic provider. Since having that prosthesis made, Melissa has had UnitedHealthcare with a cap of $2,500 and BlueCross/BlueShield with a cap of $5,000. So it is not just one insurance company that is doing this; it is all the major carriers in Nebraska. We tried on several occasions to get an individual policy or to get a rider to the policy that Melissa had, and we were told that there was nothing available to purchase. And I want to point out that this is a benefit that has been taken away from amputees over the past few years...a benefit that has been taken away. Melissa still enjoys playing coed softball, but decided last summer that she wouldn't play. She didn't want to risk breaking her prosthesis, and having to pay to have it repaired. What is ironic is if Melissa would break her left leg while playing ball, the insurance company would pay for any surgery, casts, or physical therapy that she would need. She is in need of an adjustment right now on her prosthesis, and is concerned about how to pay for it. It will start to affect her hip and back soon if she doesn't get it done. Melissa is a hard-working, good, active resident of Nebraska. She graduated from the University of Nebraska in Kearney, and has stayed in Nebraska to live, to work, and someday to raise a family. The lack of insurance coverage on a prescribed item by her doctor worries her a lot, and quite frankly, it worries me as a mother. I would like to make one last point. The insurance companies are concerned about, you know, this type of mandate will bring out the bionic arms and the bionic legs. All the amputees that we know, and we know many, just want to live a normal life as possible, dealing with pain every single day. They are just asking for help on their insurance that other medical issues are given. Many of these people could go on state programs. They can do Medicaid and vocational rehab where there are no caps, and get their artificial limbs paid for. They do not want to do that. They want to be productive citizens of Nebraska. I

ask that you stop this insurance inequity here in Nebraska, and support LB149 so that amputees such as my daughter, Melissa, can have the prescribed prosthetic legs and arms that they need to live a normal life. Thank you. [LB149]

SENATOR PAHLS: Senator McCoy. [LB149]

SENATOR McCOY: Thank you, Chairman Pahls and thank you for your testimony this afternoon, Ms. McCabe. [LB149]

NANCY McCABE: Thank you. [LB149]

SENATOR McCOY: Mr. Huggenberger mentioned it in earlier testimony, and you touched on it as well. Are we to understand that before 2000, all health insurance policies had prosthetic coverage? Is that correct, did I understand that correctly? [LB149]

NANCY McCABE: I can't really specify that all coverage, all insurance companies did. I just know that my insurance had, you know, complete coverage and I have been told that the insurance, you know, that other insurances had the complete coverage. [LB149]

SENATOR McCOY: Okay. Thank you. [LB149]

SENATOR PAHLS: Seeing no more questions, thank you for your testimony. Appreciate that. [LB149]

NANCY McCABE: Thank you. [LB149]

SENATOR PAHLS: Next proponent? [LB149]

PAUL KRABBENHOFT: Hello, I'm Paul Krabbenhoft. I'm a physician at Madonna Rehabilitation Hospital. My name Paul, P-a-u-l K-r-a-b-b-e-n-h-o-f-t. Again, I'm a physician at Madonna Rehabilitation Hospital here in Lincoln, and I've specialized in rehabilitation, physical medicine, rehabilitation. My medical training is at the University of Minnesota, and I did my residency training in physical medicine, rehabilitation. And what physiatry or physical medicine rehabilitation is, is a subspecialty where we dwell and focus in on people, the rehabilitation needs, stroke, prosthetic amputation-type injuries, spinal cord injury, that type of thing. That's something I also do, but anyway, in my clinic, I have a very busy clinic where I focus in on a number of different disabilities including amputee patients. And I see over and over again the effects of poorly fitting prostheses, prostheses that are suboptimal in terms of the patient's lifestyle conditions, and so what I'm seeing lately with these...the capitation on the coverage for these prostheses is the potential for some very serious long-term effects with the poorly fitting prostheses, the suboptimal type of prostheses, and the potential for wear and tear on

the spine, the hips, the knees. I see this over and over again, and so I just would impress upon the committee here the importance of passing...or looking at this bill favorably, so that we do not run into the issues of potential, you know, large catastrophic expenses--total hips, total knees, spinal surgeries which I've encountered with some of my patients, with poorly fitting prostheses and suboptimal prostheses. [LB149]

SENATOR PAHLS: Senator Gloor. [LB149]

SENATOR GLOOR: Thank you, Chairman Pahls. Dr. Krabbenhoft, and you may not be the right person to ask this question to, but we'll try it and see. Is there any type of specific regulation or licensure for prosthetists? [LB149]

PAUL KRABBENHOFT: For prosthetists themselves in the state of Nebraska, I believe they don't have to be licensed. [LB149]

SENATOR GLOOR: Okay. [LB149]

PAUL KRABBENHOFT: Yeah, that's a somewhat unique thing in the state of Nebraska. [LB149]

SENATOR GLOOR: Well, what I'm trying to get a handle on here is the concerns that you have about poorly fitted, poorly manufactured, I'm assuming, prosthetics. Might not we be talking about some degree of proliferation of even more of that if that's not...I'm trying to decide if we're headed towards...if this were passed, are we headed towards some other level of regulation we have to put in place where people begin to jump into this area to fabricate prosthetics who don't have the appropriate training or do a poor job of that? [LB149]

PAUL KRABBENHOFT: If it would enhance that or increase the amount of that type of thing? [LB149]

SENATOR GLOOR: Yeah. [LB149]

PAUL KRABBENHOFT: I don't see that as a potential problem, again, because of that component of the bill that it has to be within the Medicare, you know, allowable and that type of thing. It would still...I don't see how this could circumvent the process of a patient becoming an amputee, being evaluated by an appropriate physician and such as in my situation where that patient would be evaluated by myself, physical therapist, a prosthetist, an experienced prosthetist preferably. And as a team approach, come up with the appropriate optimal type of prosthesis to fit for that patient based... [LB149]

SENATOR GLOOR: Are most prosthetists in private business for themselves as

opposed to affiliated with an organization or institution? [LB149]

PAUL KRABBENHOFT: Most of them are in the city of Lincoln which I have familiarity with, they are in business for themselves. NOPS, you got Prosthetic Solutions, you got different groups... [LB149]

SENATOR GLOOR: And how do you normally connect with them? I mean, do you have your own preferences for people who you think do a good job and, I mean, is some of this self-regulating just based upon people who do a good job versus people who perhaps don't? [LB149]

PAUL KRABBENHOFT: A combination of all that right now. At Madonna, we are contracted with the NOPS...Nebraska Orthotics Prosthetics, and so we preferentially utilize them, because of our contractual agreement. But that doesn't preclude me as a practicing physician at that facility to refer to a company that I've had good experience with where I feel comfortable that they've done a good job in terms of fitting the prosthesis, coming up with the right componentry, and doing a good job in follow-up. [LB149]

SENATOR GLOOR: Okay. [LB149]

PAUL KRABBENHOFT: Ideally, what we'll have is that kind of thing carrying forward even with this bill, where it will be a team approach where you have a physician working in conjunction with a physical therapist, especially on a newly amputated patient, working with a prosthetic company. [LB149]

SENATOR GLOOR: But that would relate less to the bill and more to the way that you provide care to your patients. [LB149]

PAUL KRABBENHOFT: Yes, yes, specifically. [LB149]

SENATOR GLOOR: Okay. Thank you. [LB149]

PAUL KRABBENHOFT: You bet. [LB149]

SENATOR PAHLS: Seeing no more questions, thank you for your testimony. [LB149]

PAUL KRABBENHOFT: Thank you. [LB149]

SENATOR PAHLS: Next proponent? The floor is yours. [LB149]

JOHN RUSH: (Exhibits 9 and 10) Thank you very much, Mr. Chairman, members of the committee. My name is Dr. John, J-o-h-n Rush, R-u-s-h. I'm the chief medical officer for

Hanger Orthopedic Group. We are the largest providers of orthotics and prosthetics in the United States of America. We have 670 patient care centers in 46 states and D.C. We have nine patient care centers here throughout Nebraska. I'd like to thank Senator Pankonin for sponsoring this legislation and doing all the work, not only this legislative year, but last year and throughout the year as well as Mr. Chairman for working with us and the committee. I'm here today to support the Amputee Coalition of America and the Amputee Coalition of Nebraska in support of this important legislation. And I'd like to begin my testimony with the same question I did last year. Why do the people of Nebraska buy health insurance? I would submit to you they do so to protect themselves and their family against catastrophic illness or injury--stroke, heart attack, cancer. Certainly the loss of an arm or a leg is a catastrophe and should be covered even in the most basic health insurance policies. However, beginning in the year 2000, commercial health insurers began to cap or restrict what they would pay for prosthetic devices to $1,000 per year, $5,000 per lifetime, one prosthetic per lifetime. When I testify in other states, I say, I don't even think the health insurance companies did this maliciously. I think some smart MBA looked down a column called DME--Durable Medical Equipment, and said, you know, we spend $1,864.53. Let's just cap that at $2,000, not understanding that prosthetics are captured under DME. The average prosthetic device, based on 2005, is $8,360. To put these kinds of caps is ridiculous to these people that are paying health insurance premiums every single month. All this bill does is move prosthetics out from under DME and treats it just like everything else in the health insurance policy. You want 20 percent in network, 40 percent out network, fine. You want to prior auth it, fine. You want to do utilization review, fine. Just don't put an artificial cap or restrict it. The cost--cost of this mandate is approximately 20 cents. That's with the NovaRest thing. These are the cost estimates from the mandate studies from these other states. As you can imagine, many states are reticent to pass mandate bills. Because why? Everything that you mandate increases everybody's healthcare costs, right? More people have access to that mandated benefit whether it's cochlear implants that you're going to hear about, autism, drug benefit, on and on and on. Not so with this bill. No one is going to cut off their arm or leg to access the benefit. That's what makes this bill different. By passing this bill, he's not going to do more amputations in the state of Nebraska. Importantly, these mandate commission reports as the one done for Nebraska did not contemplate the economic costs. Senator Pankonin mentioned Chairman Kleckley who sponsored the bill in Louisiana. He's a Republican small business owner, and he authored the bill because it was the right thing to do. We have seen people lose their jobs and go onto Medicare or Medicaid. Medicare, Medicaid, the VA, and the federal employees' benefits all cover prosthetics without caps or restrictions just as commercial insurers did before 2000. Why shouldn't your constituents paying those ever-increasing health insurance premiums every single month be afforded that same coverage? You've already heard about the 11 states that have passed this bill. I attached the fiscal note from North Dakota that says their annual cost would be 28 cents. Again, right in that range. I attached the fiscal note for Nebraska here, and I would like to read that into the record that says the bill will have no fiscal impact for the

state agencies or the University of Nebraska because health insurance plans for these entities currently cover prosthetics. In the state of Oregon, BlueCross/BlueShield of Oregon came out in favor of the bill. They were already covering it fully, so to the extent that United or CIGNA or Aetna were not, they were at a competitive disadvantage. They had no idea that people were cutting back on these benefits. When I testify in other states, I hear arguments from the health insurance lobby, and I'd just like to take a moment to tell you about them and refute them. They say that you should let the marketplace determine the benefits provided under any single policy. The marketplace is not working. That's why you're being asked to consider these mandates. We have evidence of employers asking for this coverage, and they won't even price it. In addition, they say, they should have choice--the employers. That choice they speak of is illusory. They got to employers--I'm sure some of you have your own small businesses and say, you know what? This year your premium increase is going to be 18 percent. Whoa, I can't take that. I can't pass that along to my employees. What can I do? Well, you can go to generics only. You can increase your hospital copay. Oh, here's this thing called DME. We'll just cap it at $2,000. The employer says, well, you know, Joe had the knee surgery. He was in a wheelchair and some crutches. That sounds fine to me, not understanding prosthetics are under DME. I've heard the health insurers say that this bill passes, everybody will get a microprocessor device. That is certainly not true. It has not been true in the 11 states, and it will not be true here. The mandate commission report from Maryland on page 3 shows you the Medicare guidelines. If you are a 94-year-old bed-bound diabetic who loses their leg due to diabetes, you don't even qualify for a prosthetic device. There's different K-levels, and physicians like this prescribe those prosthetic device based on the K-level of the patient. There's no abuse here. These people want to get back to work. In Louisiana, what finally pushed Chuck Kleckley to author the bill, we had a 45-year-old man who stopped by the side of the road to help a woman change her tire. He was hit by an oncoming car. He's now getting Social Security disability, Medicare, Medicaid for his children, food stamps, a housing allowance, and he said to the committee, "I don't want any of it. I just want two prosthetic legs so I can go back to work." He has a $4,000 cap from United. The last argument they make is one of costs. They say things like microprocessors cost $100,000 or more. Again, this is simply not true. In 2005, the highest year for reimbursement, a microprocessor cost $41,500 on average. By 2007, that had decreased to $38,000. The insurance companies love to put out actuarial assumptions that pretend vast increases in future costs, but I've never seen a projection that takes into account the declining cost of technology. I would urge you, instead, to look at the evidence from the 11 states that have already passed this needed legislation. None of the concerns raised by the insurance industry have come to pass. And with all due respect, Senator Pahls, on the Shriners. These people are paying for insurance. This is one of fairness. Ask a hundred of your constituents if they lost their leg in a car accident on the way home from work, would their insurance company pay for it? They should. There's cost shifting to you and I, the taxpayers. They're taking premium dollars from your constituents, capping and restricting what they'll pay for the benefit; in this case,

prosthetics. So these people have to go to Medicare, Medicaid to get a device to go back to work. I also attach to my testimony all of the bills that have passed; the 11 that have already been introduced; 8 pending, and this is a moving list. I just reviewed the Ohio bill that's not on here so the 27 states that are introducing this legislation, and I think you've already been given--Senator Pankonin already distributed Chuck Kleckley's letter from Louisiana. I'd be happy to take any questions that the committee may have. [LB149]

SENATOR PAHLS: Well, so you sort of tossed an arrow to me at my Shriner group. I'm just going to toss one back. It looks to me like this is sort of self-serving, what you're doing. I mean, I'm not...as I'm reading the first paragraph, this is a mega money thing for you. [LB149]

JOHN RUSH: So let me ask...let me answer... [LB149]

SENATOR PAHLS: No, no, no... [LB149]

JOHN RUSH: Oh, I'm sorry. [LB149]

SENATOR PAHLS: ...don't ask any questions. [LB149]

JOHN RUSH: I'm sorry. [LB149]

SENATOR PAHLS: I'm just saying that I read the first paragraph, and I'm reading it, and it's all I need to say. Thank you. Any other questions? Seeing none, thank you for your testimony. [LB149]

JOHN RUSH: Thank you. [LB149]

SENATOR PAHLS: Next proponent. [LB149]

BRUCE RIEKER: (Exhibit 11) Good afternoon, Senator, Senators, members of the committee. My name is Bruce Rieker, R-i-e-k-e-r. I'm vice president of advocacy for the Nebraska Hospital Association, and we are here testifying in support of LB149. I think that without going over a lot of the testimony that's already been offered regarding the physical quality of life as well as the social quality of life, that covering these prosthetics would provide to those in need of it. I want to point out that we believe that there's critical language or very important language in the statute or in the bill that requires only the most appropriate prosthetic deemed medically necessary by the treating physician, so we believe that that's a necessary component to...what shall I say, handle the issue about microprocessors or are there any limits within this legislation? We as hospitals, I would imagine that some may think that we are here just simply looking to get paid, because we are the providers of healthcare, and I think that that's often made the

perception of hospitals in some of these equations. But I also want to point out that Nebraska's hospitals, at least the 85 that we represent, employ 41,000 people. We're also the purchasers of health insurance, and so we have to be very cautious about the things that we ask for. We are cautious about asking for mandates. We realize that there is a cost benefit analysis for all of the people that we employ, and after careful consideration of the pros and cons or the costs and benefits, it is our members' contention that this is a vital component that should be covered in health insurance policies. And with that, I will close my comments and urge you to support and advance LB149. [LB149]

SENATOR PAHLS: Seeing no questions, thank you for your testimony. Appreciate that. Any more proponents? [LB149]

SHERYL HAVERMANN: I have a quick one. [LB149]

SENATOR PAHLS: Good afternoon. [LB149]

SHERYL HAVERMANN: (Exhibit 6) Good afternoon. My name is Sheryl Havermann. I turned in a written testimony. Do you need me to spell my name? [LB149]

SENATOR PAHLS: Yes. [LB149]

SHERYL HAVERMANN: S-h-e-r-y-l, last name Havermann, H-a-v-e-r-m-a-n-n. I just wanted to touch base a little bit regarding the Shriners because that wasn't in my written letter. I am the mother of a 7-year-old amputee. I also have two other teenage girls at home. We do utilize the Shriners. We go up there for...so that Brielle can get a swim leg, so that she can take a shower independently and play at like the water parks like Coco Keys, that kind of thing. The swim legs are something that is not medically necessary, so it's not covered under our insurance. We've benefitted greatly from the Shriners because of that. But as a working parent, I want to let you know that I have four weeks of vacation. For me to travel 600 miles up to Shriners for every one of her legs would exhaust all four weeks of that plus. I have other children that expect to do something fun during summer break (laugh) that would like to enjoy vacations. If we had to solely rely on Shriners for 100 percent of her leg coverage, we certainly would, but that would mean that my other two children would not go on vacation unless, you know, it was whatever there is to do in Minneapolis, because we would exhaust all four weeks of that time off, and probably more traveling up to Shriners four to five times a year for her legs. So I just wanted to make that clear. [LB149]

SENATOR PAHLS: I appreciate those comments. Any questions? Thank you, appreciate your testimony. Any more proponents? Seeing none, now we will go to the opponents. Do we have any opponents? If I get some of you...yeah, to move in front. And I see there...it looks like we have four opponents, at least four, five? Okay. That just

gives us a feel. We may begin. [LB149]

TONY SORRENTINO: Good afternoon, Senators. My name is Tony, T-o-n-y Sorrentino, S-o-r-r-e-n-t-i-n-o. I represent employers through the Nebraska Chamber of Commerce and Industry, but my day life is as a general counsel and principal of the Silverstone Group in Omaha, Nebraska. We are employee benefits consulting firm. We take care of the needs of just over 1,000 employers who access group insurance through us as their broker. Our opposition today is certainly not based on a lack of concern, a lack of sincerity on behalf of those who have testified or a fear of fraud being perpetrated on the insurance industry. Rather, instead, our opposition is based on the facts as follows. There is a long list, and I know in front of this committee a little bit later today of such services that could be added to the list of mandated services of the state of Nebraska, all worthy of consideration, all genuine, but in total, could add a significant amount of cost to the health insurance in the state of Nebraska. There are two specific issues which I want to address regarding the cost of the health insurance, and that is access affordability. This body of the Legislature addressed in 1994 the small group health reforms act, trying to make healthcare more affordable to those groups under 50 which comprises an awful lot of the insureds in Nebraska. However, the imposition of these types of mandated benefits automatically adds to the cost equation. We've heard estimates this morning...or this afternoon of 3 tenths to 6 tenths for this particular item. In total, we've seen 3 to 4 percent of such items that could be added to the bottom line cost of these plans. Currently, over 75 percent of Nebraskans access their healthcare through their employers. As an employer ourselves of 200 people, we know that there's only so much you can pass on to our employees before you begin to look at other plan designs such as high deductible health plans which pass on higher deductibles, perhaps take away certain types of first dollar benefits and even add health spending accounts where employees can contribute to those types of plans. The next step, and we're starting to see it in our own practice, is small groups are not able to afford healthcare coverage. We had 37 groups the past renewal cycle, drop their health insurance, not necessarily groups of two, but groups as high as 100 employers. So it is much more with an eye towards affordability and affordability breeds access in the state of Nebraska. If we continue to pile on more costs on our employers, we soon will do just what we tried not to do back in 1994 and grant greater access to healthcare for our employers. I'd be happy to address any questions. [LB149]

SENATOR PAHLS: Senator Gloor. [LB149]

SENATOR GLOOR: Thank you, Chairman Pahls, and thank you for your testimony. Can I ask you in your experience, have you noticed a lot of plans that are adding benefits over the past five or six years? [LB149]

TONY SORRENTINO: I can't say that any have, what I would call add benefits to make the plan richer. Some who have migrated towards the high deductible health plans

simply because they cost less because very high deductibles might add things like a health spending account or health savings account. Of course, that's at the employee's dollar. The only types of accounts we see added are the types that are employee pay-all such as cancer insurance, critical care insurance, additional life insurance, but we don't see employers contributing towards the cost of those. [LB149]

SENATOR GLOOR: Would it be a stretch for me to say that my personal experience would be that we've seen a growth in what isn't covered and/or an increase in out-of-pocket payments by individuals in order to come up with plans that are affordable? [LB149]

TONY SORRENTINO: That would not be a stretch at all. I would say in most cases, those employers who are blessed with not being affected so much by the economy are trying to hold the line and keep their plan steady, but most are adding costs back to the employee, either in the form of additional premiums or taking away benefits. [LB149]

SENATOR GLOOR: It's just sort of a commentary. My concern would be eventually we'll have health plans that don't cover anything, and we pay for it out of our own pockets. [LB149]

TONY SORRENTINO: Um-hum. [LB149]

SENATOR GLOOR: That would be an interesting insurance policy to try and sell probably, but there seems to be an inevitability... [LB149]

TONY SORRENTINO: It would be difficult. Some would say that we're migrating towards that now with the idea that the federal government, through either this particular stimulus package or something later, will mandate, probably pass it down to the states is my guess, such as happened in Massachusetts that employers will be mandated to have bare minimum coverage or be taxed or get a fee-per-person which they don't cover. And then additional coverage as will be filled in by voluntary coverages purchased by individuals on an individual basis. [LB149]

SENATOR GLOOR: I appreciate the education. Thank you. [LB149]

TONY SORRENTINO: All right, thank you. [LB149]

SENATOR PAHLS: Senator Christensen. [LB149]

SENATOR CHRISTENSEN: Mr. Chairman, thank you. Thank you for your testimony. Is there any reason why you couldn't have this as an add-on to insurance? We can run actuarial numbers; it could be offered to an employer or individual to add on. Why couldn't it be a separate add-on? [LB149]

TONY SORRENTINO: Well, I might let the insurance carriers speak to the add-ons and safe to calculate the cost of the premiums, but specifically, in group insurance--I'm only speaking group insurance not individual, these types of riders are added for the plan in general, not specific individuals. On the individual side, would that be a possibility? Certainly, it is. I can tell you that in the state of Nebraska you can have an add-on, for instance, for mental health and substance abuse. You can have an add-on for maternity coverage. So on the individual side, that may be a possibility, but on the group side, not currently. [LB149]

SENATOR CHRISTENSEN: But on the group side, it could be offered to the employer as an add-on. [LB149]

TONY SORRENTINO: It could legally. I won't get into the pricing, because I'm just not familiar as an underwriter what that would cost. [LB149]

SENATOR PAHLS: Senator Langemeier. [LB149]

SENATOR LANGEMEIER: Thank you, Chairman Pahls. Mr. Sorrentino, does your company work in other states other than Nebraska? [LB149]

TONY SORRENTINO: Yes, it does. [LB149]

SENATOR LANGEMEIER: Do you work in South Dakota? [LB149]

TONY SORRENTINO: Yes, we do, extensively actually. [LB149]

SENATOR LANGEMEIER: We were handed out some testimony that said that this was on like 28 cents. That's 28 cents per month per insured. Is that realistic? [LB149]

TONY SORRENTINO: Well, once again, not being an underwriter, I can tell you that it is an add-on cost. Where we look at the dangers for employers, and I don't mean dangers, but the concerns for employers is, this is certainly a worthy and sincere cause. Later, I'm sure that the committee will hear testimony on other issues. Typically, mandated benefits are grouped or aggregated together, and while we're talking about 28 cents, my guess is when we look at some other things, it could be more than that. Every state is going to address it a little bit differently, depending on how much coverage is provided by group insurance. Nebraska is blessed to have heavy, heavy group coverage. We don't have a lot of individual coverage compared to some certain states, so I can't give testimony to the specifics of whether or not the 28 cents is correct. I'm just not an underwriter. [LB149]

SENATOR LANGEMEIER: Okay, thank you. [LB149]

SENATOR PAHLS: Seeing no more questions, we thank you for your testimony. [LB149]

TONY SORRENTINO: Thank you, Senator Pahls. [LB149]

SENATOR PAHLS: Next opponent? And just for...some of you are not used to this...when you see senators come and go, it doesn't mean they don't have interest. It means they're presenting bills in other committees. [LB149]

ROBERT HALLSTROM: Chairman Pahls, members of the committee, my name is Robert J. Hallstrom, H-a-l-l-s-t-r-o-m. I appear before you today in opposition to LB149 on behalf of both the National Federation of Independent Business and the Nebraska Bankers Association. With respect to the opposition of NFIB, the affordability and availability of health insurance has been designated as the number one problem by small business owners. We survey our members on an annual basis, and have gotten back that message loud and clear. We're working with other groups on the federal level on the issue of healthcare reform, association healthcare plans, all other types of ideas that are designed to try and address both the cost of health insurance to continue to be able to provide that coverage for our employees and the access to the market that kind of goes hand in hand with the cost of the product. But our small business owners on those annual surveys have consistently indicated opposition to mandated benefits, certainly can echo most, if not all, of Mr. Sorrentino's comments with regard to the incremental cost of mandated benefits. Certainly from the testimony that you've heard today, you'll see and later on this afternoon I would assume as well, that there's merit individually to these types of mandates. But the employer community, particularly the small business employer community is very concerned about the aggregate cost of adding on these mandated benefit types of proposals. And ultimately, that leads to increased deductibles, increased copays, or discontinuance of health insurance coverage for the employees that employers do provide on a large-scale basis here in Nebraska. I would be happy to address any questions that you may have. [LB149]

SENATOR PAHLS: Well, I have a question. So you're saying, if you add more on, more employers would be likely to not have insurance available for their employees? [LB149]

ROBERT HALLSTROM: Well, I think, Senator, incrementally you end up getting to that breaking point. You have small business employers who are at a disadvantage to begin with. That's why we're supportive of association healthcare plans. We don't bring the buying power or the group buying power to the table that other larger employers that are perhaps self-insured, exempt under ERISA, and all those types of things that come into play in terms of the cost or even the impact of mandated benefits for many plans that are ERISA-exempt under the federal law. [LB149]

SENATOR PAHLS: Seeing no more questions. [LB149]

ROBERT HALLSTROM: Thank you. [LB149]

SENATOR PAHLS: Thank you. Next opponent. [LB149]

JANIS McKENZIE: (Exhibit 13) Senator Pahls, members of the Banking, Commerce and Insurance Committee. For the record, my name is Jan McKenzie spelled J-a-n M-c-K-e-n-z-i-e. I'm here today testifying in opposition to LB149 on behalf of the Nebraska Insurance Federation. I have a little different approach to take today in terms of what I want to share with you. There are a couple of company spokespeople who will be here after me to address specific concerns relative to LB149. I want to take a little broader perspective today and talk to you today about what's happening in Nebraska. As policymakers, you are obligated to consider all of Nebraska's needs along with your particular district's and constituent's needs. That makes us unique because of our Unicameral and our dual role we play as senator/representative. But as we start to look at what's happening overall at the federal level and then also for us here in Nebraska, I wanted to give you some important information about what the trends are. I've given you kind of a graphic representation of things that we've told many of you who have been on the committee year after year. What's happening in Nebraska is something that is sometimes very confusing and hard for people to understand. We hear words like ERISA and self-funded over and over and over, and yet it doesn't make sense. I'm trying to explain all of this to my husband. As you know, we rehearse these things at home on the weekends, and he's going, what are you talking about? So I figured the best way to maybe go back to my teacher roots and explain this so we can understand what's happened over a number of years is to make you a little picture. The sheet that you have on top which is why health benefits don't make sense anymore for Nebraska is basically giving you a visual representation of who gets a state mandate and who does not. Now if you look at your little circle there, you'll see that about 55 to 60 percent of Nebraskans are now covered under a self-insured or ERISA plan. Bottom line, what that means is these groups, primarily large groups, the reason there is no fiscal note for the state, Senator Utter, the reason there's no fiscal note for the University of Nebraska is because they're in this group. The only mandate they ever receive is a federal mandate. We can mandate everything in the world in Nebraska, and they don't have to do it. Most of these people, and I'm going to tell you that I listened to the proponents, a number of the proponents are in this group. The employers who are providing their health insurance to them are ERISA plans and they are exempt. So as much as they would want this coverage for themselves, they will not receive it. The other piece of the pie I want you to pay attention to is above the little yellow colored-in spot. These are the uninsured Nebraskans. Unlike many states, Nebraska's uninsured rate went up again, and I have given you two pieces of supplemental material for you to examine. One is from the AHIP documents from 2006 to 2007 that says we've gone from 11 to 12 percent, and the other piece behind that which is a map of the states and then a chart of

the U.S. census uninsured shows that Nebraska went up 2.3 percent as of March, 2007 or 2008. This is the 2007 report. So we are one of those very fine states that continues to have more and more Nebraskans uninsured. The other piece I want to bring up is the fact that the people that we are talking about putting a mandate on are those folks that reside in that little yellow section of the circle. These are the small employers of Nebraska, the self-employed of Nebraska, the farmers of Nebraska, the people like me who buy their policy as an individual, who are not provided insurance by their employer, or if they are an employer, they are a small employer and cannot take advantage of an ERISA plan. Now, these people already have 18 mandates on their backs, because that's how many mandates we currently have in Nebraska. Some of them are federal, but some of them are state. Just a quick calculation shows that our current mandate burden for this segment of the population runs somewhere about 20 to 25 percent. As of all the things you've heard today, most of these are best estimates. They are not necessarily set in stone numbers. The two sheets that I've given you that also correspond to this group are these two--one that's kind of blue, and one that's kind of green. They say, people with private health insurance coverage, and this comes from the American Health Insurance Plans documents that they do every year, and I have six copies I could provide the committee, but I only brought one for today and I can provide those to your offices later. If you look at the top section with the bar, you'll see that people covered by private insurance in Nebraska has gone from 61 percent self-insured--remember those are exempt from mandates, in 2006 to 64 percent in 2007. What that means for your circle purposes is that that little section of ERISA or the big section of ERISA grew 3 percent, and our little 23 to 28 percent who are the self-employed and small employers shrunk. Likewise, our uninsured pool grew which means our yellow section shrunk. Now, this is what's happening in Nebraska. This is the trend. These are all documented by the materials I've provided, and they are not materials that I came up with. They are just things that I found searching for information about Nebraska. For us to continue to add mandates to a section of the population that is already having the hardest time buying insurance for themselves or providing insurance for their employees, is probably not the direction we want to head. The other part of this argument for this segment of the population is, it really doesn't do a lot of good to require additional coverages when, in fact, if you have a $3,000 deductible it doesn't really matter what's covered, because you're going to pay out-of-pocket until you hit the $3,000 or the $4,000 or the $5,000. My sister and brother-in-law have a $10,000 deductible on their health insurance policy. This is the reality for a lot of Nebraskans who are self-employed or own their own businesses. Now, what should we think about doing in Nebraska? Every year we've heard these...this is my tenth year of coming in to testify against mandates. And for five years I sat in your chair, so I know it's a difficult, and always real concern and real problems that we're faced with. A number of states have already set trends for us to consider. Actually, I will provide some materials to the committee clerk for research, but I'm going to argue that what we ought to start thinking about in Nebraska is what 23 to 30 states have already done, and that's to require any proposed mandate to a health insurance policy must go through a full-blown

mandate review process by an independent group. Now, the group can be a panel, an agency, a Governor-appointed group; 23 states currently have what's called a mandate review commission. Kansas, our neighbor to the east just proposed legislation of this sort this year. Actually, Colorado, these studies that you got from the proponents were all the result of these kinds of review committees. In fact, Colorado does have this mandate, but they also have something I'm going to tell you about in a minute, that makes this mandate kind of a soft mandate. Massachusetts, California, New Jersey, Virginia--I have one here that I will also leave with the committee counsel from Maryland that's a brand new one. These are the kinds of things that are brought before a committee or brought to a Legislature before it becomes a bill, so that you can see in a very nonpartisan, nonemotional way whether or not this is something that's really needed. Who it affects, what the consequences might be, what the costs might be, whether or not in the bigger picture of things, this is the most important thing we should do to help Nebraskans afford health insurance, or to be provided good health coverage. We can do a mandate review commission, and I would argue that's something we ought to consider. These have been around for a long time; we've just never proposed it in Nebraska, because we weren't in the situation we're in at this point. The second thing I would propose is what's now become kind of a term of art. We all like the word lite, l-i-t-e as we can try to keep ourselves in those categories that we keep hearing about. Mandate lite legislation, 19 states have introduced and passed legislation that allows the state to provide insurers can offer plans with no state mandates attached. Geared specifically to small employers, so that if I'm shopping as a small employer, I can go out and buy a policy for my employees that has none of the required mandates on it or the ones that I pick and choose. Colorado actually has this law; it was passed in 2003. So while they have the mandate to cover the prosthesis at the Medicare rate, they also allow that insurers can produce products that are out there for employers who might need to buy something that's a little leaner. And the third thing that states have been doing is an outright moratorium. Two states have actually had moratoriums on their books, prohibiting passage of any mandates until they know what exactly is going to be happening in this economy, until they know whether or not our unemployed rates are going to go up, how many people might lose insurance completely as prices change, and/or as to what's going to happen at the federal level. I would implore the committee to consider that we do take a full-blown look at creating a better way to set policy relative to health insurance for Nebraskans. And remember, I'm talking about the 22 to 28 percent who are affected by what we're talking about today. These bills, by the way, also affect the CHIP program, and you'll be hearing about that next week. This is also an area that we're concerned about because the state...that is a program that's available to uninsurable Nebraskans. It's the only place they can go when they can't get insurance anywhere else. So these mandates go to that group as well, and that's a concern for...it should be a concern for us as policymakers and as insurers also. I would say just one last thing, in particular. There really only are six other states that have this kind of requirement to pay at Medicare rate. There are other kinds of parity pieces out there, and one of them is Colorado, so at current time, there are really five states that

have this identical legislation, and most of them have just passed it, so we don't really have a good idea as to how it's actually going to play out. We also are opposed to the idea that we're going to mandate to a private business industry a rate that should be paid. We don't do that. The state doesn't get involved in telling tire dealers what they have to charge for certain products or services, and we just think it's a bad business practice to tell companies they have to charge or pay a certain amount for a certain product. The idea is that there should be a wide array of products available so the consumers can find one that best meets their needs. With that, I would answer any questions you might have, and I appreciate your kind attention. [LB149]

SENATOR PAHLS: You put a different twist on what we've been going. The only question I have, and let's say we take a look at whatever you're talking about. I mean, I would be suspect of who is going to be "this commission." And I'll just give you an example, because just pulled this health insurance mandate in 2008. You know, it really sounds good. It gives all of the groups involved...but then I turn it on the back page, and I see who made this study. And this was to a group that would actually be to their benefit a little bit. I mean, they were telling the truth here, but you see what I'm saying? [LB149]

JANIS McKENZIE: Correct. [LB149]

SENATOR PAHLS: So that's why I'd be...I'd have to know...I mean, I know, it seems like this is the umbrella which you're tossing at us. But I would have to know, just...and I...we probably won't go into this too much today because this...but who would be on that commission? I mean. [LB149]

JANIS McKENZIE: It varies, Senator, from state to state. In some states, for example, the Maryland study that I'll leave with you today, this is actually...what Maryland does is they contract through an independent consulting agency who then gathers information from the constituency group. They gather information from the insurers. They go to a number of places to gather the information, but they are not funded by the advocacy groups or by the insurers or by...I mean, they're completely independent. Different states do it differently. Some put it in the hands of their agency like in HHS. Some, as I said, put together a committee that it's a governor-appointed commission that reviews anything that's introduced, and in some states, there's even a requirement that they have to review current mandates, and if at any point in time, the current mandate increases costs, that has to be repealed so. [LB149]

SENATOR PAHLS: Yeah, and like I say, we're getting maybe more than we probably need to today. [LB149]

JANIS McKENZIE: Yeah. [LB149]

SENATOR PAHLS: But the thing about it is, I find it interesting...I'm intrigued by this idea, but as you know, the cost is a factor. [LB149]

JANIS McKENZIE: That's why it would be up to you to draft what we'd look at. That's why we'd need to take a little time considering it. I will leave this packet of materials and this example of the study here for the committee counsel for consideration. Any other questions? [LB149]

SENATOR PAHLS: Senator McCoy. [LB149]

SENATOR McCOY: Thank you, Chairman Pahls and thank you, Ms. McKenzie, for your testimony this afternoon. I guess a couple of quick questions then that peaked my interest, and you mentioned mandate review commission and what not. The proponent's amputee coalition provided us with some testimony and some data as to per month premium increases in some states. You mentioned the state of Colorado. Do you agree with those numbers that were given to us, as in specifically, Colorado they increased on the premium by 12 cents? [LB149]

JANIS McKENZIE: What I have had a chance to see, Senator, is what they had presented to us in this study originally, and they had done the basis of that study on, as I read it, Medicaid cost, not necessarily across private groups. And the reason that it's difficult to find that information in that, in some cases,where you may be talking about small groups, it is a violation of HIPAA rules to provide...you know, be sharing particular pieces of information on groups to...because it could violate their privacy. Or in cases, it's proprietary information, and they won't share it, because it's theirs and they own it. I don't know whether or not that's accurate for Colorado, but I would certainly be willing to check with some people out there who might know exactly what's happening in terms of cost. [LB149]

SENATOR McCOY: And you had also mentioned that Colorado is one of those states that their legislation provided a match to where Medicare is, correct? [LB149]

JANIS McKENZIE: Right, yes. [LB149]

SENATOR McCOY: One of the states, I think, you had mentioned across the country that have that parity standard? [LB149]

JANIS McKENZIE: Yes. They also have the mandate lite option... [LB149]

SENATOR McCOY: Um-hum [LB149]

JANIS McKENZIE: ...which is that insurers can create policies that don't cover the mandates. [LB149]

SENATOR McCOY: I guess my second question would be do you agree with the numbers that we've been given, and Senator Langemeier touched on that earlier, and that is 28 cents, the number that's out there, do you agree with that number, if that could be what the cost would be under this bill? [LB149]

JANIS McKENZIE: Senator, I can't agree. That's like looking in a crystal ball. It's like saying, well, we think this will happen. But what you'll see if you look at the Maryland study is they said, well, that's based on what we think we knew from this time period. But we really don't know what might happen in this time period, because you're trying to predict what everything will be in the future. And that's difficult. That's why actuaries get paid the kind of money they get paid honestly, because they're trying to predict risk based on a series of factors. Some come absolutely on mark, and others are harder to guesstimate, I guess, or run through their models. So I guess the long answer to your question is, I can't say I agree with those. [LB149]

SENATOR McCOY: Thank you. [LB149]

SENATOR PAHLS: But this commission that you talked about would probably give us straight-up information. Is that what you're implying? [LB149]

JANIS McKENZIE: I would guess to the best of their ability like actuaries can, but again, it's a guessing game either way, in some cases. [LB149]

SENATOR PAHLS: Senator Utter. [LB149]

SENATOR UTTER: I'm interested in the mandate lite idea. Is there any figures out there that in those states where mandate lite has become an option that tells what kind of a shift there has been from the regular health insurance policy to the mandate lite policy? Was there a big shift in those states, do you know? [LB149]

JANIS McKENZIE: You know, that's a good question, Senator. I had not heard of this myself until I started doing research for this year's hearings, and I was completely unaware of this pattern. But I will certainly see if I can find that out for you, because I think that's a very good question. [LB149]

SENATOR UTTER: Thank you. [LB149]

SENATOR PAHLS: Senator Christensen. [LB149]

SENATOR CHRISTENSEN: Thank you, Chairman Pahls. Thank you. Jan, in this ERISA group, you said that aren't covered by the mandates, do they still cover...I understand what self-insured is, but do they still cover the prosthesis or not? [LB149]

JANIS McKENZIE: Well, Senator, it's going to depend on what the employer chooses to put...to have covered in the policy, and I think what you heard earlier, in some cases, the durable medical equipment category was one that some people believed was being abused and mostly because of the scooter issue. You know, we'll get you a scooter, and your insurance will pay for it, commercials. Some abuse that was going on in that area, and I think probably to some extent, prosthesis got rolled into that, and it probably was unfortunate in those cases. A lot of what happens in the ERISA plans because they tend to be very large groups are that the employee group negotiates with the employer group, and they come up with what they think puts together a good plan for them. It is actually a benefit that the employer provides the employee, and so they range in scope from all sorts of more focus on preventive to more coverages to higher deductibles, lower deductibles, cafeteria plans. It's a wide array of coverages that are available in the ERISA market. [LB149]

SENATOR CHRISTENSEN: Thank you. [LB149]

SENATOR PAHLS: Thank you. And you're going to leave this information here? [LB149]

JANIS McKENZIE: I am going to leave that for you. [LB149]

SENATOR PAHLS: Thank you. Jared, could I get you...? Thank you. Next opponent. [LB149]

TOM SPAIN: Good afternoon, Senators. My name is Tom Spain. That's T-o-m S-p-a-i-n, and I'm the manager of special investigations unit of BlueCross/BlueShield of Nebraska, and I'm appearing on behalf of BlueCross/BlueShield. On behalf of our customers, we oppose LB149 as drafted, because mandates in general increase total healthcare costs. While mandates do guarantee more health coverage, they don't necessarily ensure better healthcare coverage. Mandates can increase premium costs and potentially increase out-of-pocket cost to patients. This is especially true when the patient utilizes noncontracted providers, and we can't protect them under our contracts. BlueCross/BlueShield of Nebraska currently covers prosthetics in our group and individual contracts. There is only one segment of our business where dollar limitations of coverage are imposed, and that's our small-group contract product called Blue Pride. These contracts were designed to offer affordable coverage to small business by placing limitations on certain medical equipment and procedures. We have further concerns about the bill as it's written. Minimum payment for services, the Medicare fee schedule for prosthetics. What happens when a specific procedure code and associated allowance doesn't exist under Medicare? How is the insurance carrier supposed to handle reimbursement related to miscellaneous healthcare procedure codes that don't have a reimbursement level set? It may take years for new technologies, at times, to be

assigned hick-pick codes such as appear in these books yearly as the basis for both submitting bills and reimbursement. Currently, carriers and providers in our state use contracted rates as part of the system of reimbursement under agreements with us. This system, in our opinion, is more preferable than fees set by the federal government. The bill states medical necessity is up to the patient's physician. This is contrary to any procedure or service we provide under an insurance contract currently where we and the other carriers provide that medical necessity for benefit purposes will be determined by the payer pursuant to the criteria set forth in the plan subject to appeals under the grievance act. Why aren't prosthetics subject to the same medical necessity and review criteria as any other medical procedure? If the desire is parity, then prosthetics should be on par with other medical services and procedures in our contracts. The bill also states that covered persons shall have access to care from a nonparticipating prosthetist to the same extent that the policy provides for out-of-network services for other covered benefits. Does this mean that we have the right to reduce reimbursement in line with our noncontracting language? Currently, for example, we would normally reimburse a noncontracted provider at 60 percent of our fee schedule. The bill states, though, that we have to pay Medicare rates at a minimum, so does this apply to noncontracting? We don't understand that. The proposed legislation doesn't prohibit the application of a deductible or copay provision of the contract, but the copay can't exceed the Medicare copay. For 2009, Medicare has $135 deductible and 20 percent coinsurance for prosthetics, no copay. How are we supposed to handle this? Legislation in Virginia states that coverage shall not be required for a prosthetic device that is designed exclusively for athletic purposes. What's the intent of the proposed legislation in our state? Since medical necessity criteria is decided by the prescribing physician, this seems to be contrary to what the bill says. Are we to pay for any and all prosthetics billed? The proposed legislation is not clear to us. Furthermore, language in the Virginia bill states that fitting, repair, or replacement necessitated by negligence of proper care or maintenance or by an abusive act committed by the individual having the prosthetic device shall not be covered. What's the intent under the proposed legislation in Nebraska? And finally, open-ended payment criteria and lack of carrier-based medical review will potentially increase our exposure to fraud, waste, and abuse by unscrupulous providers. BlueCross/BlueShield Nebraska would be amenable to working with the introducer and the committee to make changes to the bill that we could support. Thank you. [LB149]

SENATOR PAHLS: Mr. Spain, after listening to...you know, I'm hearing you say, the bill does this, doesn't do this, doesn't make it clear in this. Other than the concept, can these corrections be made within the bill to make your concerns doable? [LB149]

TOM SPAIN: We think so. But we'd have to review what they are. [LB149]

SENATOR PAHLS: Right. But what I'm saying is, if we take a look at the bill and you say, well, it's written this way, and it's the terminology or not, we're not being clear

enough. [LB149]

TOM SPAIN: We think that there are other legislations that have been passed that would put some safeguards in the bill that we're looking for. [LB149]

SENATOR PAHLS: Okay. So, for you to feel more secure about this bill, you need to take another...or you need to take a look at it and say, this really is a section of the bill that causes us some major concern...not against the concept, but just making it clear, you know? [LB149]

TOM SPAIN: Right. Understand, we're not opposed to the concept in all of our policies except for one, we already provide coverage, unlimited coverage for prosthetics and include repairs, replacements, and other things. So, you know, the concept is not foreign to us. We wrote a policy for small group, at the request of small group, to get premiums down. We did that based upon actuarial input. That's the only policy that applies to. Is that...? [LB149]

SENATOR PAHLS: Yeah, I see. So, basically, you feel BlueCross and BlueShield are really meeting the needs in most cases. [LB149]

TOM SPAIN: Well, we have...we insure about a third of Nebraskans, and this legislation, out of that one-third, would only cover about 30,000 people. So, we believe that that's being met currently. [LB149]

SENATOR PAHLS: Oh, okay, okay, okay. So, to go ahead with this, we do need to take a really serious look at the bill to make sure that... [LB149]

TOM SPAIN: We think that there are holes in the way that it's written, frankly, but we're not opposed to trying to help you work through that. [LB149]

SENATOR PAHLS: Okay. Can I have you come with...when I go to my stockbroker...can I have you come with me and (laughter) clean up some of the issues that I have? I appreciate your not initially being against the concept, but thinking that there are some holes here that we need to be aware of before we move on. Let me throw this at you. You know, just before we had something about this commission concept, I know that's different than what we're doing today. Would those type of things...if you had gone in front of this commission or something like this with your proposal, better legislation would come to us, is that? [LB149]

TOM SPAIN: We believe so. [LB149]

SENATOR PAHLS: Okay, okay. Senator McCoy. [LB149]

SENATOR McCOY: Thank you, Chairman Pahls, and Mr. Spain, thank you for your testimony this afternoon. You had mentioned specifically the bill in Virginia. I guess my question to you would be, did BlueCross/BlueShield support the legislation that's been passed in the 11 states? [LB149]

TOM SPAIN: I'm not aware what each one of the BlueCross plans did. All of us are an independent part of an association, so, you know, we...each carrier looks at how things are applied in their state, but I'm not aware of that. [LB149]

SENATOR McCOY: Okay. My second question would be kind of a piggyback to Chairman Pahls's question, and that would be some phraseology and some different ways of maybe putting together some language in this bill or change. Would that have affected your opposition to it, to a neutral or otherwise if some of this is changed? [LB149]

TOM SPAIN: Oh, I think so. And I think if we address a number of the issues that I've brought up, we would be more amenable to the bill. But there...to me, it's written extremely broad, and it does not have many safeguards put in the bill, in our opinion. [LB149]

SENATOR McCOY: Thank you. [LB149]

SENATOR PAHLS: Senator Christensen. [LB149]

SENATOR CHRISTENSEN: Thank you, Chairman Pahls. Thank you, Mr. Spain. [LB149]

TOM SPAIN: Yes. [LB149]

SENATOR CHRISTENSEN: Can you tell us on BlueCross/BlueShield's side, what it is costing per person as we've seen for other states? [LB149]

TOM SPAIN: No, I can't. I'm not an actuary, so I can't tell you that (laugh). [LB149]

SENATOR CHRISTENSEN: Is there some...can you get that to us? [LB149]

TOM SPAIN: We probably could, yeah. [LB149]

SENATOR CHRISTENSEN: Appreciate it. [LB149]

TOM SPAIN: Keep in mind, it'll only be...we can look at it in an entirety across all lines of business, but this bill would only affect that small group that I'm talking about. [LB149]

SENATOR CHRISTENSEN: Correct. [LB149]

TOM SPAIN: Okay, so are we only talking about the small group or the whole? [LB149]

SENATOR CHRISTENSEN: Well, I'm interested in what it costs the whole group across. [LB149]

TOM SPAIN: I think we could probably. [LB149]

SENATOR CHRISTENSEN: Thank you. [LB149]

TOM SPAIN: You bet. [LB149]

SENATOR PAHLS: Seeing no more questions, thank you. [LB149]

TOM SPAIN: Thank you. [LB149]

SENATOR PAHLS: Next opponent. [LB149]

BRIAN URBAN: (Exhibits 14, 15, and 16) Rest assured, gentlemen, a lot of this is duplicate, so I will only give you what you haven't received already in the interest of time. My name is Brian Urban, B-r-i-a-n, last name U-r-b-a-n. I sit here today representing the Nebraska Association of Health Underwriters. I am also a small business owner, a health insurance producer, a financial service industry representative also. Chairman Pahls, distinguished committee members, thank you for your time in hearing us here today. I would like two words to ring out through my testimony which will, again, be brief as I will not double up on a lot of the cost of mandate information that has been disseminated here today. But the two words I would like us to think about are "unintended consequences." When we are looking at mandated legislation, many times it will be well intended and have unintended consequences. As we look at some of the material in front of you today, we can discern that mandates do cost money. There's been discussion here today as to what that price point is for the particular mandate in question, and a big question mark, I think, behind that. One of the reasons I think that this is, is as mentioned prior, these mandates are so new, the data on them is very fresh and, as data goes, the more of it we have, the better picture that we're going to get. Right now, a small picture a little bit hazy. But mandates, by and large, can be compared across state. If you will look at the piece that is in front of you, the single sheet piece that will have the mandates numbered as well as the cost of premium average, between the state of Nebraska versus the state of New Jersey. That is a data piece, the state of Nebraska currently carries 18 instead of 17. However, what we can see and the difference between the two states in just premium level alone, now for the average in the...for the average Nebraskan, the cost of premium per individual per year to cover for insurance is $3,890. That number is $4,471 in New Jersey. That is on an

employer-based level. If we look at a nongroup level, single premiums in the state of Nebraska of $2,505 for the state of Nebraska versus $5,326 for the state of New Jersey. As you see at the bottom, New Jersey has 26 state level mandates. Nebraska has currently 18...17 as of 2007. The point of that exhibit is to merely point out that mandates do cost money. Now, the unintended consequences of the mandate is an increase in premiums as we are well aware. Whether that is a third of a percent, a tenth of a percent, a percent, we're not aware, but we do know that on the industry level, for just about every percent increase in premium, the uninsured population increases by a percent. Now, Nebraska is currently trending somewhere between 170 and 198 thousand of uninsured. If we were to install 1 percent of insurance premium increase, we are going to put somewhere between 16 and 19 hundred of Nebraskans out of the insurance altogether. How do we choose who we benefit? When we're serving the state as a whole, this is a very tough question. I don't envy the gentlemen on this committee's position one bit in having to make those decisions. They are tough decisions. What I hope that we would do is take a wide-angle lens and look at this thing from the 30,000-foot view to really look at the greater good of all Nebraskans. I couldn't sit here today and tell you nor would my association assert that coverage for prosthetics is a bad idea in an insurance policy. They have been capped recently, and as was shared with us prior, these caps start at somewhere around the year 2000. I think we want to look a little bit at the reasoning and the root for those caps and procedures, and why they came to be. I would assert that when we are looking at putting a benefit on parallel with Medicare, we may have to take a step back and look at why that benefit was capped in the first place. Insurers are constantly trying to keep costs down, to stay competitive in the marketplace, and to keep people in the insurance pools. Capping certain benefits is nothing new. Prosthetics may be just a more recent, but if you look at any insurance policy, there are caps on many benefits. There are caps on preventative care, one of the most important benefits of every insurance policy. You'll find a cap ranging anywhere from $150 to $1,000. Why are there differences in these caps? It's a competitive marketplace; it allows people to pick and choose what they need. Now again, capping and cost containment, I think, is ultimately a bit of a by-product of the Medicare system itself. So when we look at putting a benefit on par with Medicare, we need to look at that system in a vacuum also, and realize what it's done to the policies in the first place. The Medicare reimbursement rate causes, what we call a Medicare cost shift. Now those policies will reimburse the doctors and providers somewhere around 60 cents on the dollar, so for a doctor or provider who is getting reimbursed at 60 percent of what their actual costs for delivering the services and treatments are, they have to charge the private insurer or the private insured policyholder a higher rate. This is a round-and-round process that has been going on for decades, and is one that will be coming to a head as we have baby boomers going into the Medicare system. We need to understand that this is part of the root for cost containment. If we go back and try to mandate that private insurers are covering things at the same rate as Medicare, they should be able to have the same reimbursement rate as Medicare, with about a 40-cent on the dollar reduction. So that is something I think needs to be brought into the

discussion. When we're looking at this, I just wanted to echo again, what we are looking at when we're increasing the cost of insurance through an implementation of a mandate, is ultimately going to be affecting the small business owner the most. As was shared with you here today, and I will share with you as an insurance producer, we are seeing a greater, greater interest, and are starting to write self-insured policies in the state of Nebraska down to ten lives. This is a level that has probably been unheard of in a lot of areas. Nebraska, thankfully, is an insurance friendly state, but as we see the size of the self-insured group decrease, one would have to ask themselves, why would they be willing to take on that much more risk and/or what are they benefitting from going from a fully-insured mandated policy to a self-insured, ERISA-qualified or a policy free of state mandates and only subject to federal mandates? I would subject that the reason is for the growing rate of mandates as well as the cost of insurance. So I hope that the committee will take that into consideration as I myself am a small business owner and, obviously, would be affected through this. And then, I guess, the other question to ask ourselves, is how do we pick and choose and decide which mandates make the most sense? We're going to hear today cochlear implant mandates be brought up before this committee, clinical trials to be mandated and covered. Who is more important than the next person, or do we let everyone in? And as you can see, with some of the data in front of you from the insurance, state-mandated insurance piece that you have there, that states what's the highest mandates obviously have the highest cost of insuring their individuals in the state. I would like to direct your attention, mostly for a point of clarification on the piece, that is from the Department of Justice as well as the Federal Trade Commission, that is an excerpt of that study. As you can tell, that is a 367-page study. It is sourced by page. I wanted to point that out. As you'll see in the conclusion area of the FTC/DOJ study, the scope or thrust of the recommendation or conclusion of that study was that mandates will increase cost; there is no question about that. The question that was posed at the conclusion of that study is, or I guess the challenge would be for us to sort through and decide which mandates are qualified over the rest. Again, don't envy you gentlemen in having to make that decision, but would like to stand as a representative of the Nebraska Association of Health Underwriters here today in opposition of the prosthetic mandate on the grounds that it will increase the cost of insurance to Nebraskans as a whole as well as push some of Nebraskans out of insurance programs altogether. And with that, that's all I have. I will entertain any questions should there be any. Yes. [LB149]

SENATOR PAHLS: Senator Gloor. [LB149]

SENATOR GLOOR: Thank you, Chairman Pahls. And thank you for your testimony. I guess I'm going to answer a question that you asked, and that is, who's going to make these important decisions? This has been going on for years. I mean, it's the...benefit plans are decided upon by somebody...how many prenatal visits are going to be made, how many homecare visits are going to be made? This isn't any different than some of the decisions that have been made in the past. It may get a little more dicey when you

start talking about larger dollars, but this is the basis for making decisions about health insurance plans from the very beginning, so I don't see it as something that is in outer space in terms of the decisionmaking process. And I have to tell you, in the short time I've been exposed to them the gentlemen who sit around this table are pretty intelligent people, who I think can sort through some of these issues. I don't think it's beyond the realm of this body to make some difficult decisions about what's appropriate to cover and what isn't, candidly. [LB149]

BRIAN URBAN: Yeah, and I appreciate that, and I didn't want to imply that that was the case, Senator. I merely wanted to empathize or share my empathy with the challenges that you face in making those decisions here today. [LB149]

SENATOR GLOOR: I'm glad you feel our pain. Thank you (laughter). [LB149]

SENATOR PAHLS: Any more questions? I do appreciate the...because I do look at who is actually making some of these studies because, to me, it lends some credibility if it's not from a certain group. You know, because some of these are self-serving. I'm not saying they're wrong, but they just have a tendency to have a little bit more credibility. Again, I thank you. [LB149]

BRIAN URBAN: The federal government is always the most credible, sir (laughter). [LB149]

SENATOR PAHLS: Well, okay, I opened myself up for that, didn't I? (Laughter) Thank you, again. Opponent. [LB149]

MICK MINES: Senator Pahls, members of the Banking, Commerce and Insurance Committee, my name is Mick Mines, M-i-c-k M-i-n-e-s. I'm a registered lobbyist here today representing the National Association of Insurance and Financial Advisors of Nebraska, NAIFA Nebraska. Our organization opposes LB149. We today and have always opposed mandates and requirements that increase the cost of healthcare insurance to our customers. We are the front-line division. We sell the insurance to the clients. I won't go into any more detail. You've heard it all, and we would ask that you indefinitely postpone this legislation. Thank you. [LB149]

SENATOR PAHLS: Seeing no questions, thank you. Any more opponents? Anybody in the neutral? We have one in the neutral? Good afternoon. [LB149]

REX MOATS: Thank you. Good afternoon, Chairman Pahls, Vice Chairman Pirsch, members of the committee. My name is Rex Moats, R-e-x M-o-a-t-s, and I am here today to testify in a neutral capacity on LB149. Had an opportunity this afternoon to listen to the various comments by the parties that have come before the committee. I had a unique opportunity last year with Senator McCoy to canvass Legislative District

39, and during that time, I personally met with the Havermann family back here as well as five other families who are amputees. They shared similar concerns regarding coverage of prosthetics in Nebraska. One of the things that hasn't been asked here today is how many Nebraskans are impacted by this? There were five in our legislative district alone; if there are almost 50 legislative districts, that would mean there's about 250 Nebraskans, if you want to hold trending true that are impacted by the availability or nonavailability of coverage in this state. I think something else that's important before this committee makes a decision is to look at how many adults are impacted versus how many children are impacted, because I think it's a little more onerous burden on the child and the multiple prosthetics that they will require during their growing lifetime as opposed to an adult who is, my understanding, seen every few years as from testimony today. One of the other pieces of testimony that was heard today was about the Shriners Hospital. I've been a member of that organization for about 22 years, and there's one thing that I can tell you, and that is the number of Shriners Hospitals is decreasing. It's decreased four since the time that I became a member in 1986. I don't think that we can shift our costs necessarily to an organization that is certainly not growing at this point in time, and I would suggest that that might be a dangerous road to go down to think that you could somehow shirk your burden as a state...you and you alone under the McCarran-Ferguson Act or authorized to act and regulate the insurance in this state. And so I would just state to you that I think this is a tremendous opportunity for this committee to get out in front of the issue. I don't think that it needs to be studied anymore. I don't think there needs to be any more commission. That's what was ordered or mandated last year when these same groups were before this committee, and I would urge you to think about some of those issues as you decide whether or not to advance that to the full floor of the Unicameral. Thank you. [LB149]

SENATOR PAHLS: Any questions? Seeing none, thank you, Mr. Moats. Any more in a neutral? Senator. [LB149]

SENATOR PANKONIN: Thank you, Chairman Pahls. First of all, I want to indicate, I am in the yellow group right there (laughter), that's me, small employer. I just want to tell the committee first of all, my motive behind this effort, and I want to in the spirit of full disclosure, you know, I'm not an amputee; my family...none of my family members are amputees or the employees of my small business. Some of the folks that spoke to you today do have vested interests. Dr. Rush's company would surely benefit if we pass this. Some individual families would benefit. I have no financial interest in a company that makes prosthetics that I know of since all my stocks are about zero (laughter), probably isn't applicable. But I made a decision as a small businessperson, a cold-eyed financial decision. I buy insurance to manage risk in my business and my personal life. And I look at this the same way. When I see that the...we talk about numbers for costs, and the folks came back after a year, after we asked that question last year, and they did some studies, and we've had some different numbers. But the highest number we heard was not 1 percent or 6 percent or what--.06 percent, a range from .03 to .06

percent. We heard from zero to 41 cents per member per month. I think that's the largest number we heard today. The insurance companies didn't dispute those numbers; they didn't say they were accurately necessarily, but they didn't dispute those numbers. I'm willing to pay 41 cents per member per month in my company's, small company's insurance, for this protection if this is what it costs, because I've worked with the same folks in my small business. I've got three employees who my dad hired. I've been there 34 years; out of 15, three of them were there before I was. Most everyone has been there a long time, the people that I love, my family, my two children, my grandchild. It's worth it to me. I buy insurance, pay for insurance all the time to manage risk, and to me the cost benefit on this issue is there. If the costs are this low, and we haven't heard that they aren't, I think the benefits for me personally to take care of that risk is worth it. Plus, a lot of other people benefit, people that need this coverage. And you know what? We don't know. We may need it, we may need it. I drive back and forth everyday. I work in the farm equipment business. It's somewhat dangerous, and we may need this coverage, and to me, it's worth it. Thank you. [LB149]

SENATOR PAHLS: Any questions for the senator? Senator Christensen. [LB149]

SENATOR CHRISTENSEN: Thank you, Chairman Pahls. Thank you, Senator Pankonin. Do you see there's a society cost if it isn't covered? For your particular business, if a mechanic got hurt and couldn't get back on his feet to work, he's basically changing jobs. [LB149]

SENATOR PANKONIN: Senator, not only that, but, you know what I'm talking about. I've worked with these people for a long time, and I'm just making the financial decision. I don't...I shouldn't say I don't care about the people behind me, because I do care about them. But I'm talking about making this decision for my business. I'm willing to pay it, because the people I value in my family and have worked with me for all these years, and I wouldn't be what...well, first of all, I wouldn't be here, because I was home the last two days. We had our open-house in my business. If it wasn't for the people I've worked with keeping that thing going, my family and the folks that have been there, I wouldn't be able to serve here. So I appreciate them, and to me, this coverage is worth it. And I want to also mention that I really appreciate BlueCross/BlueShield. They were in my office at the noon hour, and they offered to work on this policy and this legislation, as you mentioned, Chairman Pahls, I think, is a real positive step. And if we can...I'm sure willing to work with them and the committee and the folks affected, if we can come up with some kind of workable policy issue here that extends coverage and helps folks, I think it's great, and I want to say I personally appreciate them for coming forward with that. [LB149]

SENATOR PAHLS: Seeing no more questions, thank you. [LB149]

SENATOR PANKONIN: Thank you. [LB149]

SENATOR PAHLS: (Exhibit 17) And that closes the hearing on LB149. Now we're going to take a little bit of a break before you hit yours, Senator. Good afternoon. I think we are ready for LB378, and the floor is yours, Senator. [LB149]

SENATOR GLOOR: Thank you, Chairman Pahls, and fellow members of the committee. My name is Mike Gloor, G-l-o-o-r. Given the discussions we've just had about mandated coverage and the discussion that I think is to follow, I think you'll find this a little refreshing and maybe even be a bit bemused by it. We are talking about when it comes to mandated coverage in this particular piece of legislation, is encouraging insurers...legislating that insurers pay for services that, ultimately, they end up paying for anyway. Sometimes during medical clinical trials, and understand that we're talking about clinical trials that are only done by a very small and select group of approved institutions in this state, patients under those clinical trials are being denied coverage of routine care, and I'd emphasize routine care, typically covered by their private insurance policy. The basis for being denied is that participation in the clinical trial disqualifies them for coverage. The denials range from complete denial of all care to partial denial of coverage when the patient is in this approved clinical trial. Medicaid and Medicare provide coverage for routine medical care not related to the patient's participation in a clinical trial, and that is an important point to emphasize. LB378 asks that private plans cover the same routine care that public plans already cover for these clinical trials. LB378 mandates that private insurance and self-funded employee benefit plans to the extent that those self-funded plans aren't preempted by federal law, provide coverage of routine care when the patient is receiving treatment in a federally-approved clinical trial. Coverage of routine care for the patient would be the same coverage as outlined in their insurance policy, the same coverage that would be in effect if they were not a participant in the clinical trial. The mandated coverage would not include any expense of a drug or device, physicians, clinicians, administration, data collection of the clinical trial, or incidental expenses such as housing or travel. Testimony of those following me will explain the approval process that clinical trials go through, provide you with a better view of this issue from both a physician's perspective, a hospital's perspective, and, of course, most important of all, the patient's perspective. I'd be glad to answer questions, but there will be a number of people who come up here that will cover specific areas that I've just identified. Thank you. [LB378]

SENATOR PAHLS: Seeing no questions, Senator, we'll let you sit back. I'm assuming you're going to close. [LB378]

SENATOR GLOOR: I will close, thank you. [LB378]

SENATOR PAHLS: Okay. Just, so I can get a feel. Proponents who are going to testify? I should add that on. One, two, three, four, five, six. Six proponents. Opponents? One, two, three, four, five. Five opponents. Neutral? No neutral. And just for...we're doing it

for this bill. If we have anybody who wants to at least get their opinion noted, they can fill out the form that's on the table over there. Otherwise, we are ready for the proponents. [LB378]

KENNETH COWAN: Thank you, Mr. Chairman and members of the Banking, Commerce and Insurance Committee for giving me the opportunity to testify in support of LB378, which only requests that healthcare cover the cost for routine medical care of patients when they are enrolled in clinical trials. [LB378]

SENATOR PAHLS: Could I just...okay, okay. [LB378]

KENNETH COWAN: I am...okay, Dr. Kenneth Cowan, K-e-n-n-e-t-h C-o-w-a-n, director of the Eppley Institute for Research and Cancer and the UNMC Eppley Cancer Center at the University of Nebraska Medical Center, one of 63 national cancer institutes designated cancer centers in the United States. Prior to my recruitment to the University of Nebraska Medical Center, I worked for 21 years at the National Cancer Institute in Bethesda, Maryland. And since joining the Eppley Cancer Center, I was appointed by President Bush in 2002 to serve on the National Cancer Advisory Board which oversees the national cancer program of the National Cancer Institute. I am here today speaking in favor of LB378, not as a representative of the University of Nebraska, but on behalf of the several hundred breast cancer patients that I had the privilege to care for at the University of Nebraska as well as the thousands of cancer patients seen by cancer physicians at UNMC and the tens of thousands of cancer patients and cancer survivors in Nebraska. I'm certain that everyone on the committee recognizes the important healthcare problem of cancer. One out of two Americans will be diagnosed with cancer in their lifetime. In 2009, over 1.4 million Americans will be diagnosed, and over 8,000 Nebraskans will be diagnosed with cancer. Over 600,000 Americans will die and 4,100 Nebraskans will die from cancer this year. I'm certain that everyone on this committee--indeed, everyone in this room has been touched by cancer either personally or through family or friends. Since the average age of Nebraska is increasing every year, it is expected that the incidence of cancer in this state will increase steadily over the next decades. The thousands of years of productive lives lost prematurely in Nebraska every year from cancer deaths is an enormous economic burden to the state. A rural state like Nebraska can simply not afford to lose even a single productive life prematurely from this disease. In 1971, the U.S. Congress passed the National Cancer Act which greatly increased federal funding for cancer research. Over the past 37 years, this cancer research has led to significant improvements in prevention, detection, and treatment of cancer which, in turn, has resulted in significant improvement in cancer survival. Over the past decade, cancer survival has increased 1 percent per year for each of the last ten years, and last year there was a 2 percent increase in cancer survival which translates into 10,000 additional Americans joining the ranks of cancer survivors. Economically, every 1 percent increase in cancer survival rates results in a gain of $1 billion to the U.S. economy. Today more than 12 million Americans are alive

today as cancer survivors which represents a four-fold increase since the number of cancer survivors compared to that time in 1971 when the Warren Cancer Act was first started. The number of patients surviving cancer will continue to increase only through the development of new cancer therapies. The FDA approves new cancer therapies only a rigorous evaluation in clinical trials. It is estimated that it takes over ten years for the development of a new therapy for cancer. This is in large part due to the time required for completion of clinical trials and every new drug or biologic agent to treat cancer must be evaluated through this rigorous phase of clinical trials. The benefit of clinical trials is readily apparent in the field of pediatric cancer. In the last 30 years, there has been a 50 percent increase in cancer survival in all pediatric cancer patients. While the rate of survival in pediatric leukemia patients was less than 20 percent in 1975, children diagnosed with leukemia today can expect a 75 percent chance of surviving their disease. This dramatic improvement of survival from childhood cancer and leukemia is a direct result of improved cancer therapies made possible through clinical trials. Childhood cancers are rare, and as a result, a high number of children diagnosed with cancer ever year are enrolled in clinical trials evaluating new therapies. These clinical trials have advanced pediatric cancer treatment, saving substantially more lives in the past three decades. Unfortunately, fewer than 5 percent of all cancer patients in the United States participate in clinical trials. So most adults are not enrolled in clinical trials. The fear of denial of healthcare insurance of medical care costs is a major barrier to cancer patients participating in clinical trials. Since clinical trials are deemed investigational, health insurance companies often refuse to cover even their routine medical expenses such as doctor visits, hospital stays, and routine laboratory tests and x-rays whenever patients participate in clinical trials or at least that option is open to them. Cancer patients receive routine care and services whether they are enrolled in a clinical trial or not. No patient should be denied potentially lifesaving cancer treatments based on their health insurance providers' unwillingness to cover the medical cost of the routine care. A significant increase in adult cancer survivors could be seen if more patients enrolled in clinical trials, if patients did not have to wonder whether their health insurance would cover the costs of routine medical care in connection with potentially lifesaving cancer therapy. In 2008, almost 300 cancer patients were enrolled in clinical trials at the Nebraska Medical Center and at UNMC. In order to ensure the protection of these patients enrolled in clinical trials, an institutional review board must review carefully every clinical trial that's done at our institution and supervises the management of that clinical trial throughout the entire course of that study. I want to stress to you that each and every drug being developed today to treat cancer in the clinical setting once moved through each of the phases of clinical trials. The studies conducted on these drugs which led to approval by the Food and Drug Administration were possible only because patients were willing to participate in these trials. Nebraskans diagnosed with cancer should no longer be burdened with worrying about insurance coverage for the routine medical costs when enrolling in clinical trials for their treatment of their disease. In closing, I would like to briefly discuss my personal experience as a physician-scientist involved with clinical trials. During my entire career, first in the National Cancer Institute

and now at the University of Nebraska Medical Center, I have witnessed cancer patients with little hope of survival who have had years added to their lives because of their participation in clinical trial programs. All cancer patients deserve the opportunities to enroll in clinical trials that may increase their chances of survival and believe this opportunity should not be limited because health insurance may be denied coverage of routine medical costs associated with clinical trial. I, therefore, strongly support LB378 passage and its requirement that certain insurance policies and benefits plans cover the routine patient care costs related to medical clinical trials. This morning, as I was preparing to come to Lincoln to testify on behalf of LB378, I received an urgent phone call from a physician at the National Cancer Institute in Maryland. He called about a young man living on a farm in Kansas who is only 26 years old and has widely metastatic sarcoma which has progressed on standard therapy. The National Cancer Institute called me to see if we can treat the patient at UNMC on a separate, special clinical trial with a new experimental drug, a brand-new targeted therapy that was specifically designed to inhibit a protein produced by this type of cancer. The new experimental drug has already shown to have dramatic responses in seven out of the first ten sarcoma patients that have been treated around the world. I am now working with the National Cancer Institute to see if we can get approval to treat this young man on a special clinical trial of this new agent at UNMC at the Nebraska Medical Center. While we can get the drug for free for the patient, I sincerely hope his family will not have any problems with other medical expenses associated with his routine cancer care from their healthcare provider; they have enough to worry about. Thank you very much. [LB378]

SENATOR PAHLS: Do we have any questions? Senator Pankonin. [LB378]

SENATOR PANKONIN: Thank you, Senator Pahls, and doctor, thanks for being with us today, and we appreciate that you're in Nebraska and all the cutting-edge work you've done. Obviously, one of the issues of the medical field is that sometimes technology and the movement in medical science is moving so fast and have to balance it with costs. And how do we handle these type of situations? You're getting out there where you can do some wonderful things, but the cost as policymakers. [LB378]

KENNETH COWAN: Sure. So, again, I think 20 of my fellow participants will tell you, there are 25 other states now that have similar legislation providing for the routine clinical care of patients enrolled on clinical trials. We're not asking the state; we're not asking the health insurance companies or anybody to pay for the cost of doing the clinical research. That will be taking part by the pharmaceutical firms developing the drugs and by federal agencies like the National Cancer Institute to actually do the clinical trial work. But in the course of actually treating any person, any patient, with an investigational drug that's not yet approved, there are routine medical costs that are actually incurred by treating that patient. Frequently, these drugs are given, for example, in combination with two or three other drugs that are already approved to treat the

patient for that particular cancer. There are costs, therefore, related to treating...with that other two or three approved drugs or with the x-rays or taking care of that patient with the routine agents that may be part of that investigation that should be taken care of by the healthcare insurance costs that the patient already has. We're not asking the insurance companies to pay for any of the experimental drug, the administration of that experimental drug, or any of the costs of the actual clinical research collecting the data, doing all the safety issues that we have to submit to the FDA to do that. We're not asking for that, but sometimes the language in the insurance plans stipulate that when a patient enrolls in a clinical trial, the rest of the care of that individual may not be picked up. And it's just that fear of not knowing, you know, we see a patient who comes into the clinic every day who may be eligible to enroll on a clinical trial. We spend a lot of time that we don't bill the insurance company or anybody else...we spend a lot of time trying to explain to that patient the risks and the possible benefits of going on that clinical trial. Now, that's not billed to anybody. That's what we do in spite of our clinical research agenda. But if the patient then goes on to clinical trial, they have a few minutes, sometimes a few days, to decide whether they go on that clinical trial or not, and we don't want them to be burdened by the idea that there'll be any additional costs incurred. We take care of all the experimental...we make sure that all the experimental costs of treating that patient are billed into that clinical research protocol. We just want to make sure the patient doesn't have the fear of having the routine costs borne by them if they choose to go on experimental therapy. If we stay today on the standard of care of cancer patients, we'll continue to have 600, 700, 800 thousand patients a year dying from cancer. We will only continue to make progress if we try to test new drugs clinically in patients. We have to get these new drugs being developed by pharmaceutical firms into approval mechanisms, but it takes years of clinical trial work to prove that they're efficacious. [LB378]

SENATOR PANKONIN: Thank you. [LB378]

SENATOR PAHLS: Senator Pirsch. [LB378]

SENATOR PIRSCH: Just to kind of give it a greater clarity in my mind, at least, as what is at issue here. Imbedded within these policies, insurance policies, are essentially clauses that say if you engage in these type of clinical trials and all bets are off, and... [LB378]

KENNETH COWAN: If it's investigational. [LB378]

SENATOR PIRSCH: Right, and investigational, and even services which would otherwise have been covered, then will not be covered. And the question is, is this, I guess, a fear by the insurers that once you start to operate in this area of doing things that they can't, you know, actuarialize that they don't want to take on risks that they don't...can't or haven't understood thus far? Am I correct in saying that's...and maybe I

should be asking them, that's probably better... [LB378]

KENNETH COWAN: I don't mean to speak for the insurance companies... [LB378]

SENATOR PIRSCH: ...but let me...let me say, assuming that that was, in fact it, is it your position then, and I'll ask them to confirm that, that...is your position that when you look at the totality of all the different types of investigative clinical trials that based in your position, you know that really there is no greater risk that envelopes, and actually it might even be safer for the people who do participate in these such that there won't be extra costs for the industry? [LB378]

KENNETH COWAN: That's a very, very good point. [LB378]

SENATOR PIRSCH: Or is your position rather, you know, we're charting new territories. There may be additional risk, but this is such a valuable thing for society as a whole, that repercussions, futures generations down, we should gladly incur these risks. [LB378]

KENNETH COWAN: There are a number of really good points that you made that I'd like to clarify a little bit more. First of all, there's no greater safety to a patient than to be enrolled in a clinical trial. There are so many oversight mechanisms. We have an investigational review board made up of specialists and community laypeople who sit on a review committee that oversees every single protocol, that gets approved by our institution before it gets offered to a patient. There are research nurses, research physicians, that actually are paid for either through the federal government or through pharmaceutical firms to actually do the clinical research that are actually constantly looking at the side effects, the toxicities, all the things that can happen to a patient when they get enrolled in a clinical trial. That doesn't happen when patients undergo routine therapy, so there are a number of actual benefits to patients actually going and getting enrolled on clinical trials. Secondly, as I said, we'll only be destined to have the same results next year or ten years from now in cancer survival if we don't have new therapies being developed. We've entered a realm which we all believe is really going to be...I'm sure we've been saying this for the last 30 years, since I started off in this field, but we always think that the next...in fact, the anecdote I'll tell you that the year I started training 30-some odd years ago in oncology was the first year that a patient was given a drug called cisplatin for treatment of testicular cancer. And it was the first time I saw this disease actually shrink from a chemotherapy agent, and this is the same agent that Lance Armstrong got to treat his testicular cancer 30 years later, and not only is he alive, but he's competing more successfully now than he did before he had cancer. So we're always looking at terms of the new therapies that might be developed. But literally, the human genome project, from about eight years ago, allowed us to look at an entire roadmap of all the genetic defects that can occur in cancer cells. And the cancer institute is now doing a very large, $150 million project to actually sequence the DNA

from DISC cancers. You know, we've sequenced DNAs from normal people, but now from individual cancers, we can now sequence individual cancer cells and determine which of the 25,000 genes in your cells are actually responsible for causing your particular type of breast cancer, not everybody's breast cancer. And pharmaceutical firms actually made literally thousands of drugs that can inhibit each one of these individual genes. We're now in the process of trying to test with these pharmaceutical firms, which one of these agents do have significant activity. One of these agents, Gleevac, five years ago, is shown to have dramatically changed the response rate of a chronic form of leukemia which was universally fatal five years ago, and now there's a 95 percent response rate to this drug, taking a pill once a day as opposed to toxic chemotherapy intravenously. Herceptin, an antibody against breast cancer, 25 percent of all breast cancers, is not chemotherapy. But when you add this antibody therapy, which has no toxicity to standard chemotherapy, it doubles the effectiveness of the chemotherapy. This has happened only in the last three or four years that we find these things out, so we're entering an age where we do think these drugs are going to have a tremendous amount of improvement. And as I say, every one...even a 1 percent increase in survival contributes about a billion dollars to the U.S. economy. And in a state like Nebraska, I'm new to Nebraska, still only ten years here, but we have a lot of relationships across the state through our Cattlemen's Ball that raise a lot of money for Eppley Cancer, a tremendous amount of support. We do feel like we're the cancer center for the entire state of Nebraska, not just for the patients, but to help all the physicians, all the healthcare providers across the state do their job better in a rural society. I've come to appreciate having been raised on the east coast most of my life, I've come to appreciate that a state like Nebraska cannot afford to lose a single person from rural Nebraska unnecessarily. If we can do anything to improve survival in rural Nebraska and keep people in the rural towns, in their rural communities, this state will be much more vibrant ten years from now than it is today, so I'm here on behalf of all the cancer patients across the state and across the nation just asking again for the coverage, for the routine clinical care costs for these patients that they're already entitled to, that will do as part of the clinical trial, but it should be covered as part...if they're not on clinical trial, they're going to get routine care costs, and they're still going to be charged the insurance company. Those patients shouldn't have to decide whether they should enroll in a clinical trial to help themselves and other Nebraskans or whether they should just go to standard therapy and have an X percent chance of surviving that disease for the next five years. [LB378]

SENATOR PIRSCH: So what I hear you saying is that at the very least, it's not going to decrease the odds or the medical costs more expensive or put the patient's life at more risk is what, and by... [LB378]

KENNETH COWAN: Enrolling in a clinical trial should not...should not or you'll hear about one study that's been done by the Rand Corporation which tried to estimate this. It's hard to get a handle on this specific issue, but again, patients are being treated

every day in a standard fashion. They should not be penalized for trying to enroll in a study that is investigating a new agent. [LB378]

SENATOR PIRSCH: Thank you. [LB378]

SENATOR PAHLS: Senator Utter. [LB378]

SENATOR UTTER: Thank you, Chairman Pahls, and thank you, doctor, for being here today. As a cancer survivor myself, some ten years ago, I appreciate very much the work that Eppley does. My treatment didn't happen to be at Eppley but at another university hospital, and I'm grateful for the care. What I think I'm hearing you say is, is that because of the medical supervision and the close control that you have over the participants, are you saying that actually, the cost of care may actually be less because of that not more? [LB378]

KENNETH COWAN: I wouldn't say that the care would be...cost of care would be less, but I would say the safety to the patient, of being enrolled in a clinical trial is much better. The oversight of the patients...that each patient that goes on to a clinical trial is so much greater than what we can actually provide in routine standard care, even in my own clinic. In addition to a research...and to a nurse that helps me take care of patients and a physician assistant that takes care of my standard patients, in addition to that, I have two research nurses, an IRB, a scientific review committee, the National Cancer Institute Review Committee, the pharmaceutical review committee overseeing everything that happens to that patient, if not on a daily basis, certainly on a regular weekly or monthly basis. Any adverse toxicities have to be extremely documented and, therefore, everything is noted in patients on clinical trials. So it's my opinion that patients get much better care when they enroll in clinical trials. [LB378]

SENATOR UTTER: So does that translate then into less cost for an insurance carrier because they were on that trial as opposed to just the routine care that might be provided by their insurance company? Can you say that? [LB378]

KENNETH COWAN: I can't say that specifically, although, again, there's so much...I can't say that specifically. I think that's out of my particular purview. But I don't...it should... [LB378]

SENATOR UTTER: Well, then let me ask this another... [LB378]

KENNETH COWAN: ...it should not cost any more to enroll in a clinical trial. I can't say that it's going to cost less. [LB378]

SENATOR UTTER: Okay, thank you. [LB378]

KENNETH COWAN: Yeah, yeah. It should not cost anything more, because the guidelines have to be so clear on how to follow the patient, that it should be the best standard of care. [LB378]

SENATOR PAHLS: Thank you for your testimony, appreciate that. [LB378]

KENNETH COWAN: Thank you very much. [LB378]

SENATOR PAHLS: And could I have some of you move over to the reserved section, so I'll get a feel, and we'll know who's the next going to be up, that kind of good stuff? [LB378]

RITA POTTER: Good afternoon. [LB378]

SENATOR PAHLS: Good afternoon. [LB378]

RITA POTTER: My name is Rita Potter, and I'll spell it for you, R-i-t-a Potter like Harry Potter. I'm not going to perform any magic tricks, although I wish I could, P-o-t-t-e-r. And I'm here in support of LB378 this afternoon. Many of the statistics provided by Dr. Cowan, and I work for the Nebraska Medical Center. I'm a director of managed care. My experience has...I've been with the Med Center for ten years. Prior to that, I worked 15 years at Mutual of Omaha Insurance Company in the group health division, so I understand...I've kind of heard hat...been wearing multiple hats. But I'm here as a patient advocate, providing not views expressed by the Nebraska Medical Center, but on behalf of a patient. I just want to emphasize a couple of key points to Dr. Cowan's speech that I want to make a specific point about the difference in the patient's access to clinical trials. Clinical trials are conducted with patients to find out whether promising treatments are safe and more effective than those already available. Clinical trials help doctors and researchers find better ways to prevent, diagnose, and treat the disease or cancer. Enrollment in clinical trials is considered a standard of care like in the differences that I want to emphasize today are the differences of enrollment in clinical trials between adults and pediatric cases. Clinical trial enrollment in the peds, for instance, pediatric blood cancer patients resulted in nearly a 90 percent participation rate among children. As a result, the survival rate is more than 95 percent for children with Hodgkins' lymphoma or more than 90 percent for those kids with acute lymphocytic leukemia, the most common form of leukemia in kids. In comparison, there's a very poor participation in adults. The trial participation rate among adult cancer patients is only 3 to 5 percent nationally, and lack of insurance coverage for this routine patient care is cited by many as a barrier to adult involvement. A study provided by the American Society of Clinical Oncology concluded in 2001 that the funding barriers in third-party payer influence was the leading cause of low adult participation in cancer clinical trials. In 2000, Medicare added coverage for this routine patient care in clinical trials to this benefit package for Medicare. Since the change, enrollment in elderly patients in clinical

trials has nearly doubled. Since 1998, 28 states have passed laws requiring insurance coverage for this routine patient care cost in clinical trials. Failure on the part of public and private insurers to cover this cost for routine patient care, not only denies patients the best care available, it also threatens clinical trial system as a whole. And I hope the committee will give it full consideration in support of LB378. I also want to be the patient advocate. I, myself, am enrolled in a clinical trial. I just started with, less than two weeks age, I have multiple sclerosis. And I signed up to be in a clinical study for the benefits of exercise to the patient who has MS. Recently, I've had multiple major falls and I'm like, I've got to do something to prevent and do that. One of the things that clinical trial is paying for in the investigation was checking my heart rates and evaluation, whether I'm capable of doing the exercise therapy. It's not going to...those tests were not sent to the insurance company; they were paid by the clinical trial. It is blood tests that I've never had done before on my annual physicals. Again, it's patient safety that's put in this, so luckily, I have a very good heart. I'm going to be fine. I'm just going to have to endure my exercise therapy for the next six months. But that is what I'm here to support. I just want you to understand the difference between adult and pediatric enrollment in support of this LB378. Thank you. [LB378]

SENATOR PAHLS: Seeing no questions, thank you. [LB378]

RITA POTTER: Any questions? [LB378]

SENATOR PAHLS: You're lucky, we'll let you go. [LB378]

RITA POTTER: Okay, thank you. [LB378]

SENATOR PAHLS: Okay (laugh). Thank you again. Proponents. [LB378]

STEPHEN DREYER: Senator Pahls and fellow senators, thank you for this opportunity. My name is Stephen Dreyer, S-t-e-p-h-e-n Dreyer, D-r-e-y-e-r. I'm a general surgeon in Fremont, Nebraska, and I'm also the Nebraska state chair for the American College of Surgeons Commission on Cancer. The Commission on Cancer is a consortium of 43 different professional organizations, and it has a mission to improve survival and the quality of life for cancer patients by setting standards for services, monitoring quality of care, encouraging prevention and early detection programs, and encouraging research as well. It implements this mission through certified cancer programs at individual hospitals. Nebraska is fortunate to have 11 of these certified programs across the state. University of Nebraska Med Center is one of them; the Alegent System in Omaha; and the Methodist Hospital in Omaha. The Fremont Hospital belongs; St. E's and Bryan are now members of this organization as is St. Francis Hospital in Grand Island; Good Samaritan in Kearney; Mary Lanning in Hastings; Great Plains in North Platte; and Regional West Medical Center in Scottsbluff. So there's a good geographic distribution of these certified programs. What this means is, 90 percent of the cancer patients in the

state of Nebraska are provided care at one of these 11 organizations. This is a voluntary organization to belong to, but it means that you develop guidelines for providing service and evaluating that service that you provide to patients. One of the key features of an approved program are clinical trials. This is very important to the Commission on Cancer because it serves several purposes. Not only do clinical trials create new knowledge as Dr. Cowan has pointed out on how to deal with this disease, but clinical trials also elevate the level of performance of a hospital. The rigorous demands of a clinical trial elevates the performance of radiologists, laboratory people, physicians, nursing. There's a greater demand for high level of services, and we all, as professionals, learn and benefit from this as well. Unfortunately, clinical trial enrollment is low across the state and across the country, and that's because there are significant barriers to enrolling the needed numbers of adult patients into clinical trials. They fall into the general categories of physician knowledge or awareness, patient fears, and cost barriers. We can deal with physician knowledge and awareness through education and by making clinical trials available to physicians and hospitals through national work groups that sponsor these trials. We can counsel patients and educate them on the benefits of them and ease their anxiety. The one barrier we have no control over is cost, and that's why I'm here to support LB378 along with the Commission on Cancer as part of its fundamental mission, to improve survival and the quality of life for cancer patients. We need to be able to enroll more of them, so that we not only come up with better answers, but also provide a better level of care. LB378 has the ability to remove one of these barriers or a portion of one of the barriers and improve access to clinical trials to all Nebraskans regardless of where they're located geographically in the state. Thank you. [LB378]

SENATOR PAHLS: Any questions? Yes. [LB378]

SENATOR PIRSCH: And I appreciate your testimony here today and it's...I guess, if I was to approach this in a logical manner, it would make sense for me to kind of talk with the opponents first and to get their kind of objections. But assuming that that...and I'll ask them about that, but assuming that that is their objection to this, is that we don't have good actuarial knowledge or we fear that engaging in a new and untested type of these clinical trials on an ongoing basis may lead to, in some cases or many cases, bad medical results that end up costing us more. I'm supposing that that is what...an argument they may make, but maybe it isn't. But assuming that that is a correct argument, are there empirical studies or anything that, you know, can...would speak to kind of assuaging that fear that, and I think Dr. Cowan kind of talked about that, but are there any kind of empirical studies that show in the totality...you know, and, obviously, there's a lot of research and clinical trials, investigatory clinical trials that have gone on, but we'd be doing the entire universe which includes things that you've worked on, and every other investigatory clinical trial. And so, for that total universe, I mean, do we have any empirical studies for a sense of, you know, of...of...of well-being that if we were to go ahead and do this, that it wouldn't lead to, you know, more costs and so that the kind

of fears are misfounded? [LB378]

STEPHEN DREYER: In the short answer, probably (laugh). Two things to consider in answering that or viewing that concern. One, most of these trials are phase III clinical trials, which means the clinical trial itself has already been tested to make certain that there's a level of safety for even doing it in the first place. So by the time it becomes a clinical, or a phase III clinical trial, the vast majority of the dangers have probably been worked out of it, the dangers that would lead to bad outcomes, that would lead to more healthcare procedures and treatments and costs. So from that point of view, it probably isn't. It's probably fairly safe to do, and will not lead to catastrophes that would require more expense. Number two, when you look at the 24 states and the District of Columbia that have already enacted this, they all ask themselves the same question about the increased cost. A lot of them had tried to do studies. It's a difficult topic to study because in many cases, you're sort of comparing apples to oranges, treatments for colon cancer are different than treatments for breast cancer, and they're different from lung cancer. I reviewed a synopsis of most of these state studies done, and they were contained in the Illinois State Study of this particular point before they passed the law. The sum of the studies, to the best of their ability, show that there was no dramatic increase in cost. In some studies, there was a slight lower cost or a slightly higher cost. So on balance, so far in these 24 states and the District of Columbia, no one came up with a study that showed a huge increase in costs. There was one study that showed...and when I'm talking about costs, this is the actual cost of treatment, not insurance premium costs, that patients that were treated with standard therapy who had cancer, and this is just an average...this is just a rounded figure from what I remember in the reading, was $63,000. The population of patients in that state that were treated on clinical trials, the average cost per case was $57,000, and when the actuaries looked at that, the difference was not a statistical significance. So to date, none of the states that have studied it and enacted it came up with a study that clearly demonstrated this was a huge financial risk for anyone to do. [LB378]

SENATOR PIRSCH: Great. Thank you for answering that. [LB378]

STEPHEN DREYER: Okay. [LB378]

SENATOR PAHLS: I see no more questions. Thank you. Do we have any more proponents? It really helps if you sit in the reserved section, because that way I know. I may go to opponents faster than you want me to. [LB378]

DALE HARTWIG: (Exhibits 1 and 2) Thank you, Chairman Pahls and the rest of the committee members. My name is Dale Hartwig, D-a-l-e H-a-r-t-w-i-g. I'm a vice president with St. Francis Medical Center in Grand Island, Nebraska. Appreciate the opportunity to visit with you today and actually, I had prepared some wonderful documents to go over with you, but I think based on what I've heard to this point, I'd like

to try and clarify a couple of things. If you or I or anybody that has an insurance plan is diagnosed with cancer, they would go to their physician or probably have a referral from their physician to a cancer specialist. They would then develop a plan of care. They would be treated for that care, and the provider would be reimbursed according to the terms and conditions of that policy. What we are differentiating, and what we are focusing on in this bill, is not to avoid treatment of a patient that may have an insurance plan that has exclusions or carve-outs for what is deemed experimental care. Having that exclusion prevents that patient from even having the opportunity to explore, are there benefits that I would qualify for as part of a clinical trial enrollment? You have heard from incredibly knowledgeable experts that are passionate about their scientific advancement of medical care. That advancement is based on the collection of data, of hard actual data, the result of treating a variety of patients with the same protocols with similar medical diseases. That gathering of that data allows medicine to view, are there advances or advantages in modifying the standard of care? That's how medicine progresses. It is important to participate in clinical trials whenever you have the opportunity, because that's what helps push this along. Now somebody should ask, and you have, is care received in a clinical trial more expensive than care that would be received outside of a clinical trial? And in most cases, I would agree with the other comments, in most cases that's hard to tell. In some clinical trials, the investigational drug or device, is actually provided by the trial sponsor, and so there's no cost to the institution; no cost to the patient; no cost to the insurance. But when you use multiple approaches to treating disease, over time, over aggregate, there can be small variations, but I'd suggest it's not statistically significant. I'm not a statistician. I'm a hospital administrator. As some of you may know, we struggle with some of those numbers. I don't author clinical trials. In my capacity with St. Francis, one of the areas that I work with is oncology, and we have a very passionate medical oncologist. I'm pleased to say that we're an affiliate of the Eppley Cancer Institute. Dr. Sitki Copur, our medical oncologist, is an adjunct faculty, is an associate professor with Eppley. We also are part of an NCI demonstrate project to deliver at a community cancer level, national clinical trials. These are very, very structured. That have been reviewed by teams of scientists, by people representing society. It is a very exact thing to walk through. From time to time, we experience denials in care coverage, and I have a letter that I will submit a little bit later from a patient that came to us with a cancer diagnosis in 2007. Correspondence with their insurance carrier, they understood this patient was eligible to be enrolled in a clinical trial. In the clinical trial, this patient received, at no cost, a pharmaceutical...a chemo-agent that was...that carried FDA approval for what's called a fourth-line defense. That means they would have had to have failed three other courses of therapy with the time and expense involved in those therapies before they would be eligible to receive this drug. This particular trial was put together to study what happens if we use that drug as a first-line. The insurance company understood this. The patient understood this, and in the patient's discussions with their carrier, they understood the care would be covered. Here's the best news. In this particular patient as part of this trial, he went to complete remission. Within nine months, his blood count had no

residual cancer cells. He was on cloud 9. About six months later, he received a letter from his insurance company that said, you know, we've been reviewing your case. We understand you're part of a clinical trial. You have an exclusion for experimental care. None of the reimbursement that was extended to any provider part of your case will be allowed to stand. We want reimbursement, and you are personally eligible for that trial. Well, since then, we have become very careful about how we approach insurance carriers with a patient with potential trial eligibility. We try and precertify them. This isn't an issue, do we code correctly? This isn't an issue, was something missed in that communication? We contact the insurance company and say, we have a patient that may qualify for a clinical trial. With your permission, can we proceed? In the last 12 months, we've had 12 denials...excuse me, in the last 12 months we've had 7 denials. Now when you get a denial, you have the opportunity to appeal that; you have the opportunity to engage with that medical director, or there is sometimes a committee to determine those things. There have been times when we've reversed those denials. The problem is, that with a denial and an appeal and a denial and appeal is the time lag. If you and I were diagnosed with cancer, we wouldn't want to sit around and wait for an appeal of an initial denial; a denial, quite frankly, that was made because there was, can I be enrolled in a clinical trial? Had nothing to do with the cost of care. It was not dissimilar to the movie in 1997 called Rainmaker. Is experimental medicine categorically denied and clinical trials are not experimental medicine. So that's the real world that we live in. I have had two of my in-laws that have been diagnosed and treated with cancer under clinical trials. One of them had an expected outcome in their early nineties. It was...my mother-in-law died within six months; she was expected to live four. She used, after failing everything else, a drug called Taxol. Taxol today, a result of earlier trials, is appropriately incorporated in breast cancer treatment with remarkable success. My father-in-law was diagnosed with leukemia, given four months to live. He enrolled in a clinical trial and lived for a year-and-a-half. During that year-and-a-half, it was quality life. He actually had an opportunity to fish for salmon in Puget Sound which he was stationed at during World War II, so he had...whether you call that a bucket list, his quality of life, his health of life was significantly extended, and he afforded himself and his family the time to prepare for his eventual physical death. Clinical trials are the right thing to do. You'll hear lots of support for that. This bill is to prevent insurance companies from just categorically denying coverage, because it is a clinical trial. They will pay for the same or very similar care outside the trial, so why not in the trial? That way we all benefit. We can take a lose, lose, lose which is the patient loses the opportunity for better care. The trial loses the opportunity to benefit from that patient's enrollment, and future diagnosed patients lose the opportunity to receive care appropriate based on the outcome of the trial to a win, win, win. The patient wins, the trial wins, the future delivery of medicine wins. So respectfully, I request you support LB378. It is the right thing to do. I do have those two letters that I'll submit--one from a patient, and one from Dr. Copur. [LB378]

SENATOR PAHLS: Thank you. No questions. Thank you. Next proponent? [LB378]

DAVID HOLMQUIST: Good afternoon. My name is David Holmquist, D-a-v-i-d H-o-l-m-q-u-i-s-t. I am Nebraska Government Relations Director for the American Cancer Society. Thank you, Chairman Pahls, and members of the committee for the opportunity to testify today. I am here in strong support of LB378, which would assure that routine patient care costs for patients enrolled in clinical trials are covered by Nebraska health plans. Many of the 8,700 Nebraskans--that's 8,700 Nebraskans, who are expected to be diagnosed with cancer this year, will be engaged in a life or death battle. For some, access to clinical trials will offer the best chance for improved survival and/or quality of life, and these patients should not also have to worry about whether or not they can depend upon their health plan to pay their routine patient care costs if they choose to enroll in a clinical trial. I wish that I could give you a clear and succinct definition of "routine medical cost." I believe if you have the flu and you go to your doctor, and you're in a clinical trial, that your insurance may not pay for that doctor visit, because you went in with the flu. Someone else suggested that if you broke your ankle and were enrolled in a clinical trial, that treatment could be denied because you're in the clinical trial. I would call on the insurance industry to answer the question of what their definition of "routine medical care" is. I believe it's the basic kinds of things that you and I go to the doctor for when we are ill and need to figure out what's wrong and make a change. And usually, when a patient enrolls in a clinical trial, the costs of tests, procedures, drugs, and extra doctor visits, and any research directly related to the study itself, are covered by the group sponsoring the trial. And the sponsor of the clinical trial many times with the government, through the Department of Defense, or the CDC, the National Cancer Institute, and others, the American Cancer Society also funds research, we send the research funding out to innovative researchers. The drug that you heard about earlier, Gleevac, was developed by someone who had been funded initially by the American Cancer Society, and I'm proud to say that we have 44 Nobel laureates to show for it. But unfortunately, some health plans define clinical trials as experimental or investigational as you've heard before, and the big concern here is that we can save many, many more lives, and we can have better outcomes for patients living with cancer if we can make the advances that we need to make. And those advances can only be made with better funding from the federal government, from the American Cancer Society and others, and with the availability of access to clinical trials. It's important that patients have the opportunity to have the coverage during these clinical trials. Lack of coverage is a barrier for many patients who might otherwise wish to be in a clinical trial for their cancer treatment. In one survey, 60 percent of patients said they feared having their insurance denied as a major reason for not signing up to take part in a clinical trial. Nebraskans are fortunate. We have many clinical trial options to choose from. We have leading cancer research facilities including Creighton University Medical Center and the University of Nebraska Medical Center. We also have the 11 cancer centers throughout the state certified by the American College of Surgeons as Dr. Dreyer mentioned. There are many new therapies for the prevention, detection, and treatment of cancer and other diseases that are tested through clinical

trials at centers like these. And where centers do not exist, patients still have access to clinical trials through their community physicians. Community physicians play an integral role in getting access to clinical trials for their patients by facilitating enrollment. Cancer patients now need the assurance that the routine patient care cost will be covered by their insurance so that they can take advantage of lifesaving options. Does the American Cancer Society have a horse in this race? You bet we do. Our horse in this race is you and you and me. We want to do everything we can to resolve the problem of cancer, to target the cancer therapies in the best way possible, and these are the kinds of things that can happen with clinical trials. So I urge you to advance LB378 to the full floor for passage this session. [LB378]

SENATOR PAHLS: Senator. [LB378]

SENATOR PIRSCH: Thanks. Just a question about how things are proceeding right now with these investigational clinical trials. Is there a standard operating procedure utilized by all the insurers or is it piecemeal? One insurance company does...covers it all even through the investigative clinical trials whereas a different insurer says, well, when you start to do this, it will kick off and then...but after you're through, at some point in time, there's a trigger date that will kick back on? Or what...if you can comment on that, if you know. [LB378]

DAVID HOLMQUIST: I can't answer specifically. What I can say is that I understand some insurance companies are covering patients for routine medical costs when they're enrolled, and other insurance companies are not. I think that a level playing field that would allow for more access would be the optimum suggestion. [LB378]

SENATOR PIRSCH: Um-hum. But you don't know a percentage in Nebraska of 90 percent are kicking it off when this... [LB378]

DAVID HOLMQUIST: I do not. I'm sorry. [LB378]

SENATOR PIRSCH: ...okay. Do you know what the ones who are turning it off, or I don't know, is it a permanent turnoff? You engaged in this so essentially, you ended it or it's just until some point in time, when we'll pick you back up again, we'll call this investigational clinical trial over, and then we'll start taking care of your routine coverage again, but that is when this condition is met. What would those conditions be? [LB378]

DAVID HOLMQUIST: My understanding is that, for example, a patient agrees to enroll in a clinical trial and begins the trial, and then learns through his physician that the coverage for routine care has been denied. They simply walk away from the clinical trial which means they may be walking away from a better treatment outcome and maybe walking away from a better quality of life outcome. [LB378]

SENATOR PIRSCH: So most times it really doesn't...it's not an issue because people walk away... [LB378]

DAVID HOLMQUIST: Yes, not...not... [LB378]

SENATOR PIRSCH: ...it's a big deterrent. [LB378]

DAVID HOLMQUIST: That's my understanding, yes. [LB378]

SENATOR PIRSCH: Okay, very good. Thank you. [LB378]

SENATOR PAHLS: Seeing no more questions, thank you. Proponents? I see we have the last proponent. Thank you. [LB378]

BRUCE RIEKER: (Exhibit 3) Chairman Pahls, members of the committee, my name is Bruce Rieker. It's R-i-e-k-e-r, vice president of advocacy for the Nebraska Hospital Association. On behalf of our 85 members, we support LB378. I will not go through our prepared written testimony, but just try and make a few comments as I have observed the testimony so far. We've had lots of discussion about the merits of clinical studies, their safety, their costs, their benefits. I think that's all important. However, it seems that the issue is much more basic. It's about choice. It's about what sort of situation we are putting the individual in who has health insurance, who may have the opportunity to participate in a lifesaving clinical treatment or a quality of life enhancing clinical treatment, but they are faced with the precarious situation. The catch-22 really, we're putting individuals in a catch-22 situation with the current dynamics that they have to choose the possibility of going through that clinical trial or the possibility that their insurance company may deny coverage for a broken arm, for flu, if they're involved in a car accident. I could give you all sorts of scenarios, but if they're involved in a car accident, maybe the insurance companies would choose to pay for the trauma that was incurred. I would speculate that there would be several tests to determine whether or not the clinical trial exacerbated the situation, whatever it may be. But we're asking individuals who have purchased insurance, and as Senator Pankonin said in the testimony on the previous bill, whether it's purchased through a group plan or an individual plan, they purchased this to manage their risk, and I understand that there's a risk management perspective from the insurance company's situation as well. But we're asking people to make that choice, not knowing what may come, but they're exposing themselves to a great degree or potential liability with healthcare costs. If they make that choice, and their insurance carrier does not pay for their routine costs, and something extreme happens or minor, more than likely, either their treating physician, their family physician, or if it's more extreme, if they come to one of our hospitals, there's a good chance that that's going to turn into uncompensated care that we provide or undercompensated, because they don't have the insurance to pay for that. We read all the time; we hear about the rising costs of healthcare. We're very much aware of that

from a hospital perspective, but there is a cost associated with this. And if they...we see often that bankruptcies...I mean, these individuals may be forced into a financial hardship. If it's extreme, they may be forced into a bankruptcy, so I think we need to take a closer look, not just at the clinical trials and the pharmaceutical companies and the insurance companies, but the patient that's truly the focus of this. From a hospital perspective, if they do come to our hospital, and we provide uncompensated care, that's part of our nonprofit mission. We know that, but I also want to point out to the members of the committee that those costs...hospitals have to have a return on their investment. I know we're nonprofit, but in order to keep the doors open, we have to have a return on our investment. Somebody will pay that cost. So I just want to point those out to the members of the committee. With that, I'll close my comments and urge you to support and advance LB378. [LB378]

SENATOR PAHLS: Yes. [LB378]

SENATOR PIRSCH: I'll just ask you, because you're the last proponent and... [LB378]

BRUCE RIEKER: I'm the cleanup hitter, huh? [LB378]

SENATOR PIRSCH: ...might not be appropriately addressed to you, but I mean, do you know how big of a problem this is in terms of percentage? Will it shut off in routine coverage when they engage in these type of investigative clinical trials? Is it a majority of the insurers who have these policies, who say...is it 95 percent or is it more like 5 percent of insurers, insurance coverage that shuts off? [LB378]

BRUCE RIEKER: I'm not capable of answering a percentage question or something like that. I would defer to some of the previous witnesses, but maybe to the actuaries and the insurance companies. But depending on what type of clinical trial it would be, the extent of it. I'm sure that there are many factors that go into consideration when they decide where and when to cut off that coverage. [LB378]

SENATOR PIRSCH: You bet, and maybe if I can just, on an ongoing basis, invite those who may have possession of that knowledge to personally get in contact with me. [LB378]

BRUCE RIEKER: You bet. [LB378]

SENATOR PIRSCH: Thank you. [LB378]

SENATOR PAHLS: Seeing no more, thank you. [LB378]

BRUCE RIEKER: Thank you. [LB378]

SENATOR PAHLS: Think that ends our proponents. Opponents, just again, I'm going to ask you to move forward so I have a feel. How many hands do I...four, five. Okay. The floor is yours. Thank you. [LB378]

TIMOTHY MERGENS: Thank you. My name is Dr. Tim Mergens. Timothy, T-i-m-o-t-h-y Mergens, M-e-r-g-e-n-s. I'm medical director for United Healthcare located in Omaha, Nebraska. And I sit here representing United Healthcare in opposition to this bill just on the basis that I feel that it's not needed, and let me explain. I've been with United Healthcare for a little over eight years and during those eight years, United Healthcare has had a policy in place that allows for coverage for routine care under certain conditions for cancer clinical trials and other clinical trials subject to certain limitations that are designed around patient safety. Unfortunately, I don't have them memorized so I'll probably have to read some of this from our policy which is a public document. We do cover the routine patient costs, and we do have a definition of what those costs are, that address clinical trials for the treatment of cancer, cardiovascular disease, surgical, musculoskeletal disorders of the spine, hip, and knee, and other diseases if they meet the qualifying criteria. The benefits include reasonable and necessary items and services used to diagnose and treat complications arising from participation in the qualifying trial. So in addition to that, we have a policy in place that covers complications of other even noncovered services. The benefits are available for clinical research that is for treatment, so we do have an exclusion in our regular policy for preventive clinical trials. We really are trying to focus on those treatments, phase III clinical trials, that are advancing treatment, particular in the area of cancer. Routine patient care costs for clinical trials include those services defined in the members' benefit plan as covered health services that are typically covered in the absence of a clinical trial. So routine care for a proven service that would be covered would be covered under a research trial for an alternative drug, for instance. Certain kinds of treatments are not considered routine covered costs under a clinical trial, and these would be things that are clearly experimental. The only exceptions to that are certain, what are called category B devices, certain promising interventions for patients with terminal illnesses, so we do have an exception process to consider treatments outside of phase III clinical trials when they show promise, and it is for the treatment of patients that are otherwise terminally ill. We further create certain boundaries around this coverage, again, for patient protection purposes. As Dr. Cowan has alluded to, many of these research protocols that are in operation in Nebraska today are sponsored and overseen by the National Cancer Institute and the NCCN of which the university is a participant. We do require that these clinical trials be sponsored by the NCI, the CDC, the agent for healthcare research and quality, or CMS, or through the defense department or the VA for their protocol oversight. That is in addition to what is in this current bill recommendation oversight by the IRB. We believe this adds an extra layer of patient protection and structured protocol to ensure that it's an appropriate trial for our members to undergo. With that, I'm just going to summarize a couple of additional points. Much of our discussion this afternoon has been around cancer. The proposed bill is not a cancer

bill. It is a clinical trial bill, and there's not definition around what types of research protocols would be covered or included under this; it's ambiguous in that area. I will tell you that from United Healthcare's perspective with our national presence and our ability to view our experience over many years, we have not found significant cost differentials between covering routine care under clinical trials versus outside that. So I think the cost question within this coverage is a moot point. However, to the extent that other clinical trials could get covered under this legislative bill that are not overseen by the National Cancer Institute or other organizations that I mentioned, this could add additional costs and patient safety issues that really aren't addressed in the bill. On an added note, within the language of this bill, there is discussion about who the provider of that service can be. It's a very vague language talking about a licensed provider operating within their scope of practice. Our boundaries replace for this coverage, really specify that a physician is in charge of that clinical research, again, for obvious purposes. And I think with that, I'll stop there and entertain any questions. [LB378]

SENATOR PAHLS: Senator Pankonin. [LB378]

SENATOR PANKONIN: Chairman Pahls, thank you. Doctor, thanks for testifying today. A little confused, you don't think the bill is needed yet you talk about, well, maybe for cancer there's some things that could be done. I guess I'm curious, is your company willing to work with the committee and the introducer to make it a better bill or you just don't think it's needed at all, or? I mean, I understand if it applies to a broader set of circumstances than cancer. Well, maybe if we limit it to a defined cancer situation, is it applicable then? [LB378]

TIMOTHY MERGENS: I can only really speak for United Healthcare, and my experience in these eight years is that the way that we approach this to ensure that United Healthcare is a good supporter and sponsor of clinical trials while creating an environment for patient safety has worked well. We want to encourage clinical trials; we want to participate in supporting those. And the current policy that we have in place allows for that to occur and occur in a manner that we, frankly, don't have to get into the details of what that trial is. It's overseen by others outside our organization. It meets those protocol requirements, and so I think that really is just an unnecessary mandate at this point. [LB378]

SENATOR PAHLS: Senator Utter. [LB378]

SENATOR UTTER: Thank you, Chairman Pahls. Doctor, can you give me some kind of an idea, in your company at least, or as far as Nebraska is concerned, either way you want to do it, of what percentage of people would apply to participate in a clinical trial do you approve, or what percentage do you turn down, however you want to say that? [LB378]

TIMOTHY MERGENS: It's a good question. I don't have an answer for it, and the reason is, is that because we have this protocol in place, we don't do precertification. As long as the trials meet the criteria in this policy available to our contracted providers, we don't go through any precertification process. It's just covered. [LB378]

SENATOR UTTER: Well, I...and I hear what you're saying, but I thought I also detected in your earlier testimony that there were a lot of loopholes, that there was a lot of criteria that your company has as to when they approve and when they don't approve. And is that approval process done after the trial, and you ask your insured to return the money that you've paid? When is that decision made as to whether or not you're going to approve that patient participating in that clinical trial and when you're not going to approve it? [LB378]

TIMOTHY MERGENS: Yeah, it's a good question. And, again, the criteria are spelled out in our policy, and so we don't put providers through a process of precertification to try to tease that out. We will entertain those requests, and if they're asked for on an expedited basis, we can answer those in 72 hours, so there isn't any significant delay in patient care. [LB378]

SENATOR UTTER: I really would be interested in knowing what percent you approve, what percent you... [LB378]

TIMOTHY MERGENS: Yeah, actually, I would like to know at least on a national basis, what percentage of trials United Healthcare has participated in. [LB378]

SENATOR UTTER: Thank you. [LB378]

SENATOR PAHLS: Senator McCoy. [LB378]

SENATOR McCOY: Thank you, Chairman Pahls and thank you for your testimony this afternoon, Doctor. I would be curious to know the percentage of Nebraskans that you insure? Do you know that? [LB378]

TIMOTHY MERGENS: Yeah, I can give you a rough estimate. United Healthcare has policies for commercial insurance both self-funded and fully-insured. We participate with the state on a Medicaid product in three counties plus a variety of Medicare products, represent about 250,000 Nebraskans. [LB378]

SENATOR McCOY: Thank you. [LB378]

SENATOR PAHLS: Seeing no more questions, thank you for your testimony. [LB378]

TIMOTHY MERGENS: Thank you. [LB378]

SENATOR PAHLS: Next opponent? [LB378]

JACK MILLS: Senator Pahls and members of the committee, for the record my name is Jack Mills, J-a-c-k M-i-l-l-s. I am here representing BlueCross/BlueShield of Nebraska. Our medical director could not be here today nor could our legal counsel who could explain some of the issues that have been brought before you. Let me share with you that we are, of course, supportive of Eppley Cancer Institute. We're supportive of those tests and processes that have brought all of us better lifestyle, and so I want to lay that out. We're not here being negative toward the idea. Let me do share with you, though, an answer to a question brought to the former witness. We have about 660,000 people carrying the Nebraska BlueCross/BlueShield card, and we have about 2,500 employer groups. Now, one of the discussion points that was brought forward here before is when you look at this bill as it starts, notwithstanding section 44-3131, that's the ERISA group. Of our group, and we look at 600 and some thousand, and if you look at 40 percent of those are fully insured, there's a lot of them who may not fit into this area. So there may be some times when there have been some denial of coverage of routine coverage because that...all we are, what we call ASO...administrative services only. We administer the program that this company has. But that...I just want to bring that out to you is that, we're just not saying no, we're not doing it. I talked to our medical director today, and he laid out some great ideas as was laid out to you by the proponents of this bill. He indicated, he thought we do need a preapproval just because of some of the issues that I brought for you. We are looking for language. I want to pledge to you, and my testimony will be very brief, that we will work with Senator Gloor and the members of the committee to perhaps make this a better bill. Our legal counsel tells me that they have looked at examples in other states that they think are excellent examples. I also can tell you that we will bring forward our medical director, someone from our legal staff, and I'd like to call upon Dr. Allan Korn, who is the medical director for BlueCross/BlueShield of the association. We have in that group about 100 million insured, so this expands as United does across the United States, and this issue is not just to Nebraska, but is across the country. We're here to assist. I had to testify in a negative position, because I didn't want to come here positive to saying yes, this bill is what we need. We would like to...we believe there are some needed amendments to this bill, and I would like to bring our folks forward to work with you, Senator Pahls and the committee, and certainly Senator Gloor, the introducer, see if we can make this a better thing. We believe that they could favor a law that would help here. That ends my testimony. I'm a generalist. I'm chairman of the board of BlueCross/BlueShield. I'm not one of these very well-educated physicians who bring forward the specifics, but I understand something about our budget. We just passed a $2.2 billion budget. I understand about...that was just for Nebraska. I understand that we pay back about 92 cents of every dollar in claims. I understand that we're a mutual, not-for-profit company. Those are things I work with. I'm just here to substitute a bit, but I am here to help bring this together and see if we can make a better bill out of it. [LB378]

SENATOR PAHLS: So we're just supposed to take it from you that you'd be willing to work with Senator Gloor. [LB378]

JACK MILLS: Of course, I am. [LB378]

SENATOR PAHLS: Okay. [LB378]

JACK MILLS: Well, and I'll bring people in, not just me. [LB378]

SENATOR PAHLS: I understand where you're coming from. Okay. Thank you, appreciate it. Good afternoon. [LB378]

JANIS McKENZIE: Senator Pahls, members of the committee, for the record, my name is Jan McKenzie spelled J-a-n M-c-K-e-n-z-i-e. I'm here testifying in opposition to LB378 this afternoon for the Nebraska Insurance Federation, and I will be very brief. I just want to clarify again for the committee's sake what few of you are sturdy and strong and hanging in here this afternoon. This insurance industry is an industry; it is not a thing, a place, a building. It is multiple companies, some in Nebraska, many outside Nebraska, who are in business just like the hospitals are in business whether they're profits or nonprofits. People shop around, and people shop around for insurance, so when you hear the Blues say that they cover 2,500 company groups, those are company groups who choose to buy a product that BlueCross/BlueShield writes. Coventry, who sat in this chair, likewise works with individuals or groups or small groups to market their products. So I listened to many of the testifiers here today say, the insurance companies. Well, the insurance companies produce products that consumers buy, and they work with company groups or employer groups to create products that they want. Many of the groups you heard from today who are in favor of these mandates are self-insured themselves. So my question would be, are they covering the things they're in here asking other Nebraskans to cover? And I think they should go back and check as well, because it sounds good to say, everybody should have this. But in reality, only 20 to 25 percent have to get and pay for the mandate in their policy whether they choose to or want to, wherein, in fact, their group...I will tell you the university is self-funded, so my guess would be that UNMC is self-funded. They don't have to cover this if they're an employee of UNMC or the university. What I...I would have to cover it under my policy. So it is a business. There are many products; there are many companies competing in it, and it isn't as it sounds--one thing out there that decides like government what people will get. There are many, many choices, and people can shop around. I'd answer any questions you might have. [LB378]

SENATOR PAHLS: ...out shopping? (laughter) [LB378]

MICK MINES: Chairman Pahls, members of the committee, for the record, my name is

Mick Mines, M-i-c-k M-i-n-e-s. I'm a registered lobbyist here representing the National Association of Insurance and Financial Advisors of Nebraska--NAIFA-NE. NAIFA opposes this legislation. By the way, we have 1,100 members throughout the state, and we are the front line. Our members are responsible for selling insurance to that 25 percent of the population that will be on the receiving end of this mandate, and those individuals, like myself, are small businesses; we are small groups. And this mandate would affect us, doesn't affect those self...those that are self-insured. And in our organization, our position is that anything that is a requirement or a mandate that increases costs and the delivery of service to our customers--I guess I heard someone earlier say they were a patient advocate. I'm a consumer advocate. The consumers that purchase the products from our membership, and we would oppose this bill and ask you to indefinitely postpone. Thank you. [LB378]

SENATOR PAHLS: Senator Christensen. [LB378]

SENATOR CHRISTENSEN: Chairman Pahls, thank you. Senator Mines. [LB378]

MICK MINES: Yes, sir. [LB378]

SENATOR CHRISTENSEN: If these are routine things that are typically covered, if they're not using a experimental drug, then what's the difference here? Why the increased costs? Why anything different here? If they chose not to use experimental, you'd be paying for it, so where's the added cost? [LB378]

MICK MINES: I presume, if it's experimental, that as a small group or small individual, I have that choice. I have the choice whether or not to use that service. In this legislation, it's a mandate; it's a requirement, and mandates and requirements come associated with higher costs, and our membership opposes that. [LB378]

SENATOR CHRISTENSEN: Thank you. [LB378]

SENATOR PAHLS: Seeing no more questions, thank you, Senator. [LB378]

MICK MINES: Thank you. [LB378]

SENATOR PAHLS: Next opponent? [LB378]

RON SEDLACEK: Good afternoon, Chairman Pahls and members of the Banking, Commerce and Insurance Committee. For the record, my name is Ron Sedlacek. That's spelled R-o-n S-e-d-l-a-c-e-k. I'm here today representing the Nebraska Chamber of Commerce, and in opposition to LB378, and we have already entered our opposition to a previous mandate bill, and we will continue to do so. We don't represent insurance companies, the insurance industry, insurers in general. Our state chamber does not

represent agents and agent groups. Rather, we are representing businesses as consumers; businesses as consumers of employer provided group health insurance as well as self-employed business people who are purchasing their individual coverage. These are people that have not yet migrated to ERISA programs, and as previous testifiers have mentioned, that is a fact that this continues on. Other products, particularly those which are products which offer the federal preemption, which these mandates do not affect, are...continue to grow. We represent over 90 local chambers of commerce, many of whom still attempt to provide some group health insurance coverage for their business membership. We represent over 50 statewide trade associations, generally of a business nature, many of which now are on ERISA plans. Some do offer group programs. So kind of setting the scenario as to our motivation, we used to as a state chamber offer group coverage for our membership. We no longer do so. We haven't done so now for close to a decade, because we could no longer be as competitive as to the choices that are offered in the market and the self-funded plans had made a difference. So we don't have any particular self interest either in regard to the legislation and as a purveyor of a product. So we're speaking truly on behalf of these businesses who have no other choice, no other place to go but with group or health insurance coverage. And it's not because of the particular issues involved. Over the years, we have had a steady policy opposed to mandated insurance benefits to try to keep products affordable and available regardless. And our position is based on the fact that we want to ensure continued healthcare access for employees of our business membership. Every mandate we've seen is always well-intentioned, no question about that. But it continues to be nothing more than a mandate. I was surprised when my daughter just recently graduated from college and is searching for a job, and now I had to purchase individual policies for her, and that's fine. I was really surprised at the costs. And the fact that she's not in Nebraska but in another state who just happens to have a longer list of mandates now than Nebraska, it's considerably more than if she were here in Nebraska. There is a difference, and it's only pennies here and a few cents there. But...and we may have the ability to cover, but there are others that don't. And that's what we're concerned about here too, and I think you should be. I think there has been some offer to the committee to work on legislation, and it might be a good idea to take that up, if that's possible. I'd encourage that, but we still find ourselves in opposed position in that regard. And I thank you very much, and be happy to answer any questions. [LB378]

SENATOR PAHLS: Seeing no questions? Thank you. [LB378]

RON SEDLACEK: Thank you, Senator. [LB378]

SENATOR PAHLS: I think we're finished with all of our opponents. Do we have any in the neutral? If not, Senator, the floor is yours. [LB378]

SENATOR GLOOR: Thank you, Mr. Chairman. I want to thank Senator Christensen for

hitting the nail on the head as is clear. Mr. Mines and Mr. Sedlacek are intelligent individuals who deal with a lot of complex issues, but even they still have missed the point which is, their insurance companies and their employers are paying for this anyway. That's what's frustrating about this whole process and the reason that running a hospital and running into this on occasions, it seemed to me sort of commonsensical that I would try and address it when I came down here. To make sure we understand, Senator Utter and his treatment, if he had been taking two pills every day with a little radiation therapy, and that had been going on, comfortably paid for by your insurance company for a month, and then you decide to go into a clinical trial that now adds one more pill, it's all off the table potentially. Even though the routine care was something that nobody had any problem paying for, now that it's combined with a clinical trial that involves one more pill, it won't be covered. And what we're trying to do is rectify that noncommonsensical approach towards things. St. Francis Medical Center was part of a large self-funded organization. And we sitting down with our plan administrator, major insurance company, had a hard time making that transition with that plan administrator. For the same reasons that we sit here today and spin our wheels on some of this, even they had a hard time understanding what we were trying to do. We want to cover what we would have covered anyway, and it is so built into the bureaucracy of how the third-party administrators operated, that it got hard to pull out. I am very appreciative of Mr. Mills' offer to sit down and work through this, but I also temper that, understanding that 25 of our 50 states have had to mandate this. And there are another four that have this teed-up. Working through the bureaucracy on this has required...and has, I think, resulted in a lot of discussions where people try and come to a commonsensical approach and could not, and eventually have to mandate it. Perhaps we can come up with a very commonsensical bill that will accommodate it. There is a bureaucracy that's hard to overcome when it comes to changing something that has been in place for a long period of time, and therein lies some of the frustration. Some of the same insurers who have testified here today do not have any problem providing this coverage in some markets of the state, but don't do so in other markets of the state. Why is that? It doesn't make any sense to me, but it's part of the process when you get involved in a bureaucracy. And I don't mean bureaucracy in a negative sense. I ran a bureaucracy in a hospital. It's just the reality of large organizations and how they operate. One of the insurers that talked here today, I bought an insurance policy from with a network that I found out had expired three months before. Six months after it expired, it was still a network that you called up on the computer with their marketing information, and I'm supposed to get comfortable that a cancer patient will be able to navigate through all this with a simple phone call? I don't think so when the marketing information isn't even accurate with some of these insurers. We are trying to make it as clear as possible by mandating coverage for routine services as a result of clinical trials. Thank you very much. And I'd be glad to answer any final questions, if you have any energy. [LB378]

SENATOR PAHLS: (Exhibit 4) Well, I just think that it's been pointed out to you, people are willing to work with you, and let's see if we can't get...touch base on that. If not, we

thank you, and that concludes the hearing on (LB)378. We'll let them shake out a little bit. We are ready to start the next hearing, so I'm going to ask you to help us out a little bit if you are finished with us, not that I want to chase you out. Okay, we are now starting the hearing on LB493 by Senator Karpisek. We are ready. [LB378]

SENATOR KARPISEK: Thank you, Chairman Pahls and members of the Banking, Commerce and Insurance Committee. My name is Russ Karpisek, R-u-s-s K-a-r-p-i-s-e-k, and I represent the 32nd district in the Legislature. I realize it's late, and I will try to be brief. I will ask the proponents to be brief and the opponents not to testify at all (laughter). Give that a try (laugh). I'm here today to introduce LB493 which would require insurance coverage for single or bilateral cochlear implants for persons diagnosed with severe to profound hearing impairment. Our own Boys Town here in Nebraska has a national research hospital that began its cochlear implant program in 1991. Since that time, about 250 children and adults have received implants there. That is over 17 years. That averages roughly 15 per year, and that is at a national research hospital. It's about 50/50 also on people that are children or adults that have been served there. Boys Town's criteria for cochlear implant candidacy currently for children, that they have to be at least age 12 months or older, bilateral severe profound hearing loss, limited benefit with appropriately fit hearing aids, lack of progress in auditory skill development, no physical constraints for placement of the implant using a CT scan, medically cleared to undergo surgery, and realistic expectations and commitment to follow-up appointments. My point is, that not just anyone hard-of-hearing is a candidate for a cochlear implant. Senator Schimek introduced the same bill last year as LB825. I noticed that that bill had no fiscal note, but LB493 does have $75,000 for the University of Nebraska for FY '09-'10 and $82,500 for FY '10-'11. At the bottom of the fiscal note, I would like to point out that it says that additional costs could be paid from other fund sources than General Funds. There is no fiscal impact for the state because state employees' health insurance plans currently cover cochlear implants. I feel that if we feel that our employees deserve this benefit, shouldn't we make it that the rest of the citizens of the state should also enjoy this benefit? With that, I would be glad to answer any questions that you may have. There are people behind me that are much more smarter than I am on the subject. [LB493]

SENATOR PAHLS: I see no questions. Are you going to stay here for the closing? [LB493]

SENATOR KARPISEK: I will. [LB493]

SENATOR PAHLS: Okay. Just so I can get a feel...again, if you do not plan to testify, but you do want to have your name, there's a sheet over there that we let you sign in. Now for those of you who are going to testify, we do need a sheet in here, and I'm trying to find out, how many proponents do we have? I see one, two, three, four, five. Okay. You may begin. [LB493]

KEVIN FRIES: (Exhibits 1 and 2) Thank you, Chairman Pahls and members of the committee. My name is Kevin Fries, K-e-v-i-n F-r-i-e-s. I'm from Grand Island, represented by Senator Gloor here. I'm here on behalf of my son, Grayson, and our family and our struggles with cochlear implants. I've been asked to go first, or I've asked to go first so I can get back to a wrestling meet for him. So I'll be very brief here. But my son's example is a good example of why LB493 is such an important bill to be passed here, or to be moved on to the floor for you guys. Grayson, at the age of four years old, was deemed to be profoundly hard-of-hearing. At that point, Boys Town National Research Hospital elected to do a cochlear implant for him, and we had great success with that implant. At that point, our insurance provided through our employer, did cover implants, and we moved forward with that surgery, and everything was going great. About a year later, he received a contusion on the implant site and infected, MRSA staph infection. The only way to clear up that infection was to remove the implant completely, and let that infection heal up. Once his infection was healed up, Dr. Lusk, who you'll hear testify later, agreed that it was in the best interest of Grayson to have another implant put in place. However, in that three-month lag time for that infection to clear up, our employer had switched insurance companies. The new insurance company did not cover cochlear implants or any follow-up appointments on that. From there, we went through the process of appealing through the insurance companies, appealing through the State Department of Insurance, obviously, with no luck. Through the efforts of Boys Town and through the provider of the original cochlear implant, they did grant Grayson the ability to have a new implant in place. They paid for the surgery and the device. So that was obviously something that we worked on on our own to have him reimplanted and have him move forward from there. At this point, Grayson is able to be fitted for a bilateral implant. Just for a little reference, obviously, when they originally do a cochlear implant, they do one ear, bilateral would be for both ears, so it would be like hearing in stereo versus hearing in mono. However, obviously, the insurance company will not provide that for us at this point, because they do not cover cochlear implants. Our option is, we currently pay $900 a month for healthcare coverage through our employer to have regular healthcare for the family. Our only option is to go through the Nebraska CHIPS program, have Grayson covered under that program which would incur us about another extra $90 a month. Obviously, we don't want to be in a place where we have to have a government-type program, but we're willing to do whatever it takes for Grayson in order to get up to speed. In your packets, there's a bunch of information about statistical data and Grayson's progress through his deaf educator and speech pathologist and things like that. Also, the Grand Island Independent was gracious enough to run an article, and that's also included in your packet, so with that, I'll answer any questions that you guys might have. [LB493]

SENATOR PAHLS: Are you going to see him wrestle tonight? [LB493]

KEVIN FRIES: Yes, sir (laugh). [LB493]

SENATOR PAHLS: Okay, so that's. Do we have any questions? If not, we'll appreciate your material and have a safe trip to Grand Island. [LB493]

KEVIN FRIES: Thank you guys, very much. Thank you. [LB493]

SENATOR PAHLS: Good evening. [LB493]

KATIE ARBATAITIS: Good evening. My name is Katie Arbataitis and I'm a speech language pathologist who has had the privilege of working with children who have cochlear implants as well as their families. I have joyfully observed as communication skills have grown, and children and adolescents have gained independence, and were more readily able to interact with their typically hearing peers and our society at-large. Before we are even born, we are listening to the world around us. By the time you're born, you've already begun the process of language learning. When a child is unable to hear, every day that they are unable to access sound, is a day that they are not gaining important information about spoken language. By nine or ten months, a hearing baby can already demonstrate the understanding of many spoken words such as the name of their family members, favorite foods, toys, common events, routines, and by 12 to 15 months, first words are emerging. By his first birthday, a child who is deaf has already missed out on countless learning opportunities that can lead to the development of spoken language, and until he has a tool to access sound, these missed opportunities will continue. Due to advances such as newborn hearing screenings, changes in hearing technology, family education, and the improved quality of our educational intervention programs, persons with hearing loss now have a greater chance to listen and speak. Specifically, cochlear implants are able to provide individuals with improved sound detection capabilities which can increase the potential for improved speech understanding and production. According to the Alexander Graham Bell Association for the Deaf and Hard-of-Hearing, benefits for most users include sound awareness, environmental sound recognition, enhanced speech reading abilities, improved speech production, and the ability to understand speech without speech reading. Today, advances in implant technology enable more children to maximize these benefits and develop listening and spoken language skills. In a study by Asperger, et al., children who were profoundly deaf were assessed both pre- and post-operatively after cochlear implantation. Before they received that cochlear implant, very few of these children were able to demonstrate the following simple auditory behaviors, but only six months post-operatively, dramatic improvements were noted on all four behaviors including the ability just to respond to their own name in a quiet situation, responding to their name in a noisy situation, alerting to an environmental sound such as a phone ringing, a horn honking, and the ability to discriminate speech from nonspeech sounds. It is important to remember that the four changes I just talked about occurred after only six months of use of a cochlear implant. So I'm just going to take a brief moment to discuss some of the changes that can occur over a greater period of time, given the appropriate support

from caregivers and service providers. Results from Project Hope indicated that children with severe to profound hearing loss with more than two years' cochlear implant experience, are able to move out of a special education classroom and into a mainstream setting at twice the rate of their age-matched peers without a cochlear implant. And that children who utilize cochlear implants are placed less frequently in self-contained classrooms and use fewer hours of special education support. Further, research by Spencer has demonstrated that the educational attainment of children who use cochlear implants tends to follow that of their parents, and that they are able to read within one standard deviation of their normally hearing peers. It is important to consider what Carol Bloomquist Traxler discovered, and she reported the median reading level of a deaf high school graduate is essentially the fourth grade level. Finally, as reported by Spencer and Tomlin, a review of multiple studies shows that children who receive cochlear implants reveal that they are able to gain access to spoken language. This access is associated with higher levels of speech intelligibility or how well they can be understood by others, better vocabulary skills, better language skills than their peers with profound hearing loss who do not wear cochlear implants. Further, as they state, on the premise that reading skills are influenced by spoken language skills, investigators have likewise begun to document increased reading comprehension at the word and paragraph level in children who use cochlear implants. I have discussed just some of the positive changes that can occur secondary to the use of cochlear implants, but there's really no adequate way to briefly summarize the benefits that may be gained when an individual has the potential to develop listening skills and oral language. Consider your daily life and how much of it depends on your hearing and your speaking, reflect on the joy you receive from hearing your child's first words, a favorite song, or the voice of a loved one. Contemplate the complexity of just many simple life situations if you are unable to rely on your own voice and your own words. I ask that you think about these things as they relate to your own life as you are contemplating this decision that can impact the lives of so many others. Thank you for your time. [LB493]

SENATOR PAHLS: May I have the spelling of your name? [LB493]

KATIE ARBATAITIS: Yes, I'm sorry. Katie, K-a-t-i-e Arbataitis, A-r-b-a-t-a-i-t-i-s. [LB493]

SENATOR PAHLS: I'm going to call you Katie (laughter). [LB493]

KATIE ARBATAITIS: That's a good idea. That's what the kids call me (laugh). [LB493]

SENATOR PAHLS: You work in the public or private schools? [LB493]

KATIE ARBATAITIS: I actually am a private practice speech pathologist. [LB493]

SENATOR PAHLS: Okay. Have you ever worked in a public school? [LB493]

KATIE ARBATAITIS: I have previously worked in a public school. I have also worked in a hospital setting as well. [LB493]

SENATOR PAHLS: Okay. I'm just curious because, and I know it would not...to the early years. But do schools, do they not provide some type, and I'm going to use the word, "devices" for children with hearing issues? [LB493]

KATIE ARBATAITIS: In this instance, no, not as it relates to cochlear implants. It's my understanding that they don't. Cochlear implants, to the best of my understanding, and perhaps others can touch on this, is specifically something that an insurance company would cover. I've never heard of a school being the person to provide that device. I can't think of any instance where a school...that was ever the school's responsibility to do so. [LB493]

SENATOR PAHLS: Okay, okay. Thank you. [LB493]

KATIE ARBATAITIS: Good question. [LB493]

SENATOR PAHLS: Senator Christensen. [LB493]

SENATOR CHRISTENSEN: Thank you, Chairman Pahls. Katie, do...my dad has one; he's 85,... [LB493]

KATIE ARBATAITIS: Um-hum. [LB493]

SENATOR CHRISTENSEN: ...but do kids...do they have to change them as they get older? [LB493]

KATIE ARBATAITIS: It's a great question, and I think Dr. Lusk would maybe be able to answer that a little bit better. But it is my understanding that, ideally, a device, once implanted, should never need to be changed. Now there are instances like the father you just heard from, where something could occur that would necessitate explanation, but in general, it's my understanding that no, once implanted, this should only occur once. Technology is changing, but typically the companies...the technology on the outer piece is able to be changed, and you can still keep the same inner device that has been surgically implanted. [LB493]

SENATOR CHRISTENSEN: Okay, thank you. [LB493]

SENATOR PAHLS: Senator Pirsch. [LB493]

SENATOR PIRSCH: Just to clarify, the state of the law is there's no mandated, obviously, two ears and two potential for cochlear devices. [LB493]

KATIE ARBATAITIS: Um-hum. [LB493]

SENATOR PIRSCH: But currently, we don't mandate any cochlear device, is that correct? [LB493]

KATIE ARBATAITIS: Correct. This bill is for both one or bilateral, so there's not currently anything in place mandating even for that one singular implant. [LB493]

SENATOR PIRSCH: Is there...do any insurance companies write policies that don't cover one? Is the problem that most of them, we're talking about the second? I'm trying to recollect back from last year, because... [LB493]

KATIE ARBATAITIS: Right. [LB493]

SENATOR PIRSCH: ...I think this was...as Senator Karpisek mentioned, a bill Senator Schimek introduced. Was the problem most of them covered the first one or all of them covered the first one, but then the second one? Is that what's at issue here? [LB493]

KATIE ARBATAITIS: I don't think that I would be able to answer that. I believe somebody after me might be able to answer that for you. It's my understanding that there is no mandate, though, even for the first implant as far as any of the insurance companies currently go. [LB493]

SENATOR PIRSCH: Very good. Thank you. [LB493]

KATIE ARBATAITIS: Um-hum. [LB493]

SENATOR PAHLS: Thank you for your testimony. Next... [LB493]

KATIE ARBATAITIS: Thank you, Senators. [LB493]

SENATOR PAHLS: Yes. Next proponent? [LB493]

DILLON CURREN: My speech is in the back of one of the packets you have. I want to say that I had a major last-minute revision done on my paper, so it may be a little bit different than what you have. My name is Dillon Curren. That is D-i-l-l-o-n C-u-r-r-e-n, and I am 14 in the eighth grade at Millard Central Middle School. I am currently the only hearing impaired person in the school. I was on the honor roll last year and I am on the honor roll again this year. Cochlear implants are a big part of my life and are very vital. When I was born, I was born premature and diagnosed with auditory neuropathy. This kind of hearing loss is very rare. I was the first kid in the state to have a cochlear implant that was diagnosed with auditory neuropathy. The first six years I could hear a little.

Imagine the loudest sounds were a very small sound for me. In April, 2001, I received my first cochlear implant. I was nervous before the surgery. After surgery, the recovery was hard, and I did not like it, but I knew that it would help me hear. Hearing new sounds is a very big deal. I can hear the dog barking, people talking, a horn honking, and a fire alarm at school. It is amazing how technology works. I can hear everything I couldn't hear before. My first day of hearing, I heard the cat meow and my mom said that it scared me because it was now so much clearer. I heard my family tell me they loved me. I can hear my friends talk and the teachers in my classroom. Unfortunately, I can now hear my mom yell at me to take out the trash, clean my room, and turn my music down (laughter). Unlike my mom's voice, my music is my favorite thing to listen to. With the help of my implants, I am able to listen to my favorite music. Then in 2007, I had my second implant. My mom did research on bilateral implants, and I agreed to have one. It was originally scheduled for August, but due to conflicts with our insurance company, it was postponed to September 9th. The insurance company cancelled the surgery the day before it was going to happen. When this was postponed, I was shocked and scared that I wouldn't be able to get my second one. Once again, I was nervous and not sure of how it would be different. Now in school, I'm very successful. Part of that success is because of my cochlear implants. Without them, I am not sure how I would be doing. Did you know that the average deaf child reads at a sixth grade level? I have also been able to learn three languages--English, sign language, and French. I mastered English and sign language, but I'm still learning French. The teacher says I'm doing a great job and I have a B plus. It's all due to my hard work and my cochlear implants. I have been able to communicate with other people and listen to them and understand them. Without my implants, it would be very confusing to me. I understand that some of the deaf may want to stay deaf, and that is fine with me, and I have a group of friends that wants to stay deaf. But for those who need an implant, they need it. For those who want them, their school and communication can be improved. I participate in football, basketball, and right now wrestling. With basketball, I can hear my teammates help me when I am stuck in a position. And I can learn moves in wrestling by listening and communication. In wrestling, I have a current record of five wins, two losses. And I was placed third in a tournament earlier in the season. Finally, implants have made my life so far successful. I have mastered two languages and I am able to play sports. I know that I can be whatever I want to be with the help of my implants. I can be a doctor, a lawyer, or even a senator. I think I might want to be an NBA player. I know the game and understand it, and plus I am tall, standing at 6 feet. I'll be tall when I'm done growing up. I have also met people and befriended them. They have hearing loss, too. All I am saying is that implants are a big piece of my life, and I have been a deaf individual and now hearing. I think the choice to get implants should be ours with my doctor and my parents, not by an insurance company. If I had to choose again, I would pick my implants. Like my mom has said, the thing that most people take for granted is the one thing she wanted for me, and that was the ability to learn. I owe my gratitude to my parents, Dr. Lusk, and many others. They fought and fought to the end, and never gave up. They finally got me a second cochlear implant. I do not want to hear

and see other people having the same struggle. Those who need it, they mean it. Please support this bill. Thank you. Do you have any questions? [LB493]

SENATOR PAHLS: Do I have any questions? Senator Gloor. [LB493]

SENATOR GLOOR: Thank you, Mr. Chairman. Dillon, nice job. Do you still take speech therapy? [LB493]

DILLON CURREN: Yes, I take it twice a month and for an hour. [LB493]

SENATOR GLOOR: How much longer do you think you'll do that? [LB493]

DILLON CURREN: For me, I don't need it anymore. I've been taking it for eight years and that's enough. [LB493]

SENATOR GLOOR: Yeah, you do very well. [LB493]

SENATOR PAHLS: Any more...let me ask you this. Did you miss school this afternoon? Did you have school today? [LB493]

DILLON CURREN: What do you mean? [LB493]

SENATOR PAHLS: At Millard North, did you have classes today at Millard? [LB493]

DILLON CURREN: I go to Millard Central. [LB493]

SENATOR PAHLS: Oh, Millard Central. [LB493]

DILLON CURREN: Yeah, I had classes today. [LB493]

SENATOR PAHLS: Oh, did you get out of any of them? [LB493]

DILLON CURREN: Yeah, I got out of science (laughter). [LB493]

SENATOR PAHLS: (Laugh) I was just...no, I understand. And I must commend you, you did quite well. And what I would do, I would suggest you have greater sights than being a state senator, okay? (Laughter) Again, thank you. [LB493]

SENATOR PIRSCH: Very nice job. [LB493]

SENATOR PAHLS: Yes, thank you again. [LB493]

TODD LUTHER: Well, Senators, thank you for having us today. My name is Todd

Luther, T-o-d-d L-u-t-h-e-r. This is emotional for me, so I apologize. I have a three-year-old son. He's the recipient of two implants, and my dream is that someday he can sit here like Dillon and be able to speak. I've been a human resources professional for over 20 years, have spent a lot of time working with insurance companies both from an employer's perspective, negotiating for coverage for my employees as well as being an advocate for employees when they would have billing issues or coverage issues or whatever it might be. Very often those conversations were less than pleasant and not a fun part of my job, but they did not even compare to the challenges that my wife and I faced when we tried to get implants for our son. In theory, our insurance coverage at the time covered implants, but it took months for us to get the approval, almost daily phone calls, lost paperwork that had to be found or replaced, missed coding on forms that made it ineligible, just endless processes that you had to go through at a time when we wanted to focus on our son, focus on learning sign language, and those kind of things. Instead, our daily focus was working with insurance companies to try to get it approved, and, again, that was from a company that does approve them. So our first one was a huge challenge. His second one was a lot less of a challenge which is a wonderful thing, so I'm very grateful that we got covered by our insurance company. Part of why I'm here today is to say that there's a lot of people out there that don't have the knowledge or experience or whatnot that I had had with insurance companies to know to keep fighting after those first denials and the second denial letters that you get in the mail. And I know there's a lot of people that don't have that, and it's one of the reasons I advocate for this bill so that people don't have to fight to give their kids an opportunity to hear. And I believe that that's why we have insurance. I did some quick calculations on my 20-some years in the business world. Insurance premiums that I've paid for that month, I've paid a couple hundred thousand dollars in insurance premiums, and that's why I've paid that is to have coverage when we have a need. That's what insurance is for. And I think second of all, that the options for my son, if he is deaf and unable to speak from a career perspective, are massively limited. And what I'm hoping for my son is that he can grow up to be a taxpayer and not somebody that's on welfare. And I think you'll hear some numbers from Dr. Lusk a little bit later on that the cost to society for kids with a significant disability like that are tremendously higher than the costs of this medical procedure. And again, my son is three. He has some other speech issues that's making it more difficult for him to learn to speak, but without sign language, my wife and I can orally give him numerous commands and requests, and he can follow those. His hearing is great. He just turned three this past week, and his behavior is amazingly different now that we can communicate. It's a life changing thing that should not be denied to those that need it, and I know one of the other things that I've been hearing today with some of the other bills that have been presented is that it's a small number of insurance companies or a small percent of people that would be impacted by this, because a lot of people are self-insured and otherwise, and I guess my thought on that even if it would only help one child or adult be able to hear, it would be worth it. So thank you. [LB493]

SENATOR PAHLS: Any questions for? Seeing none. [LB493]

TODD LUTHER: Thank you very much. [LB493]

SENATOR PAHLS: Appreciate it, Mr. Luther. [LB493]

RODNEY LUSK: Senator Pahls and members of the Banking, Insurance Committee. My name is Dr. Rodney, R-o-d-n-e-y Lusk, L-u-s-k. I serve as the director for the Cochlear Implant Program at Boys Town National Research Hospital. I'm here today to offer neutral testimony on behalf of LB493 which requires insurance coverage for all cochlear implant candidates. I think it's important for you to realize that there's an inequity across the insurance industry. Many of the insurance companies provide this benefit; others outright deny it, and that's why we're here today, and that's why you're hearing the testimony of parents and patients. At Boys Town National Research Hospital, we're performing approximately 50 cochlear implants a year. There's a tremendous investment in infrastructure which includes personnel, and there are only a few physicians in the state that can do this procedure, and only a few hospitals have invested in the equipment to be able to get this done. I provided for you a packet of articles. If you'll take the time to look through that information, you'll see that a prelingually deaf child costs society over a million dollars. And a cochlear implant as compared to other procedures that we do rank amongst the very highest in terms of the impact on the patient and the families. The device that we're passing around, cochlear implant, actually has two components, one that is implanted completely underneath the skin. This is a computer chip that's imbedded here, and it's also got an antenna around the outside. There's no batteries in here. It gets its power by centering magnet over the two implants in electromagnetic field to set up that provides the power to the computer chip, and also provides the programming from the environment to fire off individual electrodes that are put into the cochlea. This is not a hearing aid. Okay? What it is, is an electrical device that stimulates directly nerves that are inside our hair cells which allow us to hear. Think of it as a pacemaker for the ear. The problems that we're having is that there are certain insurance companies that deny even one implant. And there is a critical period for these children to get implanted, and if we don't...Nebraska was one of the very first states to adopt newborn screening for hearing loss. We're picking these kids up now at a time where we can implant them and really have a dramatic impact on their ability to gain language and speech. The problem is, we have a window of opportunity. We're implanting the children now at 12 months of age. We're actually even going down lower than that, down to nine months, and we're finding that the quicker we can get them implanted, the better we do. We have children that are mainstreamed that have no assistance at all, and it's truly a miraculous device, and I would urge you to support the bill. I'd be happy to take any questions. [LB493]

SENATOR PAHLS: Senator Pankonin. [LB493]

SENATOR PANKONIN: Thank you, Chairman Pahls. Dr. Lusk, thank you for your testimony, and I think you testified last year on this bill, if I remember. [LB493]

RODNEY LUSK: I did. [LB493]

SENATOR PANKONIN: Were you here earlier today when I had my bill on the amputee issue? [LB493]

RODNEY LUSK: I was, um-hum. [LB493]

SENATOR PANKONIN: You were? [LB493]

RODNEY LUSK: I was. [LB493]

SENATOR PANKONIN: And you heard my...did you hear my close? [LB493]

RODNEY LUSK: I did. [LB493]

SENATOR PANKONIN: Okay. So I'm going to ask you that question. I'm a small businessperson. This would cost me more. My bill would cost me more. I was willing to make that decision after the amputee coalition got their numbers. [LB493]

RODNEY LUSK: Right. [LB493]

SENATOR PANKONIN: What is the numbers? If we had, you know, the purpose for this thing, this technology, great, all wonderful. I made that decision in supporting my bill that for the cost, estimated cost involved for everybody, it was worth it. [LB493]

RODNEY LUSK: Um-hum. [LB493]

SENATOR PANKONIN: For me, because if a loved one or an employee had this issue, it would be really worth it to pay that so many cents a month. How much does this one cost? [LB493]

RODNEY LUSK: That would depend on how many deaf children you had in the population that's actually covered, but it's a few dollars. It's a few dollars per insured, insuree to cover the costs of a cochlear implant. [LB493]

SENATOR PANKONIN: Okay. So we're talking a few dollars per member per month? [LB493]

RODNEY LUSK: Yes. [LB493]

SENATOR PANKONIN: Okay. [LB493]

RODNEY LUSK: This is not a large population that we're dealing with, but the impact on that individual is dramatic. I mean, you saw Dillon here, who, if he had his implants off, standing under a jet engine, couldn't hear it. But he stood up and testified in front of you. He's going to be gainfully employed. [LB493]

SENATOR PANKONIN: Well, and I'm posing the question because, I mean, I can tell you what the negative testimony is going to be, that this is going to...I mean, people are going to lose insurance altogether because as cost goes up. So, and I'm trying to draw, quite frankly, draw a distinction between the numbers I gave and what you're testifying. [LB493]

RODNEY LUSK: I don't have...I've had discussions with insurance companies that have denied single cochlear implants, and I've asked them how much it would cost, and they say, it's changed. It's a few dollars. It's our policy though, and that's what we're trying to address. There's an inequity across the board, and it shouldn't be. You know, this is such a life changing event, treatment, for these families and these kids for a few dollars for every subscriber, it's well worth the money. Well worth the money. Does that answer your question? I wish I had a firm number, but I don't. My guess is it's less than $10. Not per month but less than $10 altogether. Yes. [LB493]

SENATOR PAHLS: Senator Pirsch. [LB493]

SENATOR PIRSCH: Thanks, and you had testified last year so...and going off to my memory from last year, but I had thought that the issue last year was that...well, I mean, I thought that all insurance carriers had covered the first cochlear implant. Then in Nebraska, the issue was the second one. Is that not...this is...but we're talking now...or the testimony here today is that some insurance carriers are not covering the first cochlear implant in Nebraska? [LB493]

RODNEY LUSK: I wish that were the case. The case that we're dealing with right now is that there are carriers, substantial carriers in the state of Nebraska that are not covering the first implant. And the data is overwhelming that the kids do better with bilateral implants, and that's why the bill states that if they meet the criteria for both unilateral and bilateral implants, that the mandate should require the insurance companies to cover it. [LB493]

SENATOR PIRSCH: Thank you for clarifying. [LB493]

RODNEY LUSK: Any other questions? [LB493]

SENATOR PAHLS: Seeing no more questions, we thank you for your testimony.

[LB493]

RODNEY LUSK: Thank you for your time. [LB493]

SENATOR PAHLS: Thank you. Next proponent? [LB493]

BRUCE RIEKER: (Exhibit 3) Senator Pahls, members of the committee, my name is Bruce Rieker, R-i-e-k-e-r, vice president of advocacy for the Nebraska Hospital Association. On behalf of our 85 members, we support LB493. I think we've heard a lot about the medical and technological advances that have brought dramatic change to healthcare delivery and the quality of life in recent years, and cochlear implants are one of those innovations. In recent years, I mean this probably addresses one of the questions I believe Senator Gloor had in an earlier bill this afternoon. Are very many insurance companies expanding coverage? In this area in recent years, health insurance for cochlear implants services has expanded. The increase in coverage is largely due to enhanced education regarding the costs and outcomes of cochlear implantation, Medicare, the Veterans Administration, and all other federal health plans provide benefits for cochlear implant services. Federal law requires that all state Medicaid agencies provide coverage for cochlear implants for children under 21 years of age, and most states provide benefits for adults as well. I think it's important to note that in LB493, it requires individual and group sickness and accident insurance policies as well as self-funded employee benefit plans to provide coverage for single or bilateral cochlear implants for persons diagnosed with severe to profound hearing impairment. This bill would bring these policies in line with the coverage afforded by all federal plans as well as many of the state plans. Once again, we as hospitals are on both sides of the equation. We're in the business of providing care, but we're also in the business of providing benefits for the 41,000 people that we employ, and based upon our cost benefit analysis, even though the costs of such surgery are high, the benefits, as you have heard, from previous testimony far and outweigh or exceed the costs of such procedures. Therefore, we respectfully ask you to support and advance LB493. [LB493]

SENATOR PAHLS: Are there any questions? Seeing none, we thank you for your testimony. Any more proponents? Opponents? [LB493]

TOM SPAIN: Okay, last one. Good afternoon. My name is Tom Spain. That's T-o-m S-p-a-i-n. I'm the manager of special investigations unit for BlueCross/BlueShield of Nebraska, and I'm appearing on behalf of BlueCross/BlueShield. On behalf of our customers, we oppose LB493 because mandates in general increase total healthcare costs. In addition, BlueCross/BlueShield of Nebraska currently covers cochlear implants in our group and individual contracts. The only segment of our business where any dollar limitation of coverage are imposed is our small group contract, again, called BluePride which we've gone over before. These contracts were designed to offer affordable coverage to small business by placing limitations of dollar amounts on certain

medical equipment or procedures. We would also like to suggest that instead of carving this particular procedure out, we urge you to look at a neuroprosthetic class in general. These are medical devices that replace or improve the function of damaged neuromuscular organ systems and restore normal body processes, create or improve function and/or reduce pain. We feel it's premature to carve out one member of the class. If we do carve out one member of the class, we'll be back to look at the single-item mandates again. Some of the members of the class include cochlear prosthetics, mechanisms for bladder and bowel control, devices for restoration of respiration and paralyzed individuals, and devices for the treatment of footdrop. So we would be more than willing to help you look at these things, but we don't feel that it's wise to just carve out this one piece at this time. Thank you. [LB493]

SENATOR PAHLS: Any questions? Seeing none, I thank you for your testimony. And Senator Karpisek, I think somebody's talking to you. [LB493]

MICK MINES: Chairman Pahls, members of the committee, for the record my name is Mick Mines, M-i-c-k M-i-n-e-s, registered lobbyist for the National Association of Insurance and Financial Advisors of Nebraska. As I have said before in the hearings, our association opposes mandates, opposes regulations that increase the cost to our customers, and we would oppose this bill. Thank you. [LB493]

SENATOR PAHLS: Thank you, Senator. [LB493]

SENATOR PANKONIN: Can you just say ditto? (Laughter) [LB493]

JANIS McKENZIE: I know. [LB493]

SENATOR PANKONIN: You already beat me up. You have to... [LB493]

JANIS McKENZIE: (Laugh) No, I'm not done beating people up yet. Senator Pahls, members of the committee, I'm Jan McKenzie. I've spelled my name twice. I think you'll be able to figure it out. I'm here testifying in opposition to LB493 on behalf of the Nebraska Insurance Federation. I just want to make two clarifications. One, I think you've heard today why I think my appeal at the beginning on Senator Pankonin's bill is a legitimate one. All of these arguments have been heartfelt, emotional. People believe these things should be covered; they want them to be covered. And it's...I'm glad I'm not in your seats right now, trying to figure out which...one, if you could only choose one. I know which one Senator Pankonin would choose to send to the floor, and I know which one Senator Gloor would choose. So if we do...had to choose one, I don't know which one you'd have a hard time deciding which one you might want to send out, if that was the rule. I want to clarify one thing that was said by Dr. Lusk. He said the mandate should require insurance companies to cover it. Well, insurance companies aren't who cover it. Who covers it are the people who pay the premium, so if you want to put it on

an insurance policy, it's not the insurance company who pays it. It is the consumer who pays it or the employer who pays it, depending on the situation or the individual who pays it, just like government. If you want a road, you all put your pennies in the jar to pull it, together build a road. And that's who pays it, not the insurance carrier, pays out what they say they will pay out. And so they don't...it's somebody else's money that supports paying that out. With that, I admire your resilience and stamina this afternoon. I'd answer any questions. Oh-oh. [LB493]

SENATOR PAHLS: Two people you mentioned. I will start with Senator Gloor. We'll get over here to my left. [LB493]

JAN McKENZIE: I know (laugh). [LB493]

SENATOR GLOOR: Thank you, Ms. McKenzie, and I would say, therein lies some of the challenge that we have I think as a society. In my almost three decades of running a healthcare institution, I can only think of once, and the fact that I can think of once tells you how rare it is that somebody came to me and said, you do too much for us, here, do less. I mean, I think when people are ill, when people have healthcare needs, it's the most important thing in their life for them or for their child or for their parent. I mean, it's difficult what insurers are faced with, and that is the expectation that I didn't want to get sick, I didn't want to get ill, I didn't want this to happen. What can we do to make it right? And so it's not an insurance problem, and it's not a legislative problem. It's a societal issue we have to wrestle with is trying to do as much as we can for people with limited resources. And so it's certainly a challenge, and I think we all recognize that. [LB493]

JANIS McKENZIE: I agree, and part of the problem, I think, is that over time because so many of us have had the benefit of having our insurance provided by employers for our lives or part of our lives, I was in that category before. I don't realize how much it costs. I don't realize how much it costs until I...I didn't know until I had to go out and buy it myself as you've indicated this year as well. And so there's this belief somehow that it is...somebody else is going to pay for it somehow magically, and that magical place is an insurance company that prints money off by the boatload, and that's just not the way it works. [LB493]

SENATOR GLOOR: On the other hand, we do spend governmental money to develop and do research on things, and then dangle it out there, and that we have this available and gee, isn't it too bad you can't have this? So we work at crossed odds to ourselves, at times, and it's got to be terribly frustrating to a patient to know that services are available, but just beyond reach. And so it's hard not to be empathetic with all parties involved in some of this. It's a challenge. [LB493]

JAN McKENZIE: I agree. [LB493]

SENATOR PAHLS: Well, we're printing money at the federal level (laughter). [LB493]

JAN McKENZIE: I know (laugh). [LB493]

SENATOR PAHLS: Senator Pankonin. [LB493]

SENATOR PANKONIN: Thank you, Chairman Pahls. See, and I didn't think I was going to bring this up today, but you gave me my opening. [LB493]

JANIS McKENZIE: Okay. [LB493]

SENATOR PANKONIN: I talked about this Wall Street Journal article on the floor today, and I wasn't going to use it, but, you know, this comes out last week that the new chief exec of United Healthcare, the other Dr. McGuire is out because of predating stock options. This guys turns his in for $100 million. So we're telling these people we can't cover them, and I know how insurance works. We all pay for it, and then you see this. And someone takes $100 million payday out of the system, and it makes me ill. How do you feel about it? [LB493]

JANIS McKENZIE: Well, as did the bankers walking away with that kind of money. [LB493]

SENATOR PANKONIN: Absolutely. [LB493]

JAN McKENZIE: I think it's absurd, to be honest, personally that... [LB493]

SENATOR PANKONIN: So, you know, so that's a little bit of the reason that people are suspect of this. When people abuse our system, our capitalistic system for a profit...I'm a businessperson, I'm for profit. This is a rape of people who need coverage. And I just wanted to see how you felt about it. [LB493]

JAN McKENZIE: Well, your assumption in that is that the CEO raped people who may or may not have had a policy from them which, again, insurance is many companies selling products to many groups of people. And CEOs of great big, huge, monster companies or banks tend to make very high salaries. Now, do they pay out less? Do they pay their CEOs a higher rate than others? All those things exist in a marketplace. And to assume that that means that they were not taking care of their customers is a big assumption. That would be my response. [LB493]

SENATOR PANKONIN: Do you think it's right? [LB493]

JANIS McKENZIE: Well, personally, we can talk about that later (laugh). [LB493]

SENATOR PAHLS: Well, then, now I want to try to pin you down. [LB493]

JAN McKENZIE: Okay, good. Whew. I thought you guys were tired. [LB493]

SENATOR PAHLS: No, I'm not. I'm truly not. Here's the thing because you intrigued me earlier with this concept of commission. [LB493]

JAN McKENZIE: Right. [LB493]

SENATOR PAHLS: Now, do you truly...you know, just for now, this is speculating. If we would set up something like that for all these mandates that flow there, would the insurance companies then, if that was tossed up from the commission, says, hey, Senators, this is a good bill. Would you sit across the table from me and say, no, it's not? [LB493]

JAN McKENZIE: Gosh, I don't know. That's a good question. [LB493]

SENATOR PAHLS: Because we're having another group of people who will make that...I'm trying to find some solutions, because like you say, we have an awful lot of emotions involved in this... [LB493]

JANIS McKENZIE: I hear you. [LB493]

SENATOR PAHLS: And if we're saying no or yes, but if we have this...you brought this on, because you talk about... [LB493]

JANIS McKENZIE: I think what you've seen in the past and those of you who have been here awhile know that, in fact, there are times when that has happened, and let me give an example from just a year ago. We had for years heard about colorectal screening being covered as a mandate, and in fact, in the beginning companies and the insurance industry as a group, opposed it. In the end, we supported it, because we had seen over time and as it became standard practice and the procedures were a part of a good cost benefit ratio, that the industry made it a standard practice. Now we didn't need to necessarily mandate it, because it is standard practice. In many cases, for a number of procedures, it is now standard practice. And in a lot of cases, the coverage of clinical trials regular care is standard practice for companies. But there are always...because it's not a one group, there are always some often people out there who aren't doing that. So, yes, there are times when we've actually been able to come in and support ideas. [LB493]

SENATOR PAHLS: Okay, I'm waiting for this commission to evolve so I, you know,... [LB493]

JANIS McKENZIE: As a former senator, I can say I cannot hold myself to a future legislation (laugh). [LB493]

SENATOR PAHLS: I hear you, I hear you. Thank you, appreciate your testimony today. [LB493]

JANIS McKENZIE: Yes, thank you. [LB493]

SENATOR PAHLS: Next opponent? [LB493]

RON SEDLACEK: Chairman Pahls and members of the Banking, Commerce and Insurance Committee, my name is Ron Sedlacek, R-o-n S-e-d-l-a-c-e-k. I'm here today representing the Nebraska Chamber of Commerce in opposition to LB493. We opposed LB493 the year before, and again, consistent with our policies, in regard to trying to hold the line, trying to keep insurance accessible, available, affordable for employers who are utilizing group health, particularly those that remain, we would continue to urge the committee to be aware and to be cognizant of the effects of legislation. And on those who are going to be insured or not, that's the end of my testimony. [LB493]

SENATOR PAHLS: Seeing no questions, thank you, appreciate it. Any more opponents? Neutral? Senator. [LB493]

SENATOR KARPISEK: Thank you, committee, for the late hour. I appreciate it. I will have to say that Dr. Lusk either needs to update their web site or, but I looked on the web site, and I did the math, and he said 50 a year. They probably didn't do that many in the beginning, so you did hear two different numbers there. I did...I've paid my own insurance for the last 20-plus years. I may look older than that, but that's really as long as I've been out of college. I know what it costs. I've sold my business. That's one reason. I understand what it costs, but I introduced this bill, because I think it's that important. Senator Pankonin's bill, my dad has had a prosthetic leg since I was two years old. I've been there; I've seen the kind of worn-out legs that he's had to use because he couldn't afford it. He probably could have had them paid for by the state, but as you have gotten to know me, he's even more stubborn than I am (laughter). So I understand the situation, and I do know it's tough. Somebody does have to pay for it, and we can only say, it's only a couple more dollars, but it does add up, and I do understand. But I think that this is a huge issue. We can get people into the work force; we can improve their lives. That's what we're talking about is improving their lives. Dillon can be a normal, functioning person. He did a great job today. I'm so proud of him, I have goosebumps, and I just met him today. Anyway, our state insurance plan covers these cochlear implants. Those on Medicare can get cochlear implants covered. I've even heard stories of people being told to get divorced and go on Medicaid so they could have theirs paid for. I think that's crazy that we would pay for people on the system, but not those that are trying; the middle-class people, you either have enough

wealth that you can pay for them on your own, or you're so poor that you can't. And who again gets squeezed out? It's the middle-income people, the middle-class getting it again. The NHA has put out in 2006, there were 76 outpatient surgeries in Nebraska for the cochlear ears; 42 were Medicaid or Medicare; 34 were commercial plans. There were two inpatients, and 15 of the 78 were non-Nebraska residents. So roughly, 34 commercial plans in 2006, and that's the last that I have. I don't have 2007 or 2008. It has been said that for every one dollar spent on implants, it saves $25 for society. I'm sorry, I do not have where that came from, but it's thrown out there. My other question is, when did we start covering cancer treatment? Senator McKenzie talked about the colon screening; blood disorders. It all has to start sometime. The point is, I feel that it's time for cochlear implants. I feel that it's time for prosthetics, and Senator Gloor, I apologize, I was in between on your bill, but I would probably feel that it's time for your bill too. We need to do something for the middle-class people trying hard. I mean, Senator Pankonin hit it right on the head. What if it was some of our family? I've been there in his bill's case, so that's why I'm carrying this bill. I understand it's not free, but I think that it's the right thing to do. And with that, I would take any questions that the committee has. [LB493]

SENATOR PAHLS: Seeing none, thank you, Senator. [LB493]

SENATOR KARPISEK: Thank you for your interest. [LB493]

SENATOR PAHLS: (Exhibit 4) That will conclude the hearing on LB493 with Senator Karpisek. Thank you. That is it, no exec tonight. [LB493]

Disposition of Bills:

LB149 - Held in committee.
LB378 - Held in committee.
LB493 - Held in committee.

______________________________ Chairperson

______________________________ Committee Clerk