[LB326 LB358 LB445]

The Committee on Banking, Commerce and Insurance met at 1:30 p.m. on Tuesday, February 24, 2009, in Room 1507 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB326, LB358, and LB445. 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: I want to welcome you to the Banking, Commerce and Insurance Committee hearing. My name is Rich Pahls. I'm from Omaha, and I represent District 31 which is sometimes called the Millard of Omaha. I serve as the chair of this committee. The committee will take up the bills in the order posted outside. I'll just go over them: LB358, LB326, and LB445. As many of you know, this is your part of the process when we develop and push bills out to the floor. And just to better facilitate today's meetings, I'm going to have you take a look at the small chart over there. There are a few simple guidelines that will make our hearing run much smoother. Of course, you all know about turning off your cell phones. We have reserved chairs up here, so after the bill is introduced, if we could have you move to the front, that would give us a feel so we have a feeling who is going to be testifying, and then we will not lose time on people moving around. Of course, the order of testimony is we have the introducer, proponents, opponents, neutral, then closing. We're asking the testifiers to sign in, put your name on the sheet in the little box up here. And, again, we're asking you to spell your name for the people who are taking notes, and they record everything we say, so we'd appreciate if you'd spell your name. Again, we're asking you to be concise. If the person or persons before you have given us some of the information, please, we're asking you not to repeat it unless it's definitely necessary. We need ten...if you have copies to give to the committee, we need at least ten of those. If you do not have ten, if you'd raise your hand, I'll have one of the pages pick up...if we could do it now, it'd make...again, make things easier. Seeing none, we'll move on. Just to introduce, to my immediate right is committee counsel, whom many of you know, Bill Marienau. And all the way over there...today it's Jan Foster. Sometimes I change her name on her, but today it's Jan Foster. And we must be nice to her, because she's got the little button over there that can shut us down, so if it's not recorded, it ain't legal, so let's be nice to Jan today. I'm going to start all the way over here. It looks like we will have several senators who are gone, who, as you can see, are not here. They have other hearings. And for those of you who are new to the process, if senators get up and leave, it's not that they are objecting to your testimony; it's that they are probably going to other committees, so we'll start all the way over here. []

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

SENATOR PIRSCH: I'm Pete Pirsch, representing Legislative District 4. I represent

west central Omaha, parts of Douglas County and Boys Town. []

SENATOR McCOY: Beau McCoy, District 39, and I live in Omaha. []

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

SENATOR PAHLS: And our two pages over here who will be helping with the information is Jared Weikum; he's from Lincoln, and Becky Armstrong, who is from Omaha. Again, we will take up the bills in order that I called. LB358, and today that deals with changing the Comprehensive Health Insurance Pool and is the bill that I am introducing, but I am going to have the director of the Department of Insurance start with the introduction. Good afternoon. []

ANN FROHMAN: (Exhibits 1, 2, and 3) Good afternoon, Chairman Pahls, and thank you for the opportunity to be here today to testify. My name is Ann Frohman, A-n-n F-r-o-h-m-a-n. I'm the director of insurance, and here to testify in support of LB358. We refer to the program under consideration as the CHIP program which stands for the Comprehensive Health Insurance Pool. It is a pool that serves the...what I'd call the sickest 5,000 Nebraskans in the state, who are unable to find coverage for their health insurance needs on the admitted market. This is not a Medicare program, it is not the Medicaid program, but it fills the niche essentially between the two. It's been around since the mid-1980s, and it involves a significant subsidy from the state of Nebraska, and that's why we've been watching it fairly closely over the years, and monitoring some of the healthcare financing troubles that we see in this plan that are not unlike what we see nationally with the challenges in healthcare financing and dealing with chronically ill populations. The subsidy that the state pays in this program is growing at a rate that is one that is somewhat alarming because at the growth that we are seeing in the program, we do not expect this program to remain viable in the distant future without some significant cost containment efforts. The department has been concerned about the long-term fiscal health, and we've done a few things both through the CHIP program itself and through the Department of Insurance on the administrative regulatory side. And a couple of years ago, we asked and convened an interim study as well to get the legislators' participation on discussing the problem with CHIP, and I asked the CHIP board to review coverages which they have done under the program. They made some changes to the policies to shore up, to make sure that they're in line with marketplace coverages which is what the statutory requirements insist on. We've taken a few administrative changes, but the day is still before us where we needed to come here and ask for some assistance from the Legislature as it's outgrowing its source of funding. And we really have done, I think, about all we can do outside of coming to you, and we realize that those measures always need to be taken first, and we've done that. What we're trying to do in the bill proposal before you is keep the program within its existing source of funding within the foreseeable future with cost containment measures that will include stabilizing the growth of the program in terms of its expenditures

coupled with a revised rate structure for the program. And in view of the state's financial situation, we're always looking at proposals that attempt to bring the state subsidy back to a more reasonable level. Although it varies in terms of what the state actually contributes to the plan from year to year, because the participants in the plan pay a premium and the state picks up that amount which the premium does not cover in claims, so it can vary year to year. It averages about 40 percent of the entire program, the part which the state pays, and then the premiums by the participants covers about 60 percent of the program on an annual basis. As of December, 2008, I'm going to refer you to...if I ask you to look at anything in addition to listening to the testimony today, it is a chart that I have included with my testimony that we've highlighted a couple of numbers just to exemplify where the problem exists, and the problem is this. As of December, 2008, the state subsidy was more than $26 million. That's your number over on the right-hand column at the bottom. It's up from $11.5 million if you look at the 2001 number over in the right-hand column. It says from the CHIP fund. That is actually the state subsidy. In addition, the CHIP has a premium tax available on health insurance policies, out of which this program funding, the state subsidy relies, and that funding source, unlike the costs associated with the program, remains fairly flat. And the CHIP premium that's been available from the premium tax is between $34 million and $35 million currently. That's up from only $33 million in 2001, so what we have is a very flat source of revenue not keeping up with the escalating healthcare costs and a mismatch. And as a result of that, we're seeing a point where, at some date in the future, the program needs are going to outstrip the funding available for it. Attached to my testimony is also, I think, some other information we have for you to review. The distribution of premium taxes that are also allocated to the General Fund in excess of this is something that's worth being noted, because what we have here is to the extent we have $34 million, $35 million of health insurance premium coming into the state. In 2001, only $11 million of that was used to subsidize this program. Today, $26 million out of the $35 million is used to subsidize this program. Well, where was the other revenue going before it was used for this program? Well, it went 40 percent to the General Fund, of which now you're losing that revenue source; and then 10 percent to the fire districts. The other 50 percent went to an insurance tax fund that was allocated; 10 percent to the counties; 30 percent to the Municipal Equalization Fund; and 60 percent under the TEEOSA formula. So that is being reduced as the needs of this program escalates, so you push on one, and it comes out the other side. So I think it's important to know that as the CHIP program needs escalate, those revenues are being reallocated to CHIP from other sources that they had previously been used for. The bill contains the following proposals that we'd asked you to consider in shoring up the financial wherewithal of this program. The first one involves the setting of the premium rates. Ordinarily, insurance companies have flexibility to set their rates, but because this is a statutory program, really is an insurance company, but we're limited by statute on how we formulate our rates. And we have a recommendation to increase the multiplier that's used in the premium from 135 percent of the standard risk rate to 150 percent, and that's in line with the other CHIP plans across the country. And currently, it's set...the

standard risk rate is really the average premium charged in the marketplace by the top five carriers. And we want to be able to increase that to 150 percent, so that gives us access to more premium revenue. And we estimate that it will reduce the state subsidy by about a million dollars the first year, so that's one area that we think we need to get up and on par with the way the other state plans are. And actually, after three years, we think ultimately we'll have a savings of about $3 million, because we're going to increase this staggered over three years rather than increase it all at once. We also are looking to increase the number of insurers that are used to calculate that standard risk rate from 5 to 10, and the reason we are doing that is to create a stabilization in the way rates are developed. Right now we have so much volatility, that in one year you can have a 22 percent rating increase, and if the carriers are entering and exiting the market, you can have another year where it's a 7 percent or 8 percent reduction in premium. And in talking to the CHIP participants, they've said, we'd rather have a stable rate than have a rate that's fluctuating up and down every year, not knowing what the premium is going to be for their insurance policy. We also incorporated a floor, and the floor is essentially a requirement that allows annual trend factors to be included, so that we actually look at historical experience of the program, so that policyholders would either pay an increase of the 150 percent of the standard risk rate or a factor related to the measure of medical inflation, whichever is greater, so that we're not actually losing ground every year in the program. And I think that's an important modification that really should be considered to shore up the program. There's another proposal that we are requesting that involves the rate change, and that is, this program unlike any other CHIP program in the country, has a statutory rate reduction for children, and it's set across the board in the statute at half of what an adult pays for the program. And no other insurance CHIP program has this for a number of reasons. One, the healthcare services provided aren't discounted, and so you don't see this in the marketplace. It was a unique, I think, policy decision some 25 years ago long before we had SCHIP and some other programs to provide relief to children. And what we are seeking to do is move that up to the same rate that adults pay for coverage under this program. I've consulted several actuaries who have told me that actually, this makes a lot of sense for the program because the rate is so low in Nebraska that it actually competes with the voluntary market. So rather than this being a market of last resort, we have 400 kids in this program, and they're paying less than what you would pay in the marketplace. So what we're trying to do here is put the rate where it really makes sense in terms of fiscal responsibility, and also recognizing that SCHIP exists now. At the time this discounted rate was put in for children, we didn't have an SCHIP program. It wasn't comprehended, so we think that that provides the adequate relief that children need. We also have another proposal in there involving requiring group coverage purchase and COBRA participation. This piece of the proposal would specify that applicants with group coverage comparable to CHIP would be ineligible for CHIP. And the whole idea behind the CHIP program is if you don't have group coverage, and you're not Medicare eligible or Medicaid eligible, this program can be available for you. So we don't want to...given that there's a state subsidy, we don't want to see folks otherwise eligible on their

employers' plan, under a group plan, seeking to go to a state subsidized program if they don't have to. We want to see the marketplace work for these folks. And the act would require that if a person is eligible for group coverage, then they must obtain the group coverage before looking to CHIP as a resource. And this, essentially, we have a...the term that's used in the marketplace is dumping and CHIP where you peel off the one individual, throw him into the CHIP plan, and then write the group coverage without that individual, and that's the sort of thing that we'd like to see deterred with legislation, so that the marketplace handles the group as the group is rather than sending those individuals that maybe are the higher risks under the group plan into the CHIP pool. We also are asking that, as part of the COBRA requirement, that they exhaust COBRA before jumping into the CHIP pool. This requirement currently applies to persons seeking the coverage based on HIPAA eligibility, and will be extended to those who seek coverage on a state-set eligibility basis. Associated with this then would be a repeal of the provision that COBRA...that right now it's if your COBRA premium is higher than your CHIP premium or if your...yeah, your COBRA premium is higher than your CHIP premium, you're eligible for the pool. And we canvassed a number of states and think the majority of the CHIP plans are making the right decision by requiring that you exhaust COBRA. And then particularly with the recent developments coming out of Washington where there is going to be some participation and funding stimulus aid for COBRA participants, it certainly makes sense at this time to recognize that COBRA should be utilized and exhausted to assist in retaining the viability of this program, and as a program really of last resort. And under that...the idea out of Washington, as I understand it, as of last week, 65 percent of COBRA premium will be subsidized for up to nine months, so I think that dovetails well into what we're trying to accomplish here. There's another feature that's a little unique. Well, I shouldn't say it's unique, because a number of state CHIP plans, and I think most of them, I think we canvassed 35 state plans and only eight don't do this including Nebraska, and that's prohibit third-party payments of premium. And essentially what this is about, is I've been told by members of the CHIP board that some medical providers have actually paid the premium for the participants so that they can get reimbursed at a higher rate either through the Medicare or the Medicaid...higher rate through CHIP which is a commercially negotiated rate unlike Medicaid or Medicare. And most state plans have closed that loophole, so that other than with a unique program called the Federal Ryan White Program which is an AIDS program, recognized by the federal government, we would want to close the loophole that would allow providers to drive folks into the CHIP program. We also have a recommendation of including the reference to dumping individuals off of a group plan into CHIP to include that as an unfair trade practice. We'd like to get our resources able to manage that, and to provide deterrents and think that defining that as an unfair trade practice is probably the best way to go on that one. The last area that we're asking you to consider is reducing the reimbursement rates. That's the one remaining party that has been left out of a part of the solution for the long-term solvency of the program is the medical providers. CHIP has provided a reliable source of payments for providers, and without it, they can expect large increases in the amount of charity work because we

would expect that if the CHIP program did not exist, it would increase the uninsured population and place a larger burden, especially on the hospitals to handle this care. And so we believe that CHIP currently provides generous private sector levels of reimbursement to medical providers at a commercially negotiated rate which is unlike Medicare and unlike Medicaid despite the fact that there's a state subsidy involved. And given that CHIP is a program of last resort, we think there should be sacrifices, and we're asking that, you know, currently that the state participate and provide, you know, the state subsidy policyholders are sacrificing with an increase in premium above the market rate. And we think it's time that...and businesses also sacrifice with an inability to dump the individual off of the group plan so that the group plan will incur higher costs, that we think it's probably time to pull in providers that are currently paid at fully-negotiated rates. Other states have tied reimbursement to Medicaid. We have seen Wisconsin move the administration of its pool to allow reimbursement at Medicaid rates. South Dakota requires providers to be reimbursed at 115 percent of Medicaid rates. North Carolina has a similar system. Ultimately, reducing provider reimbursement rates would reduce the cost of claims paid and reduce the taxpayer subsidy to CHIP. And providers who accept reimbursement at this level are then prohibited from balance billing of the participant. So there is a cost to this proposal, and the Department of Insurance has been advised by Blue Cross which is the current contract administrator, that creating a new network for reimbursement would incur an additional $100,000 to $150,000 in development fees for moving away from their negotiated rates, and we think it's probably well worth it in the long run to get a new network of healthcare provider negotiated reimbursement rates. And in discussing it with Blue Cross's administrator, they indicated that reducing the CHIP reimbursement rate to 125 percent of Medicare will actually save this program a significant amount of money related to medical claims, and as a reduction of perhaps 20 to 35 percent off of commercial rates. So we've evaluated this, talked to our actuarial staff, and we've come up with a difference, leading to cost savings of roughly $4.5 million to $7.5 million per year, so this is a significant savings to the program that I think would lend well to ensuring the viability of it. And we do recognize that there are issues with that, and that we have been talking with the administrator, and we've had a couple of discussions with the providers and recognize that it's not an easy issue for you all. We're not bringing you an easy task here today, but we do think it's one that needs the attention because, in the long run, we don't see this program surviving without some significant cost containment measures being undertaken legislatively. So with the bill in front of you, as a fiscally conservative proposal to rein in costs, I would be, I guess, willing to answer any questions that you have, and ask that you give due consideration to advancing the proposal. [LB358]

SENATOR PAHLS: Director, just let me ask you a couple of questions for the rest of the senators up here. We've been discussing CHIP for as long as I've been here. It's been one of those things, and it seems like we've been sort of playing with it a little bit because we did have a study. Are we getting close, are we moving closer and closer for

this program to be in totally bad shape because I heard you say that there's a possibility? [LB358]

ANN FROHMAN: Absolutely. We've run the numbers, and it's...when you're looking at healthcare inflation, 8 to 11 percent, looking at flat premium tax revenues, we've run the numbers, and plugged in different variables. But as possibly as early as 2012 through 2016, worse case scenario 2012 the program is broke. It's exhausted its resources, and I was thinking about this this morning. I thought, where does this leave the program? Let's say the participants have paid their premium. We've funded to the cap of the premium tax. Then what? I think it would probably still be the state obligation, and we'd be back for deficit appropriations, I don't know. I mean, that is not the way you run a program, I recognize that. So there's, I think, a lot of good proposals here that we've really thought through and tried to bring you to make sure we avoid that scenario. [LB358]

SENATOR PAHLS: I mean, could you go to the point of just like having waiting lists for people to get into the program? I mean. [LB358]

ANN FROHMAN: We could do that, yeah. I think we struggle, though, under the federal mandate if we do that because HIPAA dictates that we have what we call an alternative market mechanism. And there's a couple of ways of going about that. One is through this program, the CHIP program. The other is through a guaranteed issue individual insurance product. And we watch those states that went the other issue, and it was a disaster for the marketplace, drove up the costs of the individual product to the point where the uninsured market grew significantly. So we don't think that's the answer. We still think this program is the way to go when we might run afoul of HIPAA laws if we were to do something like that. But yes, I mean, we would have some serious concerns about how we contain it. [LB358]

SENATOR PAHLS: As I'm looking at all your suggested improvements, I see people...there are probably some opponents out there. I mean, as I look at the providers, they're probably going to have some issues. If I think I should be in the program, I'm going to have some issues, because I'm just trying to get this across to the committee, because I've been around...we have several new people on here. You're telling me, and I need to make sure the committee understands that if we don't do something whether anybody likes it or not, we're going to be in trouble. And is that a safe statement for me to make? [LB358]

ANN FROHMAN: Absolutely. It is. I mean, there isn't...there isn't any other way of crafting it. I think I'm bringing you a problem and I'm, hopefully, (laugh) bringing you some solutions. [LB358]

SENATOR PAHLS: Right. [LB358]

ANN FROHMAN: But it is a serious problem, and we need to fix it. And we've done as much as we can do administratively, I believe, and, you know, we've done interim studies and, you know, I think we need to continue to work on it. But we're giving it the best shot we can give it here, that I'm aware of. [LB358]

SENATOR PAHLS: Okay, and right now because you're up here, and I don't want to be directing you to any...but if anybody is an opponent of this, I just don't want you to tell the committee or myself what's wrong. I want somebody, you know, the people who are on the other side, they got to give us some solutions. Just don't tell me, I don't like what's going on. [LB358]

ANN FROHMAN: Right. I don't think we...I don't think we can afford that luxury. I think we absolutely have to have solutions, and if...yeah, if someone can come in and just poke holes in it, I don't like this or I don't like that, said, well, what do we do? We absolutely need resolution, and this is the best we've come up with. But if anybody has anything better, the Department of Insurance is willing to listen and I... [LB358]

SENATOR PAHLS: So you're willing to... [LB358]

ANN FROHMAN: Right. [LB358]

SENATOR PAHLS: ...to speak with people if you have not already met with them. [LB358]

ANN FROHMAN: Right. [LB358]

SENATOR PAHLS: Because I see sometimes things are thrown to this committee, and it's hard to make some of these judgments because some of these are significant changes and will affect people. [LB358]

ANN FROHMAN: Um-hum. [LB358]

SENATOR PAHLS: And so, okay, so I'm just saying if anybody...if you're coming forth...just to tell you ahead of time, I want some solutions. Okay. Senator Pankonin. [LB358]

SENATOR PANKONIN: Thank you, Senator Pahls. Director, appreciate you coming, and I appreciate your department's looking at this, because I just have a couple of comments. This is...I'm in the farm equipment business, and I have customers who don't have access to group policies, and I have several of them that have, because of health issues, are on this plan. And even though it's higher cost, it's this or no insurance, and it's hard for those folks to qualify for Medicaid, because their asset base

of ground and things like that, they might not be cash rich, but they're asset rich. And so this plan is sometimes their only alternative then, so this is...and there was an article in one of these magazines we get as legislators that also said in neighboring states that this is important for agriculture to have access to this plan. So even if the costs go up, access is still important, when you get to be my age, to have availability. So I appreciate you looking at how to make it viable because, as Senator Pahls has said, it could be this or nothing, and we even have a mandate from the federal government to do that. One specific question; prohibit third-party payments of premiums. I know the issue, understand about...and it kind of relates to dumping or moving people and getting them off of another plan. But what about adult children paying for an adult parent or an adult parent paying for adult child, those sort of things? Is that still prohibited under this third party? [LB358]

ANN FROHMAN: No, we've contemplated that and made sure that that's allowable. [LB358]

SENATOR PANKONIN: So families can still help each other and whatever. I... [LB358]

ANN FROHMAN: Um-hum. You bet, you bet. [LB358]

SENATOR PANKONIN: ...assumed that was the case. I just wanted to make sure. [LB358]

ANN FROHMAN: One other thing I didn't mention it on the rate stabilization. We actually have seen in the last two years a reduction in the premium rate paid by the participants two years in a row which even amplifies our need for stabilization because it's not commensurate with healthcare inflation or the costs of the program, so it's rather crazy at this point. How can I explain to the public that well, the rates are going down because that's just a function of a statutory inflexible rating structure, makes no sense with what's going on with the program. And we've actually seen that in the last two years. And so we really need some relief here. [LB358]

SENATOR PANKONIN: Well, and tell me again how many Nebraskans are on this plan? [LB358]

ANN FROHMAN: Roughly 5,000. [LB358]

SENATOR PANKONIN: Right. And versus them being on Medicaid or whatever, still from the state standpoint of the subsidy, from the tax and whatever, it's still cost effective. Right? [LB358]

ANN FROHMAN: Absolutely. I think we need this program. And we need to make sure we can shore it up, because, like I said, if we don't have this program, we will have

guarantee issue, and guarantee issue means you'll be looking at individual health insurance policies doubling, tripling in price, and forcing those folks into the uninsured marketplace, and that is not where we want to be. [LB358]

SENATOR PANKONIN: Thank you. [LB358]

ANN FROHMAN: You're welcome. Thank you. Any other questions? [LB358]

SENATOR PAHLS: Seeing none, thank you for your testimony and well-explained. We will go in the order of proponents and then opponents. Proponents. (Laugh) You had me looking at myself, Senator. The floor is yours. [LB358]

VICTOR KENSLER: (Exhibit 4) Good afternoon, Senator Pahls, Senators. My name is Victor Kensler spelled V-i-c-t-o-r K-e-n-s-l-e-r. I'm the chairperson of the Nebraska Comprehensive Health Insurance Pool known as NECHIP, here today to testify in support of LB358, and to reinforce the NECHIP board support of the issues that have been brought before this committee by insurance director Frohman. In 2006, the NECHIP board of directors submitted to the insurance director a list of proposed changes the board determined would improve the long-term outlook for CHIP coverage in Nebraska. Since then, the board of directors has completed a review of coverage, working with consulting actuaries, the administrator, and the insurance department to develop levels of coverage commensurate with that being offered by the top five carriers who write individual insurance in Nebraska. Also, an expense task force made up of members of the NECHIP board and the Department of Insurance met and reported to director Frohman that we favored the following actions: Increase the multiplier used to set premium from 135 percent of the standard risk rate to 150 percent over three years. And as you heard earlier, most pools in the nation are using 150 percent or higher. Increase the number of insurers used to set the standard risk rate from 5 to 10, and add a rate floor to stabilize future rates. While this may result in higher actuarial consulting costs, in the long run it will serve to provide a more stable rate schedule for the future. Increase the child rate from 67.5 percent to the 150 percent of standard risk rate paid by other policyholders. This recommendation addresses an anomaly which should be corrected. Require group coverage purchase and COBRA participation. The coverage provided by NECHIP is supposed to be coverage of last resort. To ensure this result, employers must be prevented from sending to NECHIP an employee with past claim experience that is ramping up the premiums for the entire group, therefore making them undesirable to remain part of the group census. Recently, the NECHIP board was notified of a situation in Omaha that involved a company with a group of 180 employees, including a 60-year-old female employee who had been very ill, and had incurred nearly $600,000 in claims in approximately three months of 2008. The carrier had increased the premiums for the group significantly, so the company went shopping and found another company willing to cover the group, but only if the chronically ill employee was not included. The company had reduced the employee's hours, making

her a part-time employee and eligible for COBRA which was offered and elected. The employee submitted an application to NECHIP on the basis of her having been rejected for insurance coverage by another company. She had been offered COBRA coverage and elected to take it and had eight months' coverage remaining, but in order to be eligible for NECHIP with the preexisting condition waiver, her premiums for NECHIP must be lower than what she was paying for COBRA, and they were not. A letter was sent to the applicant for purposes of making, with full disclosure of the situation, so she could make an informed decision, and it included the key points below. The letter told her that you may be eligible for coverage under the pool, however, if eligible, you will be subject to a six-month waiting period for preexisting conditions. Therefore, any health condition you have at the time the policy goes into effect will be considered a noncovered condition if you seek treatment for that condition during the first six months the policy is in effect. An actuarial comparison was done between the premium rates effective January 1, 2009, under your current coverage and the premium rates you would pay CHIP for similar coverage. This analysis showed that the rates you are paying for your current coverage are less than what your CHIP premiums would be. Your coverage under COBRA does not have a lifetime maximum for benefits received. CHIP has a lifetime maximum of $1 million. Considering that you have had over $500,000 in claims in less than a one-year period, it is important to keep in mind that if you elect coverage under CHIP, you will be subject to the $1 million lifetime maximum. If you elect to retain your COBRA coverage until exhaustion on September 30, 2009, you may be eligible for CHIP coverage if at that time you are not eligible for a group health plan, Medicare or Medicaid, and do not have other health insurance. If you meet those qualifications at the time, please submit a new application, and it will be reviewed. We strongly suggest you discuss these considerations with your insurance agent prior to making the decision to cancel your current coverage and apply for CHIP coverage. Please let us know if you intend to elect coverage under CHIP. In spite of this letter, which was followed by a meeting with the applicant and company officials to make certain that the applicant understood the risks, she opted to come on to the NECHIP as a policyholder. I ask that you advance the bill to General File, and I will answer any questions you may have. [LB358]

SENATOR PAHLS: Mr. Kensler, let me ask you this question. Is this an oddity or do you believe this happens on a regular basis, the one story that you told us? [LB358]

VICTOR KENSLER: I believe that this happens more often than we are made aware of. You know, this came to light because a particular broker who had been servicing the account was about to lose it, and, you know, he was calling our attention to a dumping incident. And you heard earlier from the director, you know, that this is a classic case of dumping. [LB358]

SENATOR PAHLS: Yeah. I can see where the individual may want to do something like this, because, apparently, this individual is really desperate for healthcare. I mean, you

know, whether you agree or disagree with it, I can see where a person would possibly seek that. I have one more question. If I were on the floor, a question would be asked of me, by increasing the child rate from 67 to 150 percent, would the answer be that we have SCHIP now. How could I answer that question? Because you're saying, we should change the rate from 67 to 150 percent of the standard risk rate paid to the policyholder. [LB358]

VICTOR KENSLER: Well, I would go back to what the director said earlier about the fact that we are basically undercutting the market with that premium, and there likely could be people--children being covered by CHIP that could get coverage other places, you know, and they could be eligible on other plans so. [LB358]

SENATOR PAHLS: Okay, okay. Thank you. Senator Pirsch. [LB358]

SENATOR PIRSCH: Thanks, appreciate your testimony here today. With respect to...on the first page of your prepared testimony, your written testimony rather, it says, increase the multiplier used to set premium from 135 percent to 150 percent over three years. Is a practical matter, that's putting a little bit more of the cost, or in light of the increases of the escalating 11 percent cost onto the covered. Right? [LB358]

VICTOR KENSLER: That's correct. [LB358]

SENATOR PIRSCH: What does that mean in actual dollar terms if this was advanced to the floor, and some senator had a question about if this would be a prohibitive type of thing for individuals in this...I mean, is there kind of a range or what are we talking about in typical dollar terms, do we know? [LB358]

VICTOR KENSLER: Well, as you know, the premiums will vary, depending on age and deductibles that are chosen. But if the standard risk rate which is developed is $100, and the premium is 35 percent above that, that's going to be $135, so we're proposing to take it in 5 percent increments. [LB358]

SENATOR PIRSCH: 135, then 140, then 145, 150. [LB358]

VICTOR KENSLER: Yeah, right. [LB358]

SENATOR PIRSCH: But I'm saying, would this be...I mean, realistic, feasible in terms of the actual dollars to...as the states more and more bearing and, I guess, the point of this is in an increasing amount, costs are escalating. The state has been paying...has essentially been bearing the costs of those increased costs, and in a way that's unsustainable for a long...in the long term, and so the question is...so this particular feature would say that those who are actually covered would be paying in a little bit who have had a flat, who have been flat in terms of increases in the amount that they've paid

in, would start to pay a little bit more into the system, into their own coverage, is that...that's the idea behind this one? [LB358]

VICTOR KENSLER: Yes, it is. [LB358]

SENATOR PIRSCH: Okay. And so, you know, you used an example of if it was $100 it would be, you know, $135 or $35. I'm just trying to say, is that...that seems like a feasible...for people so situated, this would be a feasible, you think, in your estimation additional requirement that we require from the covereds. You don't think it would exclude a large portion of those who are currently in the $5,000 or who are covered, that that would be cost prohibitive, and they'd drop off the program, so to speak? [LB358]

VICTOR KENSLER: No, I do not, especially in light of the two years in a row of premium decreases. [LB358]

SENATOR PIRSCH: Um-hum. Very good, thank you. [LB358]

SENATOR PAHLS: Senator Pankonin. [LB358]

SENATOR PANKONIN: Chairman Pahls. Mr. Kensler, do you have the rate charts with you? [LB358]

VICTOR KENSLER: I have them, and much to my chagrin, they're listed as percentages. I thought they were going to be the premium. [LB358]

SENATOR PANKONIN: Okay. But I mean, obviously, they would be available for the... [LB358]

VICTOR KENSLER: Oh, yes. [LB358]

SENATOR PANKONIN: ...the chair, and I think that would be important so people can see. The other aspect that I think people could make a decision on is, obviously, if we do private (inaudible) if because of these increases, they may step up to a different deductible level. Would that be a decision consumers could use to keep their premium in line? Would that be correct? [LB358]

VICTOR KENSLER: Yes. Yes. [LB358]

SENATOR PANKONIN: Okay. And in your view, this is still, as it is in mine I think an important program because it's kind of like we don't have this...a lot of people have nothing. [LB358]

VICTOR KENSLER: It's an extremely important program, and I believe in it 100 percent. [LB358]

SENATOR PANKONIN: Thank you. And I'm sure you can get us that information... [LB358]

VICTOR KENSLER: Yes, for sure. [LB358]

SENATOR PANKONIN: ...for the chair so he'll...I think you can see what we're kind of asking here is questions that people aren't on the committee, maybe haven't had as many hearings on CHIP or are not as familiar as Senator Gloor, that people ask us, we've got that information handy. [LB358]

SENATOR PAHLS: Thank you, Senator. Senator Utter. [LB358]

SENATOR UTTER: The increase in premiums in the child program, how many children does that affect? [LB358]

VICTOR KENSLER: About 450, I believe. I think the director mentioned that amount, 400--in that range, yes, sir. [LB358]

SENATOR PAHLS: Senator Pirsch. [LB358]

SENATOR PIRSCH: With respect to the dumping issue, do you suspect...I mean, should we have some sort of empirical type of analysis of whether or not this is going on in large numbers or is it just kind of anecdotal...anecdotally passed along by agents, that kind of thing? Or do we...can we assess how much in terms of savings that might account for? [LB358]

VICTOR KENSLER: I won't say that we can't assess it, but I can tell you that no assessment has been done at this point. It's a practice that, you know, we are aware of. [LB358]

SENATOR PIRSCH: Do we think it's maybe a marginal practice that may result in marginal savings to the state, or do you think it will result in meaningful substantial savings to the state, this feature alone? [LB358]

VICTOR KENSLER: I think it would be meaningful. Well, but...in the case, you know, in the story that I related to you here today, I wanted you to hear what happened to this individual. I don't think she fully understood what she was doing even though we went well beyond what our normal action would be with, you know, the letter and the meeting. She had a lifetime, you know, unlimited coverage, and she gave it up to go with the million dollar maximum plan. [LB358]

SENATOR PIRSCH: Is the unspoken part there then, do you believe that...I mean, for her to act in that way seems odd, odd to the extent that we would believe that perhaps some other influences talking to her, saying we'll make...I mean, is that the innuendo? [LB358]

VICTOR KENSLER: That is my belief, yes. [LB358]

SENATOR PIRSCH: Very good. Thank you. [LB358]

SENATOR PAHLS: Okay, seeing no more questions, thank you for your testimony. [LB358]

VICTOR KENSLER: You're welcome. [LB358]

SENATOR PAHLS: Next proponent? And just by showing...next proponent. Okay, now we're ready to go into the opponents. Just by a show of hands, how many opponents do we have? One, two, three. Thank you. If you just move to the fourth, that would help us. You may begin. We're ready, you may begin. [LB358]

DICK NETLEY: (Exhibits 5, 6, 7, 9, 10) Senator Pahls and members of the committee, my name is Dick Netley. I serve on the CHIP board of directors as the representative of the general public. I'm here today, not as a representative of the CHIP board, but as a concerned citizen addressing several issues relating to LB358. This bill contains a provision that is contrary to the purpose and intent of the CHIP Act. Specifically, if your health insurance premium is higher than the CHIP premiums, you are eligible for CHIP. However, under this bill, potential applicants who are offered coverage under COBRA will be required to pay the full 18 months of COBRA regardless of the size of those premiums if they want continuity of coverage without being subjected to the six-month pre-ex waiting period. The authors of the original CHIP Act recognize that because insurers can charge any amount to cover a plan's medical cost an excessive premium is as big a barrier to insurance as an outright denial. As such, the term "affordable premium" as used in the preamble to the CHIP statutes has an implied definition, and that is a rate higher than the CHIP rate. In 1994, prior to the COBRA waiver, Nebraska was put in the national spotlight as a result of this inequity. The family of a seriously ill four-year-old boy could not afford their COBRA premiums while his father was attempting to start his own business. During the six-month waiting period, the boy's 12-year-old brother wrote a letter to President Clinton about the ordeal that his family was going through. The boys were subsequently invited to the White House, and were later featured in Hillary Clinton's book, It Takes A Village. This was not one of our prouder moments. COBRA is typically cheaper than CHIP, especially for large companies, but it may not be for smaller companies with bad claims experience. In the first six months of 2007, we saw 34 people invoke the COBRA pre-ex waiver. Their

premiums ranged from 17 percent to 262 percent higher than the CHIP rates, forcing a sick citizen to pay excessive premiums when he is least able to afford it is a very dubious plan to save money. I strongly oppose this measure. I apologize, I had some material I meant to hand out here. [LB358]

SENATOR PAHLS: Okay, could you also spell your last name? [LB358]

DICK NETLEY: My last name is spelled N-e-t-l-e-y. There's three separate packages. You'll need the graphs, so I'll wait till you get them. The so-called standard risk rate on which CHIP rates are based has not been consistent. Please refer to the graphs that I have handed out. The bottom part of Exhibit A is a bar graph of annual rate adjustments, going back to 1998. While last year's rate decrease was partly due to changes in benefits, typically whenever we have had a low-rate adjustment, it is because there has been a change in the composition of the top five companies used in the calculations. A company with lower rates moves up to take the place of a company that is losing market share. This process reflects the free market system at work. LB358 includes a provision that will attempt to moderate these variations by increasing the database for our calculations from five to ten companies. Assuming there are ten companies in Nebraska, this provision will decrease the influence that any one company will have our calculations. However, it will also bring companies that were formerly used in the rate calculation back into the fold. In theory, these lower-tier companies probably have a lower market share than the top five companies for a reason, and that is because they are more expensive. As such, their inclusion could result in a higher standard risk rate calculation. The five to ten proposal is not ideal. It is a straight average, and as such, gives a small policy with a few hundred members the same weight as a large policy with several thousand members. Furthermore, since we no longer use the most frequently sold policies in the standard risk rate calculation, there is nothing to prevent the use of dead or dying policies that will be grossly out of line with a standard deviation. I've handed out a recent article that appeared in Consumer Reports magazine that describes the scenario. I won't read it here, but I ask you to read it yourselves because it is very germane to this topic. If you refer to my first graph that I call Exhibit A, the top part of Exhibit A is a ten-year bar graph showing the cumulative effect relative to 1998 of the rate adjustments which are shown at the bottom. In other words, for every $100 premium paid in 1998, the premiums for each subsequent year would be the amount shown at the top of each bar. By 2006, the rates were over 3 1/2 times higher than they were in 1998. This is an annualized increase of nearly 18 percent over eight consecutive years. I submit to you that increases of this magnitude are not sustainable in CHIP nor in the private sector without a reaction or a correction. The reaction in CHIP has been a significant drop in enrollment, and a movement to higher deductibles. The correction in the private sector, in my opinion, has been the aggressive marketing of new and cheaper policies to healthy people while letting the old policies gradually die. Again, there is nothing to prevent these dying policies from being used in the standard risk rate calculation. The next graph that I labeled Exhibit B is a graph of

the data that you may have already seen. I have simply added percentage increases relative to 1998 for the years 2004 and 2008 to point out the gross disparity and the unequal and inconsistent distribution in the sharing of this program's costs. The curve labeled losses is the amount borne by the state. If you would please turn to the next graph, which I've labeled Exhibit C, this provides a little different perspective on the same data. It shows the same claims, premiums, and losses except that these are on a per person basis. I took the same data, but divided it by the number of policyholders for that year. Please note that at the end of 2004, after six years, the average claim had gone up by 59 percent while the average premium had gone up 131 percent. The average loss was actually down 2 percent. At the end of 2008, you can see that the average premium was still higher and had gone up faster than the claims or the cost to the state. Note the relationship between the claims curve and the population curve. They follow almost a mirror image of each other. The 30 percent rate increase in 2003 appears to have been the straw that broke the camel's back. At this point, enrollment starts a steady decline, but per person claims continue to climb and even accelerate initially. This is telling us that healthier low claims people started dropping out while the sicker high claims stayed in. In the private sector, this could have been the beginning of a so-called death spiral. While most other states may have rates capped at 150 percent, their actual rates are lower because they have discretionary flexibility. If we fix our rates at 150 percent, CHIP rates will become some of the highest in the country. How ironic this would be in a state that funds its high-risk pool with the lowest premium tax in the nation. In 1985, Senator Don Wesely, the father of the original CHIP legislation, told senators during floor debate on the original bill, "If we miscalculate and have any losses of revenue, it is our prerogative to increase that premium tax to cover the loss in revenues." In 1992, I and the policyholders association, fought the insurance industry in the Legislature and warned that capping the insurance companies' liability for funding CHIP would eventually result in higher premiums if an alternate funding mechanism was not found. I have handed out an article that appeared in the Lincoln paper at that time. While we were sympathetic to the industry's cries of fairness, they were in a strange tango, the CHIP policyholders' biggest ally in the quest to find alternate funding. That is no longer the case. We don't know for sure what the new standard risk rate calculation will produce. There is the distinct possibility that the addition of five lower tier companies alone could have a significant upward effect on the standard risk rate calculation. Because of that possibility, increasing the multiplier to 150 percent should only be allowed on a discretionary basis which the board could invoke only within well-defined parameters that relate to the actual cost of the pool. The bill also has a provision that will eliminate the possibility of rate decreases by allowing the board to apply a supplemental trend factor to the previous year's rates. If we are going to set a bottom rate on adjustments, in all fairness, we should also set a cap on excessive increases that do not relate to the actual CHIP claims experience. Furthermore, if CHIP benefits are reduced, why would the policyholders not be entitled to a reduction in their premiums? The frustrating part about all of this is that the standard risk rate has absolutely nothing to do with the actual CHIP claims experience. We are trying to

manipulate the database and the multiplier in an attempt to achieve acceptable levels of subsidy from the state. We are averaging the cost of apples to set the price for bananas. Since 1986, Nebraska has covered about 36 percent of all claims. In 2007, all the high risk pools in the nation, on average, covered about 38 percent of all claims. Maybe we should just set the premiums accordingly. The current child rates were set by the Legislature in 1998 in conjunction with the SCHIP "Kids Connection" bill. As a matter of fact, my recollection is that they were merged into the same bill. At that time, child rates for CHIP were substantially more than 35 percent above the standard risk rate. These programs stood in stark contrast to each other; free healthcare for some families while other families with sick kids were paying twice or more of the market rate. I'll try to explain why the kids' rates got to be so high. Over the years, the average of all CHIP rates remained at 135 percent of the standard risk rate. However, the age rate slope did not keep up with the private sector. This resulted in rates for older CHIP policy holders being below 135 percent, and rates for younger CHIP policy holders being more than 135 percent. The rates were cut in half to essentially put them on par with the standard risk rate. In 2005 and 2006, actuarial adjustments were made to more closely parallel the industry age/rate slope. This resulted in child rates being below the market average in some cases. It was not the intent of the 1998 legislation to create child rates below the market rate. To retain the intent of the child rate level of 1998, the child rate would need to be raised from 67.5 percent to 100 percent of the standard risk rate. The last segment of the bill that I want to briefly mention is in regards to the restriction on third party payers. I believe that the list of acceptable payers should also include conservators, trustees, legal guardians, and nonfamily members having a legal power of attorney. In conclusion, CHIP has been and will be a lifeboat for thousands of Nebraskans. Yes, we need to keep it viable and "seaworthy." But as Roy Scheider once said, "We're gonna need a bigger boat." That's the end of my testimony. If there are any questions. [LB358]

SENATOR PAHLS: You are one of seven members on the board? [LB358]

DICK NETLEY: Correct. [LB358]

SENATOR PAHLS: I'm just going to ask, are you there by yourself or the other six, is it because you're bringing some information that maybe is a little contrary to what I thought would be the stand of the commission? Are you one of one or are you one of seven? I'm trying to see where the commission is on this. [LB358]

DICK NETLEY: I'm only here speaking for myself. [LB358]

SENATOR PAHLS: Right. But I'm sure...the point I'm trying to get across is the commission...are you and the commission rolling down the river the same direction or not? [LB358]

DICK NETLEY: Not necessarily. [LB358]

SENATOR PAHLS: Okay, that's what I'm trying to get. Senator Pirsch. [LB358]

SENATOR PIRSCH: Is it, you know, you mentioned some things that you found problematic in the bill. Is it the totality of the points, you know, that were outlined by Director Frohman? Do you have problems with all the points or is it just the narrow points that you brought out, and there are some...? [LB358]

DICK NETLEY: Well, some of the issues like the COBRA waiver, I mean, that's totally opposed to that. The refinement of the database from five to ten maybe more, you know, technical issues that, you know, I've raised points. I'm not totally opposed to that. I understand the, you know, the intentions here to stabilize the rate calculations, but there are some problems with that. [LB358]

SENATOR PIRSCH: Yeah. Is there perhaps some middle ground with regard...you know, they're trying to broaden to get rid of the, you know, the broad fluctuations. Your point, if I understood it correctly, is that when you start to include companies six through ten, there are reasons they're six through ten; they're smaller. But yet you're saying they're weighted as heavily as one through five even though they may...? [LB358]

DICK NETLEY: Right... [LB358]

SENATOR PIRSCH: ...and is it...so you would say perhaps on a percentage of marketshare, there might be some formula that you would say would... [LB358]

DICK NETLEY: Yes, it's... [LB358]

SENATOR PIRSCH: ...bring about stability, a greater stability, but would be...? [LB358]

DICK NETLEY: What I'm suggesting is a weighted average calculation where the size of the policy...now, again, it's not the company that we're using; it's the policy that we're using to make the calculations. One company may have two policies; they may have 30,000 people in one policy, and they may have fewer than a thousand in the other policy. We no longer use the most frequently sold policy. We use the policy that's most comparable to CHIP. And some of these policies are small and getting smaller for a reason. [LB358]

SENATOR PIRSCH: Yeah. And you're on the CHIP committee. Do you agree with the general premise that the costs, if left and the current kind of projections are correct, that something's got to give that the cost could be unsustainable? Or, I guess what I'm saying, first of all, is that correct or are things fine in your estimation, and if not, if you agree that something's got to be changed, I mean, do you have a...and not this plan, I

mean, have thoughts...where would you suggest...I mean, do you have any alternative type of suggestions about way...should the state be kicking in more of...if we don't go this direction? [LB358]

DICK NETLEY: Well, I believe this is a funding problem, and I believe that the CHIP policyholders...you've asked, you know, what the rates are. And, again, I apologize because I don't have them either. They're accessible if you go to our website, nechip.com, but I believe the rate for children is about $100 a month, and that's obviously half the rate. If you jump up to the age of 17 or 18, then it's $200, and I believe once you get over the age of 60 years old, you're probably over $1,000 a month. And, again, it depends on the deductible. We're seeing a significant migration to $5,000 and $10,000 deductibles. And we've got families that have got more than one person in CHIP. It's an incredible onerous burden. [LB358]

SENATOR PIRSCH: Yeah, and so it's not realistic...at the same time that that's...you're saying the...with respect to who this program was designed and created to help and to protect these 5,000 people, that life is becoming increasingly difficult and unrealistic to meet their...to meet this coverage, correct? [LB358]

DICK NETLEY: Well, yeah. We're gravitating...I mean, we're going up, there's no question about it. I mean, years ago, I heard...people used to tell me, well, I'm cancelling my subscription to my magazines and my newspaper to help me afford CHIP. Today, I'm hearing people say, I'm selling assets; I'm cashing in my life insurance policy. It's a dramatically different world than it was back when I first got involved in this 20 years ago. [LB358]

SENATOR PIRSCH: Uh-huh, and I understand it. It's becoming increasingly difficult the rates for the people we intend...who are intended to benefit from this creation of this program to continue...their rates are going up. At the same time, do you agree, the overall costs of the program...those who are...I think it was 11 percent was the figure that was quoted? I mean, is that the overall...8 to 11 percent inflation yearly of the entirely of the program? Does that seem accurate to you? [LB358]

DICK NETLEY: You can look at my graph. You can project the lines yourself there. I mean, I...that's... [LB358]

SENATOR PIRSCH: Okay. Yeah,... [LB358]

DICK NETLEY: ...your guess is as good as mine. [LB358]

SENATOR PIRSCH: Okay. What I'm trying to get at here is, do you think that there is...are are...is is is the...is the...is is is there a problem such that we should be looking at at other types of cost containment ideas, or do you think that there isn't really a a a

gigantic escalation of cost for the state where...? [LB358]

DICK NETLEY: Oh, I think there's a real potential here for... [LB358]

SENATOR PIRSCH: Okay. [LB358]

DICK NETLEY: ...escalation of costs, yes. [LB358]

SENATOR PIRSCH: Okay, and that's what I'm trying to get at. If...costs for the state, not just the individual who are participating in this, who have...you've testified here have seen incredible escalations, but... [LB358]

DICK NETLEY: Right. [LB358]

SENATOR PIRSCH: ...I mean, do you have any costs for the state, too, I mean, that may affect the sustainability of the program in future years, costs that are of such a high percentage increase? In other words, shall we be...what what...are there any concrete solutions you may have for the state? You're saying, don't punish the people who are covered by the program... [LB358]

DICK NETLEY: I'm saying, be fair. [LB358]

SENATOR PIRSCH: Right. [LB358]

DICK NETLEY: I'm saying, be fair. Their rates, in the past, went up extremely high rates... [LB358]

SENATOR PIRSCH: Sure. [LB358]

DICK NETLEY: ...and it was not paralleling the cost of the program. And so now we're seeing a correction in that. [LB358]

SENATOR PIRSCH: But but... [LB358]

DICK NETLEY: You know, at that time, you know, we let it run. Now, you know, we can't stand this. We can't have a decrease. You know, that's just anathema of our thinking; we can't have a decrease. Well, it's a correction in my mind, to a certain extent. I don't know what tomorrow is going to hold. I mean, we can't have corrections going down, you know, continually, obviously. [LB358]

SENATOR PIRSCH: Okay. So don't take it out...the extra costs on the people who are being covered, but if...but I'm trying to find a solution then or your kind of paradigm then for these...if there are, in fact, escalation in costs of the overall program, how does the

state contain those costs or deal with those costs in a manner that wouldn't punish the people who are covered, you're saying by...? [LB358]

DICK NETLEY: You...you give us some discretionary flexibility, give us a target. How much money are you talking about? How much are you willing? And we've heard the figure 60/40. I've given you some more refinements on those, but, I mean, if that's the target value, give us some discretionary latitude to try to target that number. [LB358]

SENATOR PIRSCH: Okay, thank you. [LB358]

SENATOR PAHLS: Senator Pankonin. [LB358]

SENATOR PANKONIN: Thank you, Chairman Pahls. Mr. Netley, and is that pronounced right? [LB358]

DICK NETLEY: Correct. [LB358]

SENATOR PANKONIN: Okay. I appreciate your coming, because the history has been very helpful, and the graphs have been very helpful. I think what Senator Pahls, and I'm going to elaborate, what he was saying is, you know, we're sitting up here, and you have the director of insurance testify for the bill, and you have the chairperson of your commission, committee testify. Was the decision...did you take a vote on this proposal or...? [LB358]

DICK NETLEY: On most of these issues, yes. [LB358]

SENATOR PANKONIN: ...and can you tell me what... [LB358]

DICK NETLEY: Some of them I supported; many of them I did not. [LB358]

SENATOR PANKONIN: Okay. [LB358]

DICK NETLEY: For the reasons that I've stated in my testimony. [LB358]

SENATOR PANKONIN: But were...but were the votes...how many...there's seven people on the commission? [LB358]

DICK NETLEY: Yes. [LB358]

SENATOR PANKONIN: And where were some of the splits? Can you remember any of those? Was it...? [LB358]

DICK NETLEY: I believe I was the single dissenting vote. [LB358]

SENATOR PANKONIN: Okay. That's helpful. You know, I'm just going to tell you...make a statement, and then it is going to end up being the question. I'm a small employer like 14 people in a plan, and before I was elected in 2006, had a young employee who was 33, then became 34, but he had stage IV colon cancer, very unusual for someone that age. And people...several people told me that kick him off and get him on the CHIP program. I mean, that's obviously a dumb thing. I didn't do that, and he passed away the day before I was elected. The night before the election, I was with him instead of doing any last-minute electioneering. But that, obviously, drove my group costs way up. I mean, how...I'm just...the statement is, insurance isn't fair. It...you know, (laugh) this is...we got a crazy system in this country. And this...I understand some of your points, but on the other hand, access for someone that is in my age group is just...it's access more than cost, and your idea about, you know, some people are selling assets to do it. I think it's absolutely true, and it's unfortunate. I'm...I feel bad we have the system we have. But, saying that, don't you think we have an obligation to try to make the best decisions to keep the plan viable, because it is the last resort for some folks? [LB358]

DICK NETLEY: Keep it viable, but fund it properly. [LB358]

SENATOR PANKONIN: And fund... [LB358]

DICK NETLEY: There's only so...I mean, how high can we go? We just keep charging...I mean keep charging people until we remain solvent? At some point,... [LB358]

SENATOR PANKONIN: Well, I mean, one of the alternatives would be to fund out of the general budget of the state, but I just don't think that's...I mean, that might be nice. But I don't think we're going to get that done. [LB358]

DICK NETLEY: There's a number of options that other states use, and I think that needs to be investigated. Again, I think part of this is a funding issue. Back in 1992, we heard that the program was exhausting its available funds, and we tried to stop the Legislature from terminating the liability of the insurance industry. A lot of other states assess insurers. I understand there's a fairness issue there, because we're not accessing ERISA companies. They don't contribute to this program, and they need to be tapped into also. I mean, I don't know, provider fees, user fees that doctors and hospitals pay will circulate through the entire system. That would be a fair way of doing it. But I think you need to start looking at funding issues, funding...supplemental funding. And not put the burden on the backs of the policyholders. The bulk of this bill is to minimize the cost to the state. Some states are setting up low-income subsidy programs for their lower income people. We're getting grants from the federal government, and, you know, we're using it to defray the cost of this program. We're using money to set up disease management programs, but we're not addressing the affordability of this. [LB358]

SENATOR PANKONIN: Thank you for your testimony. [LB358]

SENATOR PAHLS: Thank you. I'm taking from this, we ought to take a look at the funding. That's the issue that you're bringing forth to us? [LB358]

DICK NETLEY: Yes. [LB358]

SENATOR PAHLS: Okay. Thank you, appreciate it. Next opponent? [LB358]

DAVID FILIPI: Senator Pahls and other senators of the committee, I'm Dr. Filipi, F-i-l-i-p-i. I'm president-elect of the Nebraska Medical Association. We are concerned about section 3 which caps reimbursement to physicians at 125 percent, and it's not because of a primary financial matter. It's an unintended consequence that I'm afraid that you're not aware of, and that's among the physicians of the state, most of them are small employers. Most of them are small businessmen and small businesswomen. The commercial contracts out there that we currently get from Blue Cross, United, Coventry, are around 150 to 175 percent of Medicare. So 125 percent is significantly less than what we're currently being offered. What I'm afraid of is that across the state, you'll see a number of physicians who will decline to contract with this policy for these CHIP members, and where the CHIP members will need to go for their medical care will be the hospitals and to the emergency rooms where costs are significantly higher. So though you may be getting it 125 percent from hospitals, it will be 125 percent of a greatly accelerated fee. And so at the end of the day, you'll be paying more for care that may not be as good. The place for care for our chronically ill patient is the family physician, is the internist's office, is the primary care home, and if you under fund that primary care home by what would seem like a very good reason, it's going to impact down the road to higher costs to the member, higher costs to the plan. Senator Pahls, you asked what solution do I have? And I think a good solution was in Senator Harms' bill, (LB)656, and that is that we need to look back at community rating of patients. We have had a policy where insurance companies can cherry pick, can get low-cost members into an insurance plan where they have a very low premium, and it opts other people out of the system into either no insurance or into CHIPs. And we are seeing the fruits of that sort of policy come back to us at this point, where we're seeing a lot of people that can't afford insurance and a lot of people who can barely afford insurance, goes back into a CHIPs type program. And not that I'm against CHIPs, but it's just a symptom of an underlying dysfunctional system that we have. So, again, we are not in support of section 3 of this bill. Questions or comments? [LB358]

SENATOR PAHLS: The previous speaker made some comment about everybody...there could be fees involved. Could that be into your profession? Could fees be assessed? I... [LB358]

DAVID FILIPI: Well, you know, again, like anything else, a fee against a practice...where

it's at, what income, balances out that fee. The fact is, that we're accepting a discounted insurance plan already; that fee is already factored into that. Even if we're...we talked about...and saying is...I'm believing 125 percent is not enough. As you approach 150 percent, that may be enough, but that still is a discount that we're accepting. [LB358]

SENATOR PAHLS: So what you're telling me, by your discount, you've already factored in "a fee." [LB358]

DAVID FILIPI: That's correct. [LB358]

SENATOR PAHLS: Okay. Thank you. Seeing no more questions, thank you for your testimony. When you're ready. [LB358]

DAVID FILIPI: Thank you. [LB358]

BRUCE RIEKER: (Exhibit 8) Good afternoon, 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, and on behalf of our 85 members, we're here in opposition to LB358. I appreciate the challenge for looking for solutions. I'd like to go through a couple of our concerns about the bill first, and then talk about some possible solutions. One, we will agree that the CHIP program is a very valuable program, a very important program, and hospitals, as much as anyone, I would think, wants to ensure the viability of this program, because we would much rather see people insured rather than uninsured and presenting themselves to our hospitals for care. I've heard a little bit about dumping. I'd like to talk maybe a little bit about the domino effect of dumping. We've heard, already we've talked about people being moved from employer or group or private insurance to the CHIP program, but it doesn't end there. The domino effect of this or changes in this program, I've heard a little bit about how it may move people to the SCHIP program. The SCHIP program may shore up part of this. But once people...the higher premiums that may be imposed, higher deductibles or something like that, at a certain point, and I don't know where that critical balance is, it becomes cost ineffective for those people to participate or just prohibitive for them to participate. They may be eligible for the SCHIP program. They may, more than likely, move to the Medicaid program, so once again, we're still talking about taxpayer funds to cover this. The more Medicaid recipients there are, and we're seeing more and more of those with the downturn in the economy, we're having people laid off, not having insurance, and reimbursement for Medicaid patients is approximately 70 to 73 percent of our costs, not our charges, but our costs. So one, it's undercompensated care, and I want to make sure that I point that out. But part of what happens is there are providers within the network who can elect, and I've heard...you've already heard about that, can elect to no longer accept Medicaid patients. So then they may move from...these patients may move from Medicaid to uninsured. The uninsured and the Medicaid usually then present themselves to our hospital emergency rooms for their treatment. If cost containment is

the highest priority, I would submit to you that developing a system or modifying a system that directs people to our emergency room, is probably not the most cost effective or most effective cost containment measure that there is. To give you an idea, the 85 hospitals that we represent, 83 are nonprofit; two are for-profit. In 2007, those hospitals provided...was $694 million of charity care. That would be undercompensated care or uncompensated care. Federal law requires us to be the backstop, so when these patients in need of treatment have nowhere else to go, they come to our emergency rooms. We have nowhere else to...we can't lay that...I mean, there is cost shifting, and we'll figure out how to maybe generate some revenues to cover it from maybe sections of our hospitals that have a positive return on investment. However, as you can see, there is definitely a domino effect. I know I've testified about this issue before, before the committee, but I know there's a little bit of discussion about higher deductibles. That sounds very good in theory, and many times that works. However, once again, we're seeing...I'm not saying that it's a majority, but with more challenging economic times, more people are getting their care...the insurance company or the payer pays for their portion of it. However, we're not seeing that the individual is paying their portion of the deductible, so once again, there's some of these things. A little bit about Medicare. Dr. Filipi, I guess, gave me a nice lead-in to what I want to share with you about some numbers. Medicare reimburses us for about 70 to 75 percent of our costs. So Medicare plus 25 percent or Medicare 125 percent would reimburse us for about 87 or 88 percent, and I emphasize this word, allowable costs as determined by CMS. CMS decides what our allowable costs are, and I know that it may sound impossible to run a hospital, but without telephones and things like that, but that is not an allowable cost under CMS, so those sorts of things don't go into our costs of providing care for reimbursement. Our parking lots are not included in that, so when I say that Medicare plus 125...our Medicare plus 25 percent reimburses us for 88 percent of our costs. We have to take off all of those unallowable costs that we have for providing care. To give you a more specific example, our critical access hospitals, which we have 65 of those, CMS reimburses them at 101 percent of their costs, allowable costs. So basically what they're saying is, we will pay you for your costs. You will not go into the red for providing Medicaid...or Medicare coverage, excuse me, Medicare coverage. For those who may think that our hospitals mark up the charges excessively, when we get 101 percent of our charges as reimbursed by Medicare, they pay us for 96 percent of our charges. So there is a 5 percent margin in their figure by CMS, so there's not a great amount of margin. Our hospitals are just like everyone else in the state, in the country, that our margins are thin. So I want to make sure that as we move the financial responsibility of this down the continuum, that hospitals by federal law are the backstop truly to catch this, and so share that with you now. With all of those concerns, it was pointed out by the commissioner, the director of the Department of Insurance, that they're looking at this would save...I mean, to increase premium payments as well as to reduce our reimbursements, it would save somewhere in the neighborhood of $4.5 million to $7.5 million. Two-thirds of that savings will be borne by hospitals; one-third will be by providers. So the hospitals will probably take somewhere in a $3 million to $5

million cut, maybe a $3 million to $4.5 million, somewhere in there, if those numbers are accurate. I have no reason to dispute those. Last fall when we discussed this issue with the Department of Insurance, the number was closer to $11 million. They've refined their estimate, so that's a little bit about what the financial impact, it would look...would be to us as hospitals. If you look at this situation in a vacuum, now I know that this has to deal with a couple other issues. But I want to submit to the committee and to the Legislature, that they look at this situation not in a vacuum, but in light of some other programs. The Nebraska Hospital Association has been a long-time supporter of increasing the eligibility for the SCHIP program, and we've heard how that is a possible program or program that could help alleviate some of the problems here. Nebraska is one of nine states in the country, that is the lowest eligibility participation of those nine states. They allow participation up to 185 percent of the federal poverty level, which is roughly $38,500 for a family of four. The SCHIP program which was reauthorized earlier this year by the federal government and signed into law is a block grant program. Roughly, it is a 30/70 match, though; 30 percent invested by the state, 70 percent invested by the federal government. If Nebraska were to go to 200 percent of the federal poverty level which is the benchmark that most states use, or that's what was reauthorized to at least go to without a waiver, according to our calculations, it would require an investment on the part of the state of $1.7 million, generating an additional $3.9 million of federal money which is already appropriated to come down and help insure 5,400 children. So one, there's a federal match there. The reason I share this with you is not that we are here to say that we would give up this money from the CHIP program, but there are some cost effective measures that the state Legislature could take, leveraging state money to bring down more federal money to make sure that more people are insured, thereby alleviating some of the cuts or the responsibility that providers would have to take. And just to let you know just how wonderful we hospitals are, the bulk of that SCHIP money would go to the physicians, because it would be more primary care. Why are we a beneficiary? Because those children will get their preventative care; they won't end up at our emergency room; we won't have to shift the cost to business and other payers. So that is one thing that the Legislature could do. Another thing, again, with federal match in the Governor's proposal...budget proposal, there is $8.2 million of General Fund cuts proposed. Now I understand that the Appropriations Committee has addressed some of those issues, and we'll see that later in their budget. There's an overall...from the Governor's Office, a proposal of a 1 percent increase for providers, but an $8.2 million cut in General Fund expenditures including a cut of 10 percent to our critical access hospitals that say, you know what? We're not going to pay you at cost; we're going to pay you at 90 percent of cost. Okay. Nebraska is roughly a 40/60 state; 40 percent of our Medicaid reimbursements to providers--hospitals, physicians, so on, and so forth is paid for out of General Fund dollars; 60 percent is paid for by the federal government. That $8.2 million cut, as proposed by the Governor, will result in an additional nearly $13 million cut in federal funds to our providers which results in a $21 million cut. So right there between two programs, I'm telling you how you could leverage some state money, approximately $10

million, and bring down well over $15 million to help alleviate some of the pain. That would definitely make this program...once again, if we're going to look at this in a vacuum, I'm not here to say that we would agree to taking these cuts. But if you're going to look at the comprehensive picture, we believe that there are ways to leverage state dollars to minimize the pain. And with that, oh, one other comment. Some of you may have seen with the economic stimulus package from the federal government that there's approximately $310 million that should come down for Medicaid from the federal government to help Nebraska. That's what the congressional budget office calculates as our share. There is a maintenance of effort requirement on that money that says that the state has to maintain the level of services and the level of eligibility. However, it says nothing with regard to maintaining reimbursement levels. Indications that we have so far is that money will be used to alleviate other stresses on our state's budget. So if anyone tells you that healthcare is getting a $310 million windfall, I would submit to you that it's quite the contrary. And with that, I'll close my comment. [LB358]

SENATOR PAHLS: Okay. Thank you. Senator Pankonin. [LB358]

SENATOR PANKONIN: Thank you, Chairman Pahls. Mr. Rieker, I didn't realize I was going to get a Health and Human Services hearing at the Banking Committee. Senator Gloor and I couldn't believe when you come to that one... [LB358]

BRUCE RIEKER: Well, I've done my LB136 testimony for tomorrow. [LB358]

SENATOR PANKONIN: Before we even have it. [LB358]

BRUCE RIEKER: Yeah. [LB358]

SENATOR PANKONIN: Anyway, regarding those points, I can't tell you what might happen there, and I think there's some valid points there. But I'm a little confused. You're saying, if we got...if that happened, well, then the hospitals could accept this easier. Is that kind of the assertion you're making? [LB358]

BRUCE RIEKER: I'm saying...exactly. I mean, if we're looking at a proposal of between, you know, taking a $23 million or $24 million hit because of a reduction in General Fund expenditures for Medicaid, we're going to take that and this...I mean, that's a pretty big load. You know, 20-some million dollars. I will say that if we can focus on leveraging some of our state funds to maximize a federal return that's already been appropriated, yes, we would be at the table, and we have visited with the Department of Insurance on this issue. We're a ways away yet from solving this, I mean, I could go into the complexity of Medicare. I mean, we still have to deal with outliers. And if anybody thinks that Medicare is simple, not one of our hospitals...all 85 hospitals in Nebraska have the same Medicare reimbursement rate. So...but, yes, Senator, we would be at the table trying to figure out how we as hospitals take our responsibility in shouldering some of

the burden, but not all of it. [LB358]

SENATOR PANKONIN: And the quick follow-up is, obviously, you heard earlier testimony that the policyholders are under pressure, and you mentioned about higher deductibles. You understand that it would be...some of the things you talked about would be very tough for this committee to go to the general budget and get funds to do this; talked about insurance companies involved. I mean, this is a tough issue, and it's probably one where no one is happy with the solution. But would you rather see us have it...this program versus none when that... [LB358]

BRUCE RIEKER: Yes. [LB358]

SENATOR PANKONIN: ...that would even be worse for the hospitals, wouldn't it? [LB358]

BRUCE RIEKER: It'd be worse, yeah. [LB358]

SENATOR PANKONIN: Okay, thanks, all I needed. [LB358]

SENATOR PAHLS: Thank you for your testimony, appreciate your ideas. [LB358]

BRUCE RIEKER: You're welcome. [LB358]

SENATOR PAHLS: Any more opponents? Anybody in the neutral? We have one in the neutral? [LB358]

ADAM STEFFEN: Thank you, Senator Pahls and other members of the committee. My name is Adam Steffen. That's S-t-e-f-f-e-n. I am the manager of Nebraska CHIP at Blue Cross/Blue Shield of Nebraska. We are the current administrator for the CHIP pool. Though we are here as a neutral speaker, I think it's plain to see from previous testimony that there are many good parts of this bill in that they...you know, it serves the appropriate purpose in containing cost, and limiting the eligibility to the people that truly need it. There is one section of the bill, section 3, that I would like to bring to your attention, and it's a section that Blue Cross/Blue Shield is opposed to. And that is the section that ties CHIP reimbursement to 125 percent of Medicare. Blue Cross/Blue Shield of Nebraska feels this will severely disrupt the current provider network, and the CHIP policyholders will suffer because of access issues. For example, the Blue Cross/Blue Shield Medicare Advantage Network contains approximately 50 percent of the providers in our current commercial network. Blue Cross/Blue Shield Nebraska also feels tying reimbursement to Medicare will further increase the cost shift to the private health insurance side. At the same time, the decreased reimbursement will be met with opposition by Nebraska providers along with their associations as previously testified today. You asked for an alternative; we have one. As an alternative, we would urge you

to allow Blue Cross/Blue Shield of Nebraska to leverage our current...our strong provider relationships and try to convince our providers to lower the current CHIP reimbursement rates by 10 to 15 percent on a voluntary basis. We would start with the hospitals and propose this reduction. This could conceivably result in net savings in the range of $2 million to $2.5 million on an annual basis. Over the next two to three years, we would engage the physician side which we believe could net an additional savings of $1 million to $1.5 million per year. After this initiative is complete, we believe total annual claim savings could be around $4 million to $5 million. This is fairly close to the lower end of the revised Nebraska Department of Insurance savings projections related to the 125 percent proposed legislation without sacrificing network depth and member access. Blue Cross/Blue Shield of Nebraska would be willing to undertake negotiating this voluntary reimbursement reduction as part of our administrative fee. However, if we are forced to build a network based on a percentage of Medicare, we would essentially have to start from scratch and build a new network similar to what we have done for our Medicare Advantage product. As a result, we would anticipate that an additional fee of at least $150,000, possibly up to $250,000 would be charged to the CHIP program to cover the cost of this network build-out. Allowing Blue Cross/Blue Shield of Nebraska to build this voluntary network would allow us to keep out-of-state CHIP claims tied to the national Blue Cross/Blue Shield Blue Card network. This allows CHIP policyholders to have access to in network care outside the state of Nebraska. The CHIP policyholders would have access to quality healthcare at the local discounted price negotiated by the local Blue Cross/Blue Shield plan. The policyholder would then not be subject to balance billing which is the difference between the contracted rate and billed charges. Therefore, our recommendation is that an interim study be taken out to discuss this section 3 of this bill. If you have any questions, I will try to answer them. [LB358]

SENATOR PAHLS: Is this a relatively new concept that Blue has come up...Blue Cross has come up? [LB358]

ADAM STEFFEN: This...yes, it is, and it came from the language in this bill. The reason, I mean, we had no reason to think of this in the past until the language in this bill was proposed, saying that it had to be tied to 125 percent of Medicare. [LB358]

SENATOR PAHLS: So am I correct, is this just in what people come up here and say, just tell me the bad stuff? But you think you have something that will breathe some life? [LB358]

ADAM STEFFEN: Sure. You know, it's...it's a little bit of...you know, bad news with some good news in that, you know, the providers would have to take less reimbursement, but there would be fewer providers opting out of the network, we feel with this option. So you keep the access...the member access available and still have the cost containment provisions in there. [LB358]

SENATOR PAHLS: Because I've heard from the providers a down side, and you think this would balance that out? [LB358]

ADAM STEFFEN: It would...it would not be as severe. The 125 percent of Medicare, as you heard, is a significant reduction in their payments, in what they are reimbursed. The 10 to 15 percent that we are proposing is much less. [LB358]

SENATOR PAHLS: Okay. So you brought forth a...you think is a solution. [LB358]

ADAM STEFFEN: Yes. [LB358]

SENATOR PAHLS: I appreciate that because I do feel some air coming back into my lungs. Because sometimes it gets mighty depressing to hear some of the things I've heard. Have you had much discussion with the department on this? [LB358]

ADAM STEFFEN: They are...we brought this proposal to their attention, yes. [LB358]

SENATOR PAHLS: Okay, okay. Senator Gloor. [LB358]

SENATOR GLOOR: Thank you, Chairman Pahls. You used...and maybe this is just a matter of definition, but you used the term "providers opting out of the network." Do you mean...to me, a provider network is a network with signed contracts with the Blues. Are you saying that they would drop out of the network entirely because of just this component, or are you saying they would no longer take CHIP patients and, therefore, would be lost to the network? [LB358]

ADAM STEFFEN: No, this would be a separate network that they would opt into or opt out of specifically for CHIP. It would not be related to our regular Blue Cross network. [LB358]

SENATOR GLOOR: Thank you. [LB358]

SENATOR PAHLS: You brought an idea that I don't think had...at least I had not entertained. It seems like this is...was for some more study. I thank you. [LB358]

ADAM STEFFEN: Thank you. [LB358]

SENATOR PAHLS: And just to correct myself, you came in on the neutral? [LB358]

ADAM STEFFEN: Yes. [LB358]

SENATOR PAHLS: Okay, thank you. Any more? Okay, I think that will close the hearing on this LB358. Thank you. We are ready for LB326 under Senator Rogert. Senator, you

may begin. [LB358]

SENATOR ROGERT: (Exhibits 1, 2 and 3) Senator Pahls, good afternoon. Members of the Banking, Insurance and Commerce Committee, my name is Senator Kent Rogert representing the 16th Legislative District, and I'm here today to introduce LB326 in my television debut for the Banking and Commerce Commission. I'm excited. LB326 is a bill that seeks to provide coverage for two specific procedures related to bariatric surgery and to establish an independent review process for disputes over coverage under the Comprehensive Health Insurance Pool Act, CHIP, as you guys have been listening to all afternoon. I do have an amendment...oh, I forgot to give that to the page, that you can look at that broadens it just a little bit. In the bill we leave it very specific to two procedures. The amendment broadens it to be anything that's established by the several associations related to bariatric surgery to be improved, to be approved and covered. The purpose behind LB326 relates to the point that gastric bypass surgery can produce positive results for those persons with, for example, type 2 diabetes that currently affects around 20 million Americans, as quoted in a World-Herald article, who as they age can become subjected to blindness, limb amputations, kidney failure, coronary heart disease, and morbid obesity. A gastric bypass would allow a person with type 2 diabetes and associated obesity to lose weight in order that the insulin produced in their body need not be as much to cover the area. It has also been noted in a couple of articles that a bypass could cause hormonal changes that would stimulate the release of insulin in the body, which the person with diabetes is deprived of. The American Society for Metabolic and Bariatric Surgery has estimated that bariatric surgeries are rising from 36,700 in the year 2000 to 205,000 last year. A gastric bypass or banding procedure can cost anywhere from $15,000 to $20,000 depending on the hospital stay. So you can see, just for the procedure alone, it's pretty difficult for an individual to front the cost if they don't have proper coverage. Now we contend that the benefits in the long run will offset the costs associated with coverage for the surgeries. Patients may no longer be dependent on medication, may be able to exercise with less discomfort and pain, may no longer need medical equipment for sleep apnea, may no longer need blood glucometer and to check for blood sugar, and they may no longer need a cane, wheelchair, or scooter, just to name a few of the benefits of the surgery and the procedure at the end. Bariatric surgery may also replace those years of life expected to be lost due to diabetes and obesity. Some insurance companies yet do not cover this procedure or if they do, it's only allowed on a very narrow basis, but it's on the rise. More and more are covering it all the time. This is the reason that we've included a provision that provides a review process for those individuals who feel that they have been unfairly denied coverage of the CHIP program. That's basically the gist of it. I will have some very qualified individuals from the medical field, and a couple of those experiencing health issues coming behind me to testify. But I'll answer any questions you may have, but I would direct most of them behind me. [LB326]

SENATOR PAHLS: Senator Gloor. [LB326]

SENATOR GLOOR: Thank you, Chairman Pahls. Senator Rogert, I want to make sure I understand right the original bill was going to mandate coverage for two specific procedures, yet now the language is going to be for all bariatric procedures recognized by the American Society of Metabolic and Bariatric Surgery and the American College of Surgeons. [LB326]

SENATOR ROGERT: Well, the first half is correct. The second half would be so, if this committee so chooses to adopt the amendment. We've been toying back and forth with the idea of whether we would like an expanded version or not. We had the amendment drafted. I thought I would provide it to you for your consideration, if you so choose. That would allow...these procedures are growing and changing as technology and experience desires. They...originally these two covered were the ones they started with. They have two new procedures that are becoming very successful and probably will be covered more often by insurance companies. They may not be the replacing surgeries but they may be for certain instances the ones that they choose over these two. So it may be, if we decided this is the coverage we want to have, maybe it's advantageous to say that those that are covered by those associations that are approved, those would be the ones we would want to look at rather than having to come back again to ask for those procedures. [LB326]

SENATOR GLOOR: Will you have a testifier who can speak specifically to what kind of a number we're talking about? [LB326]

SENATOR ROGERT: Yes. [LB326]

SENATOR GLOOR: Okay. Thank you. [LB326]

SENATOR PAHLS: Senator Pirsch. [LB326]

SENATOR PIRSCH: You know, I always thought my law degree would be useful coming to the Legislature dealing with... you know, being that we deal with laws. [LB326]

SENATOR ROGERT: You can't pronounce those, can you? [LB326]

SENATOR PIRSCH: Yeah, I can. But I tell you, I've changed my...I think the most useful background now is an actuarial background and statistical background. And so much of what we're asked to do is just simply to invest a penny today for a pound tomorrow. And so towards that end, I think an empirical approach, a statistical approach toward...I mean, that's part of this, right, as in...as I've come to find almost every bill is if we pursue this path. In the short-term, which might require a little bit of extra expenditure at some point in the time, will limit the number of costs in a greater way to the state. And

so toward that end, I wonder if there is any empirical studies, have any other states done this, in terms of providing the seedling money and getting...seeing a decrease? I mean, the thought here, the underlying premise here is, if you provide the state increases these coverage here, or if you increase the coverage, right, mandatory coverage, for all bariatric procedures, that in the long run that will...the number of people that have complications due to obesity, diabetes, etcetera, which are very expensive or come down, is there any kind of statistical back? You know, has this been tried in a different jurisdiction? [LB326]

SENATOR ROGERT: Yeah, I don't have the exact statistics. Some of these guys will have the numbers behind me a little more accurate to you. But I will say that, all 12 of the nearby states of ours cover this procedure and I believe there's only 15 in the nation that aren't covering it. So a lot of them have seen the effect and the benefit of going ahead and doing that. I do also agree that healthcare, in my opinion, is all about preventive maintenance. The more you can do up-front, it most of the time will save you money in the end. Like you said, the complications do to obesity and diabetes down the road are very expensive, oftentimes they end up as part of that 20 percent that eats ups 80 percent of our budget in healthcare areas. Most folks would contend that if they were able to get this procedure done early in life that their major healthcare concerns would be over, thus saving lots of money. [LB326]

SENATOR PIRSCH: Thank you. [LB326]

SENATOR PAHLS: Senator Utter. [LB326]

SENATOR UTTER: Senator Rogert...thank you, Chairman Pahls. Senator Rogert, we have just heard prior to your bill about CHIPS program that's in trouble, or potentially in trouble. [LB326]

SENATOR ROGERT: Yes. Correct. [LB326]

SENATOR UTTER: And if I'm looking at the fiscal note properly, why we're talking about another $250,000 to $600,000 worth of trouble. How do...what's your solution to getting out of this problem? [LB326]

SENATOR ROGERT: Well, Senator, I contend that, and I'm sure those in the Health and Human Services Committee hear it every day. In spending this money up-front will save upwards to ten to twenty times that amount on the backside. Having folks in need of intensive healthcare for 20, 30, 40 years of their life would easily outweigh the $20,000 to $50,000 worth of initial cost to have this procedure done, hopefully, in terms of curbing much of the further need for healthcare insurance. And I think that's where we may get into trouble in many of these programs is that we're so afraid to go spend a little more money up front, and if we just often did that, it's the same kind of thing as

Wellness, the Wellness Program. Just by putting a little more money into the up-front and by preventing things that you can down the line, it will save you a great amount of money in the end. [LB326]

SENATOR UTTER: I don't necessarily disagree with what you're saying, but I... [LB326]

SENATOR ROGERT: It's a hard sell. [LB326]

SENATOR UTTER: ...in our current economic environment, it seems to me to be a difficult sell. [LB326]

SENATOR ROGERT: It is. And I contend that at times maybe in the current economic environment we need to figure out a way to spend our resources we have in order to save money down the road. [LB326]

SENATOR PAHLS: Senator, this just brought to my mind. My sister-in-law, who is a doctor, just went through major surgery and I was talking to her about it, and her insurance did not cover this. Do other insurance company policies, I mean, just like regular insurance... [LB326]

SENATOR ROGERT: Some do. Some do. [LB326]

SENATOR PAHLS: Okay. Because I knew it had to be an unbelievable expense but she saw the need. [LB326]

SENATOR ROGERT: Yeah. [LB326]

SENATOR PAHLS: Seeing no more questions. Are you going to be around for closing? [LB326]

SENATOR ROGERT: Probably not. I'll let these guys take care of it. Thank you. [LB326]

SENATOR PAHLS: Okay. Thank you. Appreciate it. We will go again with the proponents. Can I, just by a show of hands? I see four proponents. Four or five, okay. Any opponents? Okay. Two. Neutral? Okay. Thank you. You may begin. [LB326]

KENT BERNBECK: (Exhibit 4) All right. My name is Kent Bernbeck, B-e-r-n-b-e-c-k. Thank you for hearing testimony today. First of all, I guess I kind of want to put a...I was thinking about what I can do best for this bill. I asked Senator Rogert to introduce this some time ago. This bill has kind of been in the works for about a year, when I first encountered my situation with the healthcare system. I want to put a face on this because it's real important, especially after the previous bill's testimony. It was all about money. It was all about procedure, money, how we're going to handle this thing. I

appreciate what you said about the solution. I have come up with a solution. It's one small part of the solution. It's not the silver bullet that's going to get us out of this mess, but it's one small solution like Senator Rogert said, that if we spend just a little bit up-front, we can do a lot to save money down the road. I'm a living, breathing example of that. I'm a healthcare provider. I staff nursing homes around the state. I know very much what it means to roll with illnesses because I see it every day. I'm experiencing it. I'm a diabetic, I had my double bypass two years ago. Shortly before these pictures were taken, I almost died because of a blood disorder that I had from it. So I mean, you know, I guess that I'm saying here today is that we really do need to think a little bit different about how we approach some of these things. I'm stuck with CHIPS. I'm a CHIP member. I'm stuck with you guys. I'm stuck with the CHIP, the CHIP board, I guess, I should say. And I very much would like to have my own health insurance policy. I really would. I mean, I can probably afford it. I can...but no one will take me. Absolutely no one will take me with diabetes, heart disease, sleep apnea. I mean, there's probably a list of about ten of them I've got. This is my way out of my situation is to get a surgery that's pretty much irreversible to, to, you know, solve what has led to my heart disease and diabetes and all that. You know, I'm an eater. I love food and I really wish that I could stop. I mean I've got four kids telling me every day, stop eating, dad. I've had doctors tell me it's like, you're not going to see your kids graduate unless you stop eating. Well, after two years after my heart attack, you know, look at me, I hit my morbid obesity period, or you know, I'm there. Dr. Brandt, my heart doctor has put me back into a stress test so you can see what's going on with me right now. I mean, I'm kind at the end of my rope. I mean, I looked at this a year ago, and thought well, maybe if CHIPS could maybe change its thinking a little bit, I'm going through the appeal right now. I'm in the last stage of that, which that's why I included that last part of this bill was to have independent review because what I've been through, you know, Blue Cross is a wonderful organization, CHIP is a wonderful organization, but it was a joke what I went through. I mean, those doctors and people were paid to come down and tell me no. So an independent review, I think, is only appropriate. We're only one of seven states in the country that don't have it. And I'm asking it specifically for CHIPS. And I guess one other thing, too. I specifically asked Senator Rogert to draft this bill conservatively knowing that the costs are always a factor. And that's why I did some research and found out that the two procedures that I asked him to put in this bill are the most successful procedures. It purposely excludes banding procedures which aren't as successful. They can be very successful but they're not as successful. I try to look at this as most conservatively as I can. I have cost the state, because of...I'm in CHIPS, $52,000 a year. That's what they've paid out. That doesn't count my premiums and my out-of-pockets. In the last three years, that's what it cost. The surgery cost about $20,000 or $25,000. I mean, it doesn't take long to do the math to think, okay, we can spend a little bit here. It don't cost a lot, but if we spend a little bit here, think of the diabetes, the heart problems and all those other factors, that for the most part would go away. So anyway I'm putting a face on this bill, or my kids' face on the bill, because I think it's important that we look at the bigger picture, obviously, because we have to

have the system. We've got to have this CHIPS because I honestly would not have insurance if it weren't for CHIPS. But we have to think a little bit differently, otherwise we're going to find ourselves spending ourselves into the situation we're in. So I'm asking the board for this opportunity. I'm providing the solution for you. Take the opportunity to think differently. [LB326]

SENATOR PAHLS: Do we have any questions here? Seeing none, thank you. [LB326]

KENT BERNBECK: Thank you. [LB326]

SENATOR PAHLS: Appreciate your testimony. Next proponent. [LB326]

GARY ANTHONE: (Exhibit 9) Thank you, Senator Pahls. My name is Dr. Gary Anthone. I'm a bariatric or weight loss surgeon in Omaha, Nebraska. I'm here to speak today as proponent for this bill. [LB326]

SENATOR PAHLS: Could I have you spell your name? [LB326]

GARY ANTHONE: A-n-t-h-o-n-e. [LB326]

SENATOR PAHLS: Okay. Thank you. [LB326]

SENATOR PIRSCH: And also as an advocate for morbidly obese or bariatric surgery patients. I have great experience in weight loss surgeries performing over 2,000 in my lifetime. I've been performing this surgery when it wasn't popular, starting back in 1991. Morbid obesity is an epidemic in the United States. Approximately 12 million adults are morbidly obese. And that means, generally, having a weight over 100 pounds over your ideal weight. These are associated with the health problems, mainly type 2 diabetes and sleep apnea, such that a morbidly obese male will expect to lose 12 to 14 years of life expectancy. Now that might sound like a cost savings to some, but in the end, it's not, and I'll give you an example. There was a morbidly obese patient transferred down to our hospital a few years ago who was...had a nonthreatening life problem to most patients, an incarcerated strangulated hernia. And this patient was already on a ventilator because of their health issues, and after doing surgery for this patient, she eventually succumbed three months later in the hospital with her hospital charges in excess of $2 million. Now this was an issue that could have been taken care of with a $15,000 to $20,000, $25,000 investment up-front. I know that's an extreme example, but it's something we don't hear about all the time. Now there are four main surgeries that are approved by the surgical societies that approve or disapprove weight loss surgeries and those are the gastric bypass procedure, the duodenal switch procedure, the lap-band procedure and the vertical sleeve gastrectomy. And those procedures have all been proven to be effective and safe in the long run. I'm not sure if Senator Rogert included that in his packet, but we have numerous studies demonstrating the economic

savings for bariatric surgery. The return on investments for patients, specifically with type 2 diabetes or sleep apnea, and these studies show that a return on investment with a surgery costing between $15,000 and $25,000 is anywhere on the order of two to four years after their surgery. And that's not even using the example I used about the patient who had that other life threatening issue that eventually cost the taxpayers over $1 million. Now there's been some issues concerning the safety of weight loss surgery or bariatric surgery. In 2003, the American College of Surgeons and the American Society of Bariatric Surgery started a Center of Excellence program, such that if a hospital or surgeon was going to be certified by these societies and have a Center of Excellence, they had to demonstrate through, very similar to a JCAH site review, that they could do this surgery safely and effectively. Since the introduction of the Center of Excellence program, the morbidity and mortality rates for patients having bariatric surgery have reduced dramatically, such that most centers now that are certified through these societies, have less than a 1 percent mortality rate. To put that in perspective, if you were to go into the hospital tomorrow to have your colon surgery, bariatric surgery is now safer than patients having elective colon surgery. Lastly, I'd like to just thank the Senator Pahls and the group for allowing me to speak today. I was the director of bariatric surgery at the University of Southern California in Los Angeles prior to moving back to Omaha five years ago. And to just have the opportunity to speak on behalf of our patients, morbidly obese patients, is a great advantage for me. So thank you for that opportunity, and I'll be glad to answer any questions. [LB326]

SENATOR PAHLS: Senator Pirsch. [LB326]

SENATOR PIRSCH: I've just a question with respect to the way the bill was written. It looked like the first testifier who had some background in health sciences had suggested those. Do you agree that those, if we were to do two, that those two billiopancreatic diversion with duodenal switch and then the Roux-en-Y gastric bypass, that those two procedures are the most cost-effective or you get the best return on investment? [LB326]

GARY ANTHONE: My personal opinion is, yes. However, I know from other studies that the other two procedures that are approved by the societies have also been proven to be the safest procedures up-front, but maybe the long-term results are not as good. [LB326]

SENATOR PIRSCH: Thank you. [LB326]

SENATOR PAHLS: Senator Gloor. [LB326]

SENATOR GLOOR: Thank you, Chairman Pahls. Thank you, for your testimony, Doctor. There is a pretty intense regime of aftercare, I am guessing, for these patients? [LB326]

GARY ANTHONE: Correct. [LB326]

SENATOR GLOOR: And who is responsible for providing that aftercare? [LB326]

GARY ANTHONE: You know, in one of the statements that we have in bariatric surgery or as a bariatric surgery, is that if you're going to enter into the field of bariatric surgery, it's sort of like entering into an Italian marriage. Once you enter into that, there are no divorces. You can separate but usually it's not the doctors that are separating. So it is the surgeon and his program, his team, and most Center of Excellence programs are not just surgeons. They're teams of all sorts of healthcare professionals, nurses, mid-level, you know, professionals, things of that nature. [LB326]

SENATOR GLOOR: But in any marriage or divorce it takes two, and so if the patient is not compliant, or runs away from that particular marriage, there's not a lot that you do about that. I mean, do you have any idea of what your level of noncompliance for these patients is after, say, two years? [LB326]

GARY ANTHONE: Yes. You know, when I was at USC we published our results, our ten year results after being there, and our actual follow-up rate is around 55 to 60 percent. Since moving back to Nebraska because of less mobility in the population, since being here five years, it's on the order of 70 or 80 percent. But to go back and answer your question, our patients are screened extensively. This is not something where patients just decide to have one day and they're having surgery the next week. Our actual process is about a three-month process getting patients ready for surgery, making sure that we know they're going to be compliant, or hopefully so, having them undergo all sorts of psychological evaluations and things like that that you don't even think about with other high risk surgery. So it's a very intensive process. But, of course, you know, we're never going to have a 100 percent compliance. [LB326]

SENATOR GLOOR: But that approach that you're talking about is what's been agreed upon to by someone designated as a Center of Excellence. [LB326]

GARY ANTHONE: That's correct. [LB326]

SENATOR GLOOR: If somebody isn't a Center of Excellence, they don't necessarily have to adhere to aftercare regimes or do continued follow-up on those patients. [LB326]

GARY ANTHONE: That is correct. But I know of really, hardly any bariatric hospitals, surgery hospitals now that are going to survive if they're not a Center of Excellence. [LB326]

SENATOR GLOOR: The 1 percent mortality morbidity is an excellent number, but what is it when you look out two to three years for patients because of some degree of noncompliance? Understanding that Medicaid would be responsible for paying for those patients who are not compliant and get into trouble and overeat and have bands that now, all of a sudden, are problematic, and what not. What's the number for noncompliant patients? And I know there have to be some degree of numbers that help us with trying to figure out that end of the expense. [LB326]

GARY ANTHONE: Well, I mean, the big risk for this surgery is an intraoperative or postoperative complication. The risk of having other complications as the surgery goes on, or as the patient is further out from surgery, is very low. Very, very low. Very, much, much less than 1 percent. The big risk is in the surgery itself. And, you know, the noncompliant patients, you know, we ran across that all the time in California. You know, they've got to go somewhere and usually they end up going to somebody that, or a hospital that knows how to deal with those situations. [LB326]

SENATOR GLOOR: But there would be an expense, obviously, for noncompliant...I'm glad to hear that 70 percent compliance rate for your patients. You know, Nebraskans have a reputation for being trustworthy and dependable. [LB326]

GARY ANTHONE: Let's say, less mobile. [LB326]

SENATOR GLOOR: Yeah, and less mobile, I would imagine. But certainly, there are complications and expenses associated with those noncompliant patients and we don't really have that number. [LB326]

GARY ANTHONE: No, we don't. [LB326]

SENATOR GLOOR: Now, have there been any studies to tell us what that additional expense might be? [LB326]

GARY ANTHONE: I do not know of any. [LB326]

SENATOR GLOOR: Thank you. [LB326]

SENATOR PAHLS: Senator Pankonin. [LB326]

SENATOR PANKONIN: Thank you, Chairman Pahls. Doctor, I also served on the Health and Human Services Committee, as Senator Gloor does as well. I'm...and somewhat it relates to this. I'm just curious why you came out of L.A. to come here. Are you formerly from Nebraska or what? [LB326]

GARY ANTHONE: Correct. Grew up in Omaha. [LB326]

SENATOR PANKONIN: Okay. So just wanted to come back to this area? [LB326]

GARY ANTHONE: That's correct, for family reasons. [LB326]

SENATOR PANKONIN: Okay. Great. [LB326]

GARY ANTHONE: And to get out of California. (Laughter) [LB326]

SENATOR PANKONIN: We're glad you're here. And as far as the general population of what you see here, is this the worst situation, the worst problem with this obesity issue that you've talked about here versus there, or is it the same everywhere as it persists. [LB326]

GARY ANTHONE: That was the most common question I was asked when I decided to move back to Nebraska, is you're going back because you know that's where all the fat people are in Nebraska. But it's a 4 percent incidence in the general population. And to be honest with you, it's a numbers game. Four percent of 18 million people in southern California are a lot more than 4 percent of 1 million people in Douglas County. But you know, it's a constant number. It's pretty constant all throughout the United States. [LB326]

SENATOR PANKONIN: Yeah, through the country. [LB326]

GARY ANTHONE: Yeah. [LB326]

SENATOR PAHLS: Senator Pirsch. [LB326]

SENATOR PIRSCH: And I'll be brief. I'm not even sure if you can answer this question given your specialization within a certain area of medicine. But it's...you know, we, unfortunately, in the Legislature approach...the premise here is cost-savings, paying an ounce of prevention, a pound of cure. And unfortunately, we approach things that make sense like that in a piecemeal fashion. And so I asked you, among bariatric type of surgeries, you said, these two probably are the biggest, the low-hanging fruit, the biggest bang for the buck, so to speak. But now to broaden the scope out and say, as we look at...because we're the steward of all, you know, this would have certain costs to the state, and unfortunately, we approach things in a piecemeal fashion, so here today we address a bill that deals with limited to the scope of bariatric surgery, is it good or not. Could you place this in a greater perspective? Would this, would bariatric surgery in this type of obesity be one of the low-hanging fruit that you would first, if you're looking for investments of the state in healthcare, that broad, general kind of spectrum, would this be one of...and I don't know if you can answer this because you're in a narrow speciality, but is this one of the first places that you'd turn to and say, just within the

general spectrum of healthcare, let's first turn to actually bariatric just happened to be in that and this would be one of the greatest cost-saving areas when you're looking at what the government can do with its finite amount of ability to fund these type of things. [LB326]

GARY ANTHONE: Well, you're entirely right. I mean, I'm so biased it's hard for me to look outside my tunnel, but whether it be the first or not, I don't know. But you know, it's an epidemic and the real issue is not with adults. The real issue now is the upcoming generation. And did you know that there's a study that showed that infants that are borne to morbidly obese mothers have about a ten to fifteen full higher incidence of being morbidly obese adults. And if those morbidly obese mothers have weight loss surgery before they conceive, their children's risk of being morbidly obese go down to the general population. So there's...every last time I noticed, every patient I operated on had a mother at some point. So I think that would be a huge cost savings. [LB326]

SENATOR PIRSCH: Thank you. [LB326]

SENATOR PAHLS: Thank you for your testimony. Next proponent. [LB326]

SHELLY HOLMAN: My name is Shelly, S-h-e-l-l-y, Holman, H-o-l-m-a-n. Good afternoon, Senators. Thank you for allowing me to speak. My name is Shelly and I'm a registered nurse. I am the bariatric program coordinator at St. Elizabeth. But I'm also a weight loss surgery patient and when I read about LB326 I really felt like I wanted to share my personal experience and I will do so in a short amount of time. I have been a nurse for 30 years and I've worked in intensive coronary care out in Colorado for about ten years, emergency room medicine, and renal dialysis, so I have seen the effects of deterring health secondary to obesity throughout my career. Obviously, some patients can have hypertension and renal failure and they're not obese. But the majority of sleep apnea, hypertension, heart disease, type 2 diabetes, are result of 60, 50, 80, 100 extra pounds, plus more. So professionally I have taken care of patients in the hospital as a result of being overweight. Then my own personal experience. I really never had a weight problem until I left for college and then I was the typical yo-yo dieter, gain 20, lose 20, gain 30, gain 40, lose 30, all the way through. And you know, I'm a very intelligent successful woman and it was like, why can't I lose weight and keep it off. So I finally, after losing and gaining 70 pounds three times and being physically active working out at the Y, biking, doing the things that I knew I needed to do to take care of myself, I still was unsuccessful and as I hit my mid-life, I found that it was harder and harder to lose. I developed type 2 diabetes. I have elevated cholesterol and was feeling really pretty hopeless about this. Now I do think that obesity does come through the generations and families just like heart disease, alcoholism, mental illness, and a lot of other disease processes. I can look back on my own family and see that. So as a nurse, and as a patient really struggling with these health issues I did a lot of research and looked at the adjustable gastric lap-band for myself. Now in my letter that I wrote to

Senator Rogert, and I assume that you all received a copy of that, I would like to just touch on that I worked years in the cardiac intensive care unit and understood that when a patient had occlusive coronary arteries, they received treatments such as stents in the cath lab, pacemaker, or they have a CABG, coronary artery bypass. My thoughts are similar for patients that struggle with their weight and have demonstrated that they have tried over, and over, and over again to lose their weight and keep it off. And they may do so for three or four years, but it's back and their health has suffered from that. Weight loss surgery to me personally was my pacemaker. My lap-band is the tool that I need to help me to control my portions, to help me fill full faster and to allow me to lose...I lost 70 pounds. I've maintained it for three years. You know, it's a daily treatment for me. I cannot say where I will be in two years, because the disease of obesity to me is lifelong. It's no different than anything else. I think some aspects of it are food addiction, I think for some people it's lack of effective coping skills in their lives where they find food or alcohol or whatever as a way to deal. So anyway, I will close here and I would like to touch on Senator Gloor's question about complications or patients that are not compliant. You know, I would like to say that in my research and what I've looked at it's about 20 percent of the population. However, I do think that if you would look at a group of coronary artery bypass patients that are done at NHI, what percentage of those patients are not compliant. How many of those patients go back, are gung-ho, got to their critical access hospital, do cardiac rehab for their three months, follow their diet the way they're supposed to, and within a year have gained weight, have dropped out of cardiac rehab, have started smoking again, and show back up with reoccluded coronary arteries. It happens time and time again and I guess, you know, I'm defending weight loss surgery because it is, there's a loss of bias out there that it's cosmetic and it should not be done for cosmetic reasons, and it's done for people that are weak and can't lose weight and keep it off. And I...working in the field, I see it every day. People come to support group, stand up and talk about seeing their cardiologist and they're off three of their meds. I do believe in a strong aftercare program. I believe that surgery is the end. Your life afterwards has got to be structured, you've got to have support from the interdisciplinary team that Dr. Anthone's talked about. There has to be a high degree of engagement. The candidates for weight loss surgery have to be screened carefully because they have to have the skills and the ability to follow lifelong rules and a treatment plan for success. And I'm in the business to make sure, and my team at St. E's is in the business to make sure our patients do succeed. We want these people to get well. We had a patient reunion, a second annual patient reunion where we invited everybody back just this last fall. I had 70 participants that were there that were actually weight loss surgery patients. The total number of pounds lost with 70 participants was 4,305. The total number of patients that have eliminated their medications out of those 70 people were 84 medications gone. Six had been able to get off their CPAP, which is the treatment for sleep apnea. Nine were no longer checking their blood sugars, and six had been able to get rid of their scooters, wheelchairs and canes. Please carefully consider assisting myself and the profession that treat, and treat and do preventative education to address the obesity epidemic in Nebraska as well as throughout the rest of

the United States. I guess that's really all I have to say. I do want to...I'm sorry, I do want to close with one thing. Centers of Excellence is an awesome program. I think that a lot of times a lot of us think about weight loss surgery that was early generational in the '50s and '60s where patients died, where surgeons were maybe not trained or where facilities didn't know how to take care of these patients. If you're a Center of Excellence that means you're doing volumes. You're doing these cases day after day. Your surgeons are doing so many cases a year. Your staff is dedicated. They know how to take care of the patients. The pathways are established, and we are committed to five years to follow up with our patients. So if we don't see our patients in three months, they get a postcard or a phone call that says, hey, you missed your visit. You need to come in. Now, we can't drive to their house and bring them in but we are really trying very hard to improve outcomes and improve success rates. One thing I did want to say, I'm off my glucofast, I'm off my cholesterol meds and I'm in maintenance and I'm happy. Thank you. [LB326]

SENATOR PAHLS: You can tell by the smile in your voice. [LB326]

SHELLY HOLMAN: And I'm passionate. [LB326]

SENATOR PAHLS: Yes. Next proponent. [LB326]

KEVIN MANULAK: Good afternoon, Senators. My name is Kevin Manulak, K-e-v-i-n M-a-n-u-l-a-k. I'm here today, Senators, for supporting LB326. I am a recent bariatric adjustable lap-band patient. I've had problems with my weight all my life basically. I mean, up and down, up and down, on different diets, things like that, and then I ran across this last year. Had my surgery back in August of '08 and I've lost 127 pounds. Diabetic, 17-year diabetic, 12-year insulin dependent. I am totally off my insulin. My cholesterol dosage has dropped 75 percent. My family doctor seems to think that eventually I'll probably get off all my medications that I take. I have a cost here, just to give you guys an idea. The retail cost on my, my medications, my needles, lance, different things like that, I had sleep apnea. I'm off that now. I no longer use the CPAP machine. The cushions for the mask. That retail cost was $1,031.75 a month. It...my surgery was roughly, I think it cost right around $20,000 to have it done. So as you can see, just in my insulin and what I've saved that's $12,000 a year, you know, so it's going to pay for itself in a year and a half. And long term, I mean, it's going to, I think, really save the insurance companies a lot of money. Save the state a lot of money for, you know, just different things, like folks were saying earlier, you know, where to come up with this money, but I think in the long run it's going to save everybody a lot of money down the road. I mean, it saved, you know, it saved me...you know, obviously, I didn't pay that retail price but it still saved me money myself, too. I mean, not only...but, not only that but it will save insurance companies money. So it's only been seven months but like I belong on the hereafter care that you were talking about. I belong on the bariatric patient advisory board at St. E's Hospital, support group, and it's a very good, a

very good organization to help people to get through their rough times and stuff like that. That's what we're there for to help them, you know, work through those tough times of, you know, falling back or not, you know, going back to their old habits and stuff and keeping them on the right track. So that's basically all I got to say. It's, you know, it's, you know, I had a health fair at work, you know. Fortunately, my insurance paid for everything, but I had a health fair at work and I mean, my cholesterol has dropped, my blood pressure has dropped. I mean, everything has just been fantastic. My mobility is unbelievable. I've got twice the energy I used to have, you know. It was hard getting in and out of a car, doing anything, you know, normal people do. And it's just been a blessing to be able to have this surgery, and I know other people that I work with that have had it and they virtually got off their insulin and stuff too. So most of the people I've talked to that have had the procedure have gotten off their insulin dependency. So it does, it does make a big difference as far as your medication and stuff. And I think in the long run it will save insurance companies a lot of money down the road, you know. Yeah, the initial cost is there but, you know...I don't have the calculations here but, you know, 12 years at $1,000 a month, retail cost, that's a lot of money. So that's all I've got to say, gentlemen. [LB326]

SENATOR PAHLS: Do we have any questions? Thank you. The last two people made me feel guilty. I see...is the last proponent? You may begin. [LB326]

BRUCE RIEKER: (Exhibit 5) Chairman Pahls, members of the committee, my name is Bruce Rieker, that's R-i-e-k-e-r, vice president of advocacy for the Nebraska Hospital Association. In contrast to my testimony on the last bill, I went from lots of words to very few words. We support this bill. And just add one fact that we hope you will take into consideration is that CMS, the Center for Medicaid and Medicare Services, has recognized this, these procedures as important and cost effective measures that should be, or that they provide coverage for, for Medicare eligible individuals. That concludes my testimony. [LB326]

SENATOR PAHLS: Thank you. Seeing no...yes, yes, Senator Gloor. [LB326]

SENATOR GLOOR: Thank you, Chairman Pahls. Mr. Rieker, do you know how many of the procedures does CMS cover? [LB326]

BRUCE RIEKER: How many of the...I do not know. [LB326]

SENATOR GLOOR: Okay. And do you have any idea how many hospitals? [LB326]

BRUCE RIEKER: I know that they cover the two that were in the original bill, but as far as other ones, I do not... [LB326]

SENATOR GLOOR: Okay. They more extensive? [LB326]

BRUCE RIEKER: ...know how much more expansive it is, no. [LB326]

SENATOR GLOOR: Do you know how many hospitals do this procedure in this state by any chance? [LB326]

BRUCE RIEKER: No, I don't. [LB326]

SENATOR GLOOR: Okay. And my next question was going to be, how many are Centers of Excellence but that's... [LB326]

BRUCE RIEKER: (laugh) I can get the answers for you, Senator. [LB326]

SENATOR GLOOR: Actually, I would appreciate that. [LB326]

BRUCE RIEKER: I will do that. [LB326]

Audience Member: I can answer that question. [LB326]

SENATOR PAHLS: No, we can get that information later on. Thank you. Seeing no questions, thank you for your testimony. [LB326]

BRUCE RIEKER: You're welcome. Thank you. [LB326]

SENATOR PAHLS: (Exhibit 7) Any more proponents? Opponents? While the opponents are gathering themselves, do you want to read into the record the Association of Insurance and Financial Advisors oppose LB326. The floor is yours, director. [LB326]

ANN FROHMAN: (Exhibit 6) Thank you. Good afternoon, my name is Ann Frohman, that's F as in Frank, r-o-h-m-a-n for the record. I'm the director of insurance and while I do not ordinarily testify on mandate bills because I think it's within the wisdom of the Legislature to easily resolve the questions before them on mandates, I do feel that today it's necessary that I state the opposition to LB326 and to advise the committee why I'm here to do that. And I think we have heard a couple of really interesting and compelling stories on the surgery that is the subject of the mandate for coverage today. And I have all the compassion for these individuals going through this struggle and do believe that, you know, everything that they can do to better the situation is what we all wish for them. The issue before us is really, with respect to this bill, a mandate for one exclusive program to provide the coverage. And that mandate is for the CHIP program. And it will, in my opinion, only exacerbate the financial problems the CHIP program is experiencing, which was subject to the discussions of the earlier bill before you today. The current law requires that the standard for coverage be the coverage available in the private marketplace. Therefore, we have not had, historically, any CHIP mandate bill

ever enacted because the CHIP program simply follows what's available in the marketplace. The board with the aid of an independent actuary, adjusts the benefits per those statutory requirements and regularly and periodically updates and fine tunes the coverages available to be in touch with what the market is providing. And gastric bypass and the bariatric coverages that are before you in this bill are not benefits provided by a majority of the individual sellers of insurance in the Nebraska marketplace. In this case, the procedures, as we understand, can cost anywhere between $20,000 to $55,000 per surgery depending on the surgery, and that's in absence of surgical related complications. Because the formula for setting the rate for CHIP coverage is adjusted to reflect the provisions of the underlying policy, there would of course, be a rate increase to not only the policyholders, but that would be impacted on the state's subsidy. And the reality is, most of the cost borne by the bill would incur an increase in the subsidy. And as I stated earlier, but for clarification of the record, that's about 40 percent a year under the CHIP program. And any added amount to the expenditures, again, is not an amount that would otherwise be available to the general fund and the other programs that rely on the premium tax. The other reason that I'm here to testify in opposition to the bill, although again sensitive to the underlying needs that individuals may have to have the surgery performed, but yet the...having the funding provided through the CHIP program is where my objection lies is that there's already statutory standard for whether a coverage is provided by CHIP. And the board establishes the coverage by looking at that offered by the insurers in the state. And if there's a dispute as to what that coverage is, there is a mechanism available for individuals to appeal and be heard before the CHIP board. And there's an extensive review. It's pursuant to a formal grievance process so that the individual can make sure that their claim is actually vetted and heard and that if there's any question and what's available out there, it can go through a review. And I have attached to my testimony, I believe it was included, a copy of that review procedure if you're interested in seeing it. But it is available and I would ask that you not advance LB326. Does anyone have any questions? [LB326]

SENATOR PAHLS: Senator Pankonin. [LB326]

SENATOR PANKONIN: Thank you, Chairman Pahls. Director, I'm going to ask the question that Senator Pirsch usually asks and that is about the cost effectiveness. You've been here all afternoon and heard the testimony. We had an individual here who was on the CHIP program and we've heard from other medical professionals and other folks who have been through it that in the long run it saves money. Assuming that they are going to be in the CHIP program for a long, relatively long period of time, is the up-front investment worth it? I know from just a...if your insurance short-term and I understand that it's not, but we've heard testimony today that this alleviates a lot of other long-term healthcare situations. And so if we would allow these procedures up-front knowing that we need to be in the CHIP program for a long time, what's your view on that? [LB326]

ANN FROHMAN: If the numbers are indeed showing that, why wouldn't we? The question is, are the numbers showing that. And that is something that I don't have the information to clarify one way or another. I do know that a couple of years ago, I believe it was 2006, Blue Cross came in to the Department of Insurance and they were moving away from coverage for a number of reasons, of which involved, involved a lot of nuances in the program. I am aware that CMS is covering it. I do think that there's probably...and they will continue to reevaluate. And it's not simply this coverage, it's other coverages. It's a fluid issue and whether something is covered today or not covered today in the marketplace may be made available in the future depending on what research and numbers show. So I would agree with you, if there's definite, you know, dollar savings and it enhances the quality of life and we can show that and cost savings to the program, absolutely it would make sense. [LB326]

SENATOR PANKONIN: So who makes that call then? Do we make it here with bills like this or does the CHIP board make it or... [LB326]

ANN FROHMAN: I think that's in the competitive marketplace. And the insurance companies in the private sector, if they see benefits down the road, they're going to do that. They're going to say, hey, if I don't have to pay for diabetes medicine in four years and I can see the cost savings and I can incur the cost savings, I'm going to provide that coverage up-front. [LB326]

SENATOR PANKONIN: Would this be a true statement, is it even more important in this plan because, folks, this is the last resort plan for a lot of folks? Would that make this even a more important criteria if we get a payback because a lot of these folks can't leave, or maybe they can leave after they finally get these type of procedures so they get healthier. [LB326]

ANN FROHMAN: I think it's...if it's not available in the marketplace, of course, if they can get it here, that's great. I think you've changed the concept of what the CHIP program is, though. Because at one point it was a marketplace of last resort for the marketplace. Now it's a marketplace for what....you know, different noncovered items. I don't know. I mean, so you're really, you're changing the game of what the CHIP program is about and you'd have to keep that in mind. [LB326]

SENATOR PANKONIN: And so, you're saying the way we would determine that is what other private insurers do? There's no other place to get that information about the current cost benefit over a five year period? The best way to do that is the market. [LB326]

ANN FROHMAN: I believe so, yes. [LB326]

SENATOR PAHLS: And just for a point of clarification, in the CHIPS program there are

on the average like 5,000 to 6,000 people in the program? [LB326]

ANN FROHMAN: There's 5,000 and that's been relatively static the whole time. We had a little bump for a few years but overall it's been.... [LB326]

SENATOR PAHLS: Okay. Well, then clarify this with me because I've heard long-term. Not everyone of those 5,000, do they stay in that program like forever and a day, or is...what's the average stay of a person in this program? [LB326]

ANN FROHMAN: We...I don't have the answer for you. We are doing surveys on exit interviews that we didn't use to do with the program to find that out. I can tell you that when they leave they leave for a few reasons. One is, cost of the program. Two is, they find group coverage. Three, they get on Medicare or Medicaid. I mean, it's the obvious. It's what you think it would be. But I'm not sure what the...one point we thought it was three years but, I think, it may be longer than that. [LB326]

SENATOR PAHLS: Okay. Because I thought I read one time it was around, they are in the program around three years on average. But, okay, thank you. Senator Utter. [LB326]

SENATOR UTTER: Do you think its fair to say that there may be a higher incidence of folks who could benefit from bariatric surgery in the CHIPS program than there is in the general insurance population because of, because these folks have, maybe been crowded out of the other programs because of health conditions. [LB326]

ANN FROHMAN: In Nebraska they shouldn't be if they're employed and under a group policy. They shouldn't be, so I don't think necessarily that's the case. But I do think, yes, we are still dealing with chronically ill, but if the ill are employed, then my answer would be probably not. [LB326]

SENATOR PAHLS: Thank you, Director. Any more opponents? I see one. Do we have any more? [LB326]

VICTOR KENSLER: (Exhibit 8) Good afternoon, Senator Pahls, Senators of the committee. My name is Victor Kensler, chairman of the NECHIP board. It's spelled Victor, V-i-c-t-o-r, Kensler, K-e-n-s-l-e-r. I'm here to testify against LB326. It is the belief of the board of directors that the NECHIP program should not be singled out for mandated benefits, rather that it remain comparable to what is in the individual market. In fact, that is what the current CHIP statute 44-4226(1) requires. The pool coverage, its scheduled benefits and exclusions and other limitations shall be established through rules and regulations adopted and promulgated by the director taking into advice and recommendations of the members. And that is that members are the insurers that are authorized to issue or provide health insurance in this state. And I point that out

because we sometimes confuse policy owners with members. Moreover, 44-4226(2) requires the director to take into consideration when establishing pool coverage, levels of individual health insurance coverage provided in the state and such medical economic factors as may be deemed appropriate and shall determine benefit levels, deductibles, coinsurance and stop-loss factors, exclusions, and limitations reflective of and commensurate with individual health insurance coverage provided by the five writers of the largest amount of individual health insurance coverage in the state. Most pools in the nation and most individual carriers do not cover bypass surgery. And the top five writers of individual health insurance in the state all exclude coverage for this procedure. If NECHIP were to provide the only available coverage for this procedure in the individual market, it would very likely be a beacon for all persons seeking this coverage and could result in added pressure to the eligibility determination and application screening process, and drive up costs. The external review portion of the bill is not necessary and will raise costs. NECHIP denies claims for other reasons that should not be sent to a medical panel. There are few cases where the need for such review would arise, so the necessity is questionable. The current policy language, that's the NECHIP policy, contains appeal procedures entitling the policy owner or policy owner's representative to appeal the administrator's decisions regarding preservice and postservice claims, and other determinations made regarding the policy. You heard earlier, the director mentioned this first level appeal and second level appeal and, for the sake of time, I won't read through all of what the first level appeal is and the second level appeal is. But essentially, written notification of the decision of the first level appeal is provided to the claimant and if the claimant is not satisfied with the first level appeal determination, he or she has six months from the receipt of the determination to submit a written request for a second level appeal. The claimant and/or his representative may appear in person at the second level review and present the case before the appeal committee appointed by the administrator, and the claimant may submit additional supporting material before or at the meeting. When reviewing appeals requiring medical judgment, the majority of the committee will be healthcare professionals with appropriate expertise. The committee will not give deference to either the initial determination or the first level appeal. In addition to the first and second level appeal, there is an expedited appeal which in a case involving an urgent care claim, an expedited appeal may be requested orally or in writing. And if the claimant is dissatisfied with the result of the expedited appeal, he or she may request a second level appeal, as previously mentioned above. As far as additional information goes, if after following the procedure for first and second appeals, the claimant disagrees with the decision, the claimant may submit a request for review to the grievance committee of the NECHIP board of directors. This committee will review the prior documentation on the issues and allow additional documentation which the clamant would like to have considered. The NECHIP grievance committee will consider the claimant request and respond in a timely manner. Their decision will be the final action of the Comprehensive Health Insurance Pool. I respectfully request that you do not advance this bill. NECHIP, empowered to offer major medical coverage to every eligible individual, is challenged to contain costs

in the current healthcare market, especially considering the chronically ill policyholders that make up the pool population. Our member companies upon which we model our benefits, do not offer this coverage, thus we consider this as sound advice and recommendation to exclude it from NECHIP coverage. And I'll accept your questions. [LB326]

SENATOR PAHLS: Do I see any questions? Senator Pirsch. [LB326]

SENATOR PIRSCH: A bit of education, perhaps you can help me. We base the system we utilize now is we base the CHIPS program on that which coverage which is granted by the top five insurers in the state, is that correct? [LB326]

VICTOR KENSLER: That is correct. [LB326]

SENATOR PIRSCH: Okay. And for my edification, is there...is it generally recognized that there's a correlation then, is the reason we're deferring to these top five that their experience, that's there...what their coverage includes is there's an indicia of reliability then that those are the most cost effective types of coverages, or is that a disputed type of asking? [LB326]

VICTOR KENSLER: It, it makes certain that we offer what the applicant for CHIP could buy in the individual market if they were eligible. [LB326]

SENATOR PIRSCH: I see. [LB326]

VICTOR KENSLER: But since they're not, they come to CHIP. [LB326]

SENATOR PIRSCH: Very good. So it's more of the moral hazard, you don't want people coming to the...the reason that they're...you're trying to mimic the market is so that people aren't coming over to CHIP for something that is different, something that might entice them over, kind of a moral hazard type of...but not necessarily, because the market has a better way of estimating or finding the most cost effective types of coverages and then including that. I mean, you understand what I'm saying. [LB326]

VICTOR KENSLER: That is my understanding, yes. [LB326]

SENATOR PIRSCH: Okay. Thank you. [LB326]

SENATOR PAHLS: Seeing no more questions, thank you for your testimony. [LB326]

VICTOR KENSLER: You're welcome. [LB326]

SENATOR PAHLS: Seeing no more. Anybody in a neutral? That...I think the Senator

said he would not be here for the closing. That closes LB326. We're ready to move on to LB445. Senator Fulton. Thank you, Doctor. [LB326]

SENATOR FULTON: Thank you, Mr. Chair, members of the committee. For the record, my name is Tony Fulton, T-o-n-y F-u-l-t-o-n, and I represent District 29. I present to you LB445. LB445, the Health Insurance Access Act. Of the approximately 1.5 million Nebraskans under the age of 65, over 14 percent lack any form of health insurance. Nebraska's 223,000 nonelderly, uninsured encompass all manner of age, socioeconomic background, employment status, and ethnicity. Nearly eight of ten are of working age, and 75 percent have at least one full time worker. And while lack of insurance certainly afflicts the working poor, 40 percent of the uninsured have incomes beyond 200 percent of poverty. Further, lack of health insurance among Nebraskans is a growing problem, as the number of uninsured Nebraskans increase by 3 percent from 2004 to 2007. As we have often heard in recent months, the greatest barrier to health coverage is not a lack of initiative among the uninsured, but rather, the uninsureds' inability to afford coverage. To overcome the affordability barrier and accessing health insurance, public policy may either (1) involve increased government spending, or (2) offer a market-based approach to cost containment. LB445 proposes the latter. LB445 proposes a market-based way of making health insurance more affordable by allowing health insurance providers to offer policies or contracts that are "exempt from any and all state mandated benefits which require coverage of any type of services or conditions." And that's a quote from Nebraska Revised Statute 44-5309 which I'm envisioning within this bill. LB445 strips out government...allows for stripped-out government mandates and allows insurance companies the flexibility to offer what the market demands. Based on a conservative reading of data compiled by the Council for Affordable Health Insurance, Nebraska's 18 insurance mandates from alcoholism treatment to well childcare, these contribute anywhere from 10 to 20 percent of the cost of private healthcare policies, effectively pricing many Nebraskans out of the healthcare market. Allowing insurance providers the flexibility to offer policies that satisfy the needs of the uninsured without this built-in cost of state mandates would thus allow a greater number of Nebraskans access to affordable coverage. Indeed, several other states have found it appropriate to enact similar legislation over the past several years. While these respective measures may not be in and of themselves responsible, it is important to know that each state has experienced a significant decrease in the percentage of uninsured from 2006 to 2007, while Nebraska has experienced a corresponding 1 percent increase over the same period, according to the Kaiser Family Foundation. The states I'm referring to, I was referencing here are Arkansas, Colorado, Florida, Montana, North Dakota, and Utah. The Legislature saw fit to enact such mandate exempt policies by enacting the Health Insurance Access Act in 1991. The income and coverage limitations imposed by that act, however, suppressed the act's effectiveness. LB445 amends existing statute to expand the promise of this act. Sections 3 and 4...well, I'll just let you read that part of the bill. LB445 does not eliminate the necessity of proof of insurability nor does it allow one to transfer coverage when one is already covered by

another form of insurance. Concluding and summarizing, in 1991 the state of Nebraska allowed for the creation of basic health insurance policies with mandates stripped out. This was done to enable more uninsured Nebraskans to afford health insurance. Since this act's passage, healthcare has become so expensive that income guidelines in that 1991 act are restricting the very folks that could make this act work. LB445 is a step toward covering more Nebraskans by providing greater choice in the marketplace and making health insurance more affordable by eliminating the artificial inflation cost by misinformed government mandates. I would appreciate the committee's moving this bill forward. If there are any questions, I'd try to answer them. [LB445]

SENATOR PAHLS: Senator Gloor. [LB445]

SENATOR GLOOR: Thank you, Chairman Pahls. I can hardly get my mind around as having spent all this time talking about mandates that we're being asked to put on insurance companies, and then we have a bill where it would allow us to strip some out. I think our predicament here is most Americans, let alone Nebraskans, want the best healthcare system somebody else's money will buy. And it's...it really is an incredible predicament. Can you pull emergency services out of an insurance plan under your proposal? [LB445]

SENATOR FULTON: Can you? Let me go to the bill. [LB445]

SENATOR GLOOR: And I tried to pick that up when I read through it, and I apologize, Senator Fulton, for not asking you earlier, because I read this over the weekend. And I apologize--I spaced it off. But...and the reason I ask the question is, if I were a wise consumer and consumers are getting wiser about health insurance all the time as cost goes up, I would recognize that there's a federal mandate that emergency care has to be provided. And because of that, I drop it out of my insurance plan, knowing that if taken to a hospital, I have to be seen and stabilized. Let somebody else pay for it. I know that there's a federal mandate that requires me to be seen. And so that's a good example of a predicament this presents to me, if we can selectively let people pull out...or insurers pull out components of coverage, if I understand the intent of the bill. [LB445]

SENATOR FULTON: Well, this actually...I understand the predicament that you're putting forward, but I don't believe that that is envisioned within this bill, and here's why. This was passed in 1991, specifically for uninsured Nebraskans, people who don't have insurance now. As I understand it, it was not effectual. People are not buying these policies, and so one has to ask themself, why aren't they buying the policies? Well, number one, the income restrictions; at least 40 percent of Nebraskans who are uninsured now can't buy these policies because of the income restrictions. But the whole idea behind putting this act forward in 1991 was to allow insurance companies to offer policies where mandates are stripped out. So to answer your question, could one

be offered? I don't believe that it could be offered, because that wouldn't be health insurance. I mean, why would someone buy a policy that doesn't provide any type of insurance for a visit to the hospital, for instance? [LB445]

SENATOR GLOOR: Well, emergency care, specifically, is what I was saying... [LB445]

SENATOR FULTON: I'm not positive what the answer to your question is, but I don't think that it could be. But my...I guess my response just to play the devil's advocate here is if one were...if a company were to offer such a policy, that doesn't therefore mean that we have...that it has to be purchased. [LB445]

SENATOR GLOOR: Sure, it's a market issue. [LB445]

SENATOR FULTON: Yeah, so the target market for LB whatever it was back in 1991, was uninsured Nebraskans, and it didn't make a dent. And so, I'm going back to revisit what we thought was a good idea in 1991 to say, well, why not? Because it sure sounds like a good idea anyway. [LB445]

SENATOR GLOOR: And let me speak clear because I use that as an example, but it's probably a little convoluted thought process. I worry that an insurer will strip out an awful lot of services to come up with a price that's certainly attractive, can be easily marketed, but will cover very little, and those individuals will still show up at various healthcare facilities and healthcare providers, expecting care. And so you end up with a cost shift of that care actually being passed along to everybody else, and they get the benefit of a lower premium. Because there's no two...as best I could always tell, there are no two classes of care when you go to a healthcare provider. Everybody gets the same level of care whether they pay for it or not. [LB445]

SENATOR FULTON: My response, Senator, would be how is that different than one who is uninsured now? Because one who is uninsured now and goes to a hospital or an emergency room, we're picking up the cost of that now. [LB445]

SENATOR GLOOR: Well, the difference would be someone would draw up or move to a plan that was...well, lower cost to save the money, but cover fewer services and, therefore... [LB445]

SENATOR FULTON: Yeah. [LB445]

SENATOR GLOOR: ...there would be an enticement for people to go to plans of less coverage, expecting that the system will absorb it in some way, shape, or form. That's my concern. [LB445]

SENATOR FULTON: Yeah, and that's...I follow you now, and that's not what I envision

with this bill. In fact, this is specifically for those who are uninsured, so one would have to become uninsured before being eligible for what's offered from this act. [LB445]

SENATOR GLOOR: Thank you. [LB445]

SENATOR PAHLS: And just for clarification, if the federal government...state law can't get past federal government, so if there are federal guidelines, you know... [LB445]

SENATOR FULTON: Yeah, I just...I'm not familiar with the federal guidelines. [LB445]

SENATOR PAHLS: I'm just saying it wouldn't happen. Senator Pirsch. [LB445]

SENATOR PIRSCH: And you said, other states did this and the number of uninsureds went down in those states. In all of the states, all the 12 states? [LB445]

SENATOR FULTON: All of them. Yeah, and I...the report or the study that we read, let's see, put out by the Kaiser Foundation, I think was the name of the group, I'm not necessarily saying that there was a direct correlation to this mandate, stripped-out coverage causing the amount of uninsured to decrease, but there certainly is that suggestion. [LB445]

SENATOR PIRSCH: And aside from the numbers of uninsured, getting to Senator Gloor's kind of concern, what about the overall...for that population of, I guess you're saying this is only available for those individuals who have no insurance, so at least something would be better than nothing is what your...I mean is there any...was that what the other states experienced that there was...not just the numbers of uninsured at all were down, but that the overall costs...that there was overall cost savings to the system? [LB445]

SENATOR FULTON: I can't comment on the cost savings. I...that would be an argument I'd put in favor of this bill, but I can't tell you for certain what cost savings were realized in other states. I could research that. I'll tell you, Senator Gloor's question is...he obviously understands this issue. That was a concern that was brought forward in Utah. They just passed this recently, and in Utah that was a concern. Well, you have people who say, for instance, my situation. I don't need to have alcoholism covered as part of my basic insurance plan, so if I could go and buy a lesser plan that doesn't cover alcoholism then I could get a lesser premium and what that does is that changes the effect of the overall pool for people. That was a concern in Utah. What we've seen...I think it was in Florida, our research indicated that the look-back period to be eligible for this was three months. If that's a concern, perhaps the committee would be willing to put forward some look-back period so that people who are insured don't say, aha, I'm going to go jump onto this new plan now that they can offer, you know, different policies without the mandates. I look at this act that existed in 1991 that's not being used, and it

sure seems like a good idea, but if it's not doing any good then we should try to figure out why not. [LB445]

SENATOR PAHLS: Senator Pankonin. [LB445]

SENATOR PANKONIN: Thank you, Chairman Pahls. Senator Fulton, on this idea, obviously individuals that don't have insurance...what about there's a small business...you have been a small business employer, but small business doesn't have insurance so people are uninsured. They go for this type of plan. Would that be eligible under this or is this individual only coverage? [LB445]

SENATOR FULTON: Well, the coverage is directed toward uninsured...let me find the specific language. Okay, page 2 of the bill, line 5, so the answer to your question is, I believe, no, this wouldn't be something that businesses could jump into. [LB445]

SENATOR PANKONIN: That's...I just wanted to make sure, because I think that's a different policy issue because of what could happen and on and on. All right, people...yeah. [LB445]

SENATOR PAHLS: Senator Utter. [LB445]

SENATOR UTTER: Maybe I missed it, but help me. Why were the insurance guideline...or the income guidelines put in the initial bill? Was it a federal requirement? [LB445]

SENATOR FULTON: Well, I...yeah, I'm not entirely positive why the income guidelines were originally put in the bill. My guess is, and I could go back and read the transcripts, probably find the answer for you. My guess is that this was to apply for those who were eligible for government sponsored health insurance, but for one reason or another, didn't have it. And so if one is eligible for coverage, then that is determined by way of income, and so this 185 percent of poverty is...it's borrowed at the federal level, and it's just something specific to Nebraska. Because you see that with...there are other statutes in Nebraska that use that 185 percent threshold. [LB445]

SENATOR UTTER: The other states that you're aware of, that have passed this type of legislation had no income guidelines whatsoever in their bills? [LB445]

SENATOR FULTON: I believe that is the case, but I'm not positive. I need to find... [LB445]

SENATOR UTTER: It just seems to me like it would make...I know in my particular experience of dealing with farmers, a lot of farmers have taken a look at the risk things and said, you know, I can afford to carry my own insurance. And then, bang, they get hit

maybe to the point where maybe they...if there was a reasonable price, stripped-down insurance coverage, and a lot of them go to really high deductibles, $10,000 deductibles and those type of things, and buy from there. But I could see where this doesn't...this shouldn't apply, I don't think, to...I think everybody who is uninsured ought to be able to look at this and make a decision as to whether this makes sense from an economic standpoint. [LB445]

SENATOR FULTON: That's what prompted my interest in this. This is one I'm really interested in, this bill. Not to say I'm not interested in other bills (laugh), but this is one I'm really interested in for that reason. If 40 percent of the people in Nebraska who are uninsured make more than 200 percent of poverty. Then that says something about what's available to those people. You know, anyway. [LB445]

SENATOR PAHLS: Senator Langemeier. [LB445]

SENATOR LANGEMEIER: Chairman Pahls. My fear with that is is we sit on this committee, and we looked at colorectal scanning last year, and we start to mandate things. And you just made the comment, and I don't want to use you too much on this, but you made the comment, you don't need the alcoholism. Aren't a lot of our insureds out there saying, we're invincible; we don't need insurance. We'll be fine for awhile, in the farmers' case. We have Alcoholics Anonymous; we have Gamblers Anonymous. They all don't think they need anything until the time they get them to the program. [LB445]

SENATOR FULTON: Yeah, that's a fair assessment, but in...maybe that wasn't the best case (laughter). I have not experienced any health expenditures having to do with alcoholism. And so if I'm trying to make an informed decision on what kind of health insurance coverage I would want to get, I could be tempted to go after something that's envisioned in this act from 1991. But I'm saying that I wouldn't be able to do that because I'm already insured. So this is only for people who are uninsured. [LB445]

SENATOR LANGEMEIER: Okay. [LB445]

SENATOR PAHLS: Senator Gloor. [LB445]

SENATOR GLOOR: And as...thank you, Chairman Pahls. As Senator Pankonin knows, I have a tendency to pontificate on a couple of issues in Health and Human Services... [LB445]

SENATOR FULTON: It's okay, I'm Catholic (laugh). [LB445]

SENATOR GLOOR: ...and this is an area that I can get really passionate about, and would like to sit down and talk with you further about this, because I have some definite

opinions. But I would tell you, with a degree of absoluteness that comes from three decades in healthcare, that the reason people don't take advantage of this is because they know they don't need to. When you have few dollars to spread around, even though there may be a plan that you could buy for health insurance, you'd like to spend your money on other things, certainly not spend it on something just in case you get sick. And I think the Americans have developed an attitude, the issue that I bring up is we have to have a national debate about whether healthcare is a business or a service. And to me, it absolutely gets to the heart of policymaking. I believe people in that income level...I think most Americans believe that it is a service, and if the house is on fire, the fire department will show up, and if somebody's breaking into their home, the police will show up because those are services. And if they get sick, somebody will take care of them, and they don't need to take out health insurance. And they're right to a large extent. Somebody will get them to an emergency room and provide some care. And so, paying for a low-cost insurance plan falls very, very, very low on their list of priorities. And I think we could offer much, much cheaper strip-down versions of health insurance, but I still think that same attitude would predominate people, and they'd say, why buy it? Somebody will figure out a way to take care of me, and that gets to a big challenge we have in this country of deciding whether it's a business model or whether it's a service model. And that gets to the heart of why I think we can do a lot with this, but I'm not sure it will increase enrollments. People are convinced, somebody will take care of them when they get sick even if they don't have health insurance. Thank you for letting me pontificate. I apologize. [LB445]

SENATOR PAHLS: You guys, we'll let you discuss this behind the scenes. [LB445]

SENATOR GLOOR: Talk amongst ourselves. [LB445]

SENATOR PAHLS: Yes. Seeing no more questions, do we have any proponents? Opponents? Neutral? Senator, thank you, appreciate it. That closes LB445. [LB445]

Disposition of Bills:

LB326 - Indefinitely postponed.
LB358 - Placed on General File with amendments.
LB445 - Placed on General File.

Chairperson

Committee Clerk