[LR439]

The Committee on Banking, Commerce and Insurance met at 9:30 a.m. on Friday, September 10, 2010, in Room 1507 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LR439. Senators present: Rich Pahls, Chairperson; Pete Pirsch, Vice Chairperson; Mark Christensen; Mike Gloor; Chris Langemeier; Beau McCoy; Dave Pankonin; and Dennis Utter. Senators absent: None.

SENATOR PAHLS: Good morning. And I say good morning again. Thank you. I feel like I'm back at school. Well, we all appear to be smiling on both sides. As I look up here everybody seems to be in a good mood, and as I look out in the crowd it looks like you're in a pretty decent mood yourself. We are dealing with a pretty complicated situation and that's one reason why we're here trying to find some of the answers, and I welcome you to the Banking, Commerce and Insurance Committee hearing. My name is Rich Pahls. I represent District 31, which is typically the district in Millard of Omaha. Our committee will take up the resolution as posted. Our hearing today is your part into the process. This is your opportunity to express your opinions or questions, which I'm sure there will be plenty of. I'm going to simply ask you now, so we would run more effectively, to turn your cell phones off. And if you are going to speak, please come to the forefront and reserve chairs. It makes the process go easier. Ann Frohman, our esteemed Director of Insurance, will be one of the first ones on board. We're asking you to sign in. I don't know if we have a sign-in list to sign in. Okay. Yes, okay. For those of you who are unfamiliar with the process, we're asking you to be sure you spell your name correctly if possible (laughter) because I will spell it wrong if I am given that opportunity. And I'm going to ask you to be concise. And we will start the meeting and this order is the order that I'd like to have us proceed. We will be with Ann Frohman, who will represent...the Director of Insurance; then we will have Michaela, who would be...Valentin, who is representing Blue Cross; and Diane Bricker, who is AHIP. And of course, anybody is allowed and we desire you to come forward. Before we begin, though, I will have the senators introduce themselves.

SENATOR UTTER: I'm Dennis Utter. I represent District 33, which is the Hastings area, part of Hall County and all of Adams County.

SENATOR PANKONIN: I'm Dave Pankonin. I represent District 2, which is Cass, parts of Sarpy, and Nebraska City area of Otoe County.

SENATOR LANGEMEIER: I am Senator Chris Langemeier, live at Schuyler, Nebraska.

SENATOR PIRSCH: I'm Pete Pirsch. I represent the 4th District, parts of Omaha and Douglas County.

SENATOR McCOY: Beau McCoy, District 39, Omaha.

SENATOR CHRISTENSEN: Mark Christensen, District 44, Imperial.

SENATOR PAHLS: And, of course, most of you know the people who really help make this work is Bill Marienau and Jan Foster. And over here to our left we have Juliana Batie from Lexington, Nebraska, wave your hand for Lexington; and Sonya Sukup from Verdigre, Nebraska. All right. We're well-represented here. I think, if there's no further questions, our other senator is at a meeting right now and he will be here with us shortly and he does...it would be very fortunate because he is working in the area of health. And again, if you do have copies that you'd like to hand out, be sure you let me know and we will have them passed around. [LR439]

ANN FROHMAN: (Exhibit 1) Good morning, Mr. Chairman, members of the committee. My name is Ann Frohman, spelled A-n-n F-r-o-h-m-a-n. I am the Director of Insurance, here today to testify on some of the issues regarding the implementation of the federal Affordable Care Act which we refer to...bureaucrats will not let you down, we have an acronym that is PPACA. First, I'd like to thank Senator Pahls for introducing the interim

study resolution so we can have a chance to discuss this outside the context of specific legislation. Hopefully, this will allow us to better get a handle on all of the challenges posed by this new legislation. PPACA has already and will in the future create substantial workload for the Department of Insurance. At more than 2,000 pages of statutory language, plus hundreds of pages of regulations already released interpreting PPACA, simply getting a handle on all of the provisions is a challenge. Fortunately, department staff has been able to rearrange their workloads to meet these newly enacted federal demands. The staff of the department and I meet on a regular basis to implement the federal law and to work on issues as they arise. At an extremely high level as it relates to health insurance, PPACA, in essence, restructures the way healthcare is financed in this country by requiring all persons to buy insurance. This mandate takes effect in 2014. After that date, insurers will no longer be able to decide who they will and will not provide coverage to. They will not be able to base rates on the basis of health status or limit the amount of coverage they will provide. This law goes on to prescribe the details, exceptions, additions, interim provisions, some of which must be implemented as soon as September 23 of this month. On our review, one of our current challenges is that the federal government has significant rule making to do to implement PPACA. There have been many issues and regulations issued, and several issues posed by PPACA will not be able to be resolved until new rules and regulations are adopted. For example, the federal rule making has not even started on the area of what is an essential health benefit and that's what all plans must have and offer eventually within them to the public, so we're not even...we're not even beginning to peel the onion back on what's in these plans. Additionally, the federal government has to examine the...a very high-profile issue that's the NAIC's proposal on the medical loss ratio, and maybe some of you heard about that one called the MLR. This is a key component of the federal law that mandates that a company spend a certain percentage of their premium revenues collected actually out, send it back out in terms of medical payments. It sounds easy enough but it's a complicated formula that's taken the NAIC some time to develop. It poses an obvious challenge to both the department, as it seeks to implement these federal requirements, and to insurers, as they seek to do business

in a new environment where the rules have changed yet their reserving and their historical experience is based on one set of rules, not on the new. In the same environment, the federal government has been issuing a number of grant opportunities. These grant applications have a very short turnaround time. Generally, federal HHS will issue a press release and, simultaneously, we will learn about the grant and we will then have the opportunity to review and consider whether to apply for it, usually within the time frame of less than a month, and that's working on the description of a new program and putting the system and application together. Under these conditions, the department has requested funding for two grants. We will review further grant funding opportunities as they arise, avoiding those that we feel would require ongoing state funding when the grant expires. So we're looking for strings and we're looking for value. The first $1 million federal grant was awarded in August. It allows us to improve our current health insurance rate review and approval process. This gets into the bowels of the Insurance Department in terms of our rating processes. This grant will expire after two years and our grant request was designed to allow us to improve our existing processes with actuarial recommendations on how to improve rate reviews, as well as improve training and the computer software that we will benefit from in our analytics on an ongoing basis. The second grand, applied for the 1st of September, is what we call a plan-to-plan grant that I think many of you may be interested in, and that's the grant that Nebraska can use to determine whether or not it should create a Health Insurance Exchange, an issue I'll return to here in a moment. Moving from the process-related matters to specific issues, I'd like to discuss an earlier decision, probably the first out of the department, on whether or not to operate a state High Risk Pool or leave that to the federal government to operate. As an interim first step, the federal government allocated $5 billion nationally, in total, to fund a new High Risk Pool for people who did not have insurance coverage. It's important to note that not only did they not have insurance coverage but have not had insurance coverage for the previous six months of eligibility. So if you had coverage in the prior six months then you would be ineligible for this new federal program. We spent some time reviewing this on conference calls and discussions. The federal government would not commit to further funding, asserting

instead in the face of their own actuarial concerns that the funding may be inadequate and, if it was not, steps such as placing enrollment caps and other measures would need to be considered in the program. Nebraska was given the choice to run the pool as a state entity or allow the federal government to do so. As this committee is aware, Nebraska currently operates a pool, called the Comprehensive Health Insurance Pool, or the CHIP pool, and that's in response to another federal mandate under HIPAA. It's worth noting that under federal law our current CHIP policyholders are not eligible for this new program simply by virtue of the fact that they have coverage and they have not been without coverage for six months. So that was a consideration as well, that they couldn't cross over, and it was going...we were concerned it was going to create some confusion in the marketplace if the state was running two pools and they couldn't cross into the other. It's worth noting that Nebraska opted to vest the requirement to create the new pool within the federal government, and we understand the way they're running it is they're using the federal employee health plan as their platform for this. And I know there have been some start-up issues and some foreseeable problems in getting it up and running because it was...I believe it was June 30 when they issued the regulations and it was to be up and running July 1, so they had some challenges there. I did see in the paper where in Iowa they have very few participants in that, in that federal-funded pool. We've been trying to get the numbers for Nebraska. We think they're small. I don't have the numbers for you today but that's something we've been working on. An earlier mandate in the PPACA to the federal Health and Human Services secretary was to create a Web portal, and this is probably something very few of you are aware of, but actually it's to allow Nebraskans to compare pricing information from all admitted health insurers. And that's supposed to be up and running and providing that service right now. The Nebraska department submitted a considerable amount of information to the federal Web site for Nebraskans to use, but we were not asked to verify the information that the federal HHS received from other parties because we were just one source of information. So the federal government accepted not our business submissions but the submissions of all comers into this portal, and that's created a problem with the veracity of the information. It's come to our attention that this Web portal actually has information

in other states reflected, health finance entities, that are less than legitimate entities. So there's some kinks in that portal that need worked out and we think that in time, if they can weed this out, it's going to require the assistance of our department to tell them who the legitimate entities are that are offering coverage versus those that might be fly-by-nights and not licensed and, therefore, fraudulent. Over the course of the summer, the department has given a great deal of time and attention to the issue of the medical loss ratio I mentioned earlier, the MLR, that insurers must maintain on their health insurance plans or pay a penalty if they can't meet it. And under PPACA, in essence, on a carrier that's offering the larger group insurance, they have to return 85 percent of the premium revenue in the form of claim payments and expenses allowed...and there are some expenses also that are allowed by the federal HHS rule making. That went to the Natural Association of Insurance Commissioners to develop the initial recommendation to the Secretary of HHS, and that issue has generated a great deal of inquiry at the department and nationally, and the NAIC did vote and pull together a recommendation that will be going to the Secretary. I also mentioned September 23 coming up is a big date. That's the date that we are following for what's called immediate market reform implementation issues--in essence, the changes that need to be made and filed on insurance policies issued after that date for plans after that date. In essence, six months after the passage of PPACA, a series of new federal requirements came into effect for these so-called, first of all, the "nongrandfathered" plans, which is most of the insurance market. We've heard a lot about a grandfathered plan. It's simply one that has not made enough changes to be subject to the PPACA requirements. It's expected, in my opinion, from what we've seen, that there will be very few grandfathered plans that won't be subject to PPACA, we think maybe less than 5, 10 percent of the marketplace, simply because most plans have to make changes, and when they make a change, they're subject. As regards to the September 23 changes, of particular note to insurance consumers are the limits on rescissions, requirements for external review, prohibition on cost-sharing for preventive services, there are no lifetime limits--these are general rules; there are some caveats--restrictions on annual limits, no preexisting condition requirements for minors, requiring dependent coverage for

persons under 26. These new conditions are to be reflected in the policy contract language so we will be able to enforce them as a marketplace compliance matter. So we do have the authority to enforce them. It comes under the authority of trade practices and contract. Perhaps the biggest challenge we believe Nebraska faces is the question of the Exchanges, and I think that's where a lot of the interest is right now. Effective in 2014, PPACA creates these Exchanges as a place for buyers and sellers to get together in the health insurance market and come together almost as...I refer to it as a "Travelocity" sort of Web-based tool for buying and selling coverage. This is for the individual health insurance market and the small group health insurance market. States may opt to operate the Exchange themselves, enter into an arrangement with nonprofit third parties, create regional Exchanges, or leave the entire project to the federal government to run. These Exchanges are required to be self-supporting financially. After a start-up period, there will be some grant funding, as we understand it, to launch the Exchanges, but after that the idea here is they will be financially self-supporting. Once operational, people interested in purchasing individual coverage or small group coverage can select on-line from a number of products offered that meet the federal standards and complete their purchase at that point. The Exchanges also will be a place for a person to obtain their Medicaid coverage and there's also subsidies that are to be available. So the Exchange will basically be the initial gate. Unlike Travelocity, there's going to be an income verification feature such that when a person logs on to purchase insurance, the verification will determine whether they're eligible for Medicaid, for subsidy, or whether they're driven into the private market for purchase of coverage. While it's a fairly straightforward thing to explain at first blush, in terms of the visual and what you see, creating these Exchanges is going to take a lot of research and, to that end, the department had applied for a grant this month to allow the state, number one, to determine whether to create an Exchange and, if so, on what basis. Should Nebraska receive the grant, the Insurance Department will be working with the Governor's chief information officer, Department of Health and Human Services to convene stakeholders, as required under the grant, formulate a recommendation or recommendations for Governor Heineman on a proposed course of action and, if appropriate, beginning the

business operational planning for such an entity. There are several other issues regarding the governance of the Exchange: the status of policies, if any, that are inside the Exchange versus outside the Exchange that can continue to be offered in the private sector; and the costs of the technology and infrastructure and the financing in creating the Exchange. All of those will be examined under the funding of this grant if Nebraska receives it. PPACA gives rise to many issues. I have focused today on the issues that we've been working on this summer at the Insurance Department, the issues that will be confronting the state in the shorter term. There are other issues, there are many other issues, such as required changes to Medicare supplement policies. Those will need to take place. They're further down the road so we are prioritizing our work and that will be a great source for new briefings, I think, in the future. But rather than take you into details on that, I think for now I want to wrap up and then answer any questions you all might have. [LR439]

SENATOR PAHLS: Senator Utter. [LR439]

SENATOR UTTER: Director Frohman, the Exchanges are required to be self-supportive beyond this initial implementation period. What's their source of funding? [LR439]

ANN FROHMAN: That is to be researched and studied. I think some of the ideas I have heard is you're looking to the participants that purchase the coverage and the suppliers of the coverage. I think that is one that definitely needs to take some serious thought and study to get it right if, in fact, we're looking to move forward in such an endeavor, because you have to get it right. I mean there just isn't any way that I see the state having a financing role in the private sector purchase of coverage here. [LR439]

SENATOR PAHLS: Senator Pankonin. [LR439]

SENATOR PANKONIN: Thank you, Senator Pahls. Director, the question about the grandfathered status of plans and your comment that you think that will be very few kind

of surprises me. As a small business employer and insurance provider, I don't know that we've changed our plan in recent years. Now would that be if an insurance company made some kind of minor change, even if the employer or the sponsor of the plan didn't want to make a change but the insurance company itself maybe makes a change of some sort and pushes it out? I thought maybe that a high percentage of plans would try to stay in the grandfathered status because of maybe the cost advantage versus having to pick up a pack of items. [LR439]

ANN FROHMAN: You're correct, that's the desire. I think there is a drive for that. But the answer is, yes, to the extent an insurance company is required to make changes, they're in a Catch-22. They're going to have to make them. There goes the grandfathered status. So it just isn't what it purports to be. There may be a few. [LR439]

SENATOR PANKONIN: That was a surprise to me. I'm glad to get that clarified because I thought, as a businessperson or any kind of employer, you'd have a chance to maintain but maybe not. [LR439]

ANN FROHMAN: It may be forced on the carriers to make the changes. [LR439]

SENATOR PANKONIN: Okay. [LR439]

SENATOR PAHLS: Ann, I'd like to ask a question. Several times you said you're going after grants if it will not cost the state money in the following years. Is that...? [LR439]

ANN FROHMAN: Yeah, we're looking at them on a case-by-case basis and to the extent we see value there for Nebraskans and when we do not see...most grants have what they call maintenance of effort requirements where we have to...we can't use the grants to fund current workloads and current...our statutory responsibilities, so they're for new implementation issues. But what we have to be careful on is some of them can be seed money to, you know, just to get something up and going, and then you have to,

you know, look at where and commit to funding. And so those are the grants that we're reticent to pursue because we don't see...you know, it's just case by case. These two grants we applied for make a lot of sense because one of them has a lot of systems changes on a rate review, so that can be a one-time thing we can get done and to kind of redo some of our processes internally. And so that's good. I don't see long term...I see a way out, in other words an exit where there isn't going to be a burden financially to us to continue to do the work. [LR439]

SENATOR PAHLS: Senator Pirsch. [LR439]

SENATOR PIRSCH: Thank you, Director. At this early stage, do you see kind of a trend? There's a number of different ways states can handle this, right, the options? They can leave it to the federal government. Have any states already committed to a particular method with respect to their option to either operate the Exchange themselves, in arrangements with a nonprofit create a regional exchange, or leave it to the federal government? Have you see any commitments? [LR439]

ANN FROHMAN: No. Outside of Utah and Massachusetts, which I would call polar positions on Exchanges that exist, with Massachusetts being the Exchange that's trying to manage costs and Utah being the Exchange that's simply, in essence, more of a Web portal and getting information out there, most of the states recognize the complexity and the many moving parts and recognize the value of using grant funds and applying for the grant funds to do the analysis on, you know, integration, infrastructure, impact on the marketplace. That grant will also enable us to do research and try to, you know, monitor what the trends might be and forecast how the market is going to respond. That's going to be critical to whether this is a success or not. [LR439]

SENATOR PIRSCH: Thank you. [LR439]

SENATOR PAHLS: Senator Langemeier. [LR439]

SENATOR LANGEMEIER: Chairman Pahls, thank you. And again, glad to have you back, by the way. Director, thanks for coming to testify. As you talked about being at a high level and as I reread what you testified to, it is pretty high level and I hope over time we start to get into that in a little more specifics. And with this mandate coming into effect in 2014, do you see us having these discussions throughout the rest of 2010 and 2011 with legislation for, at best, 2012? [LR439]

ANN FROHMAN: I...yes. [LR439]

SENATOR LANGEMEIER: Or do you see something by January 5 of next year? [LR439]

ANN FROHMAN: What I see here is we want to be careful, we want to be well-studied on this. We have the time. I think the critical year is not this session but the next session. The NAIC has a number of directives to create some guidance that statehouses can use on a number of areas. There's a lot of work that needs to be done there. The timing is...and given that the federal rules are...I mean they are coming out weekly if not daily, that if you're looking for a time line, I think the dialogue will need to continue and the focal point should be for 2012. [LR439]

SENATOR LANGEMEIER: Okay. Thank you. [LR439]

SENATOR PAHLS: Yeah, I'd just like to piggyback. In our discussion, I just want to make sure the audience understands, that we're not looking for next session for a lot of major changes, is that what you're telling me... [LR439]

ANN FROHMAN: That's correct. [LR439]

SENATOR PAHLS: ...through legislation. [LR439]

ANN FROHMAN: I believe that would be premature and we would be better off to pause, study, and then take the value that will come out of this grant research and use that to develop where we need to go. I mean I think doing anything before that would just be a mistake. [LR439]

SENATOR PAHLS: And to be honest, politically, with a change...there's a possibility to change it to federal level in either one of the houses, that could affect the healthcare program, right? I mean... [LR439]

ANN FROHMAN: That's correct. Yeah, we have...I mean it's reality that there will be elections coming up and we don't know the implication of those elections on this because there's been a lot of debate and discussion. [LR439]

SENATOR PAHLS: Okay. Okay. Do you have any more questions for Ann? Thank you, Ann. [LR439]

ANN FROHMAN: Thank you. [LR439]

SENATOR PAHLS: Good morning. [LR439]

MICHAELA VALENTIN: Good morning, Senator. Nice to see you again. [LR439]

SENATOR PAHLS: Thank you. [LR439]

MICHAELA VALENTIN: (Exhibits 2, 3) Chairman Pahls, members of the committee, my name is Michaela Valentin, M-i-c-h-a-e-l-a, last name is V-a-l-e-n-t-i-n, and I am the state lobbyist for Blue Cross Blue Shield of Nebraska. I come to you today with a healthcare reform PowerPoint, kind of PPACA 101, if you will. Chairman Pahls, if it's okay with you, I'd like to get through the 15 slides I have and then take questions at the

end,... [LR439]

SENATOR PAHLS: Yeah, that sounds...that's good. [LR439]

MICHAELA VALENTIN: ...if that would be okay,... [LR439]

SENATOR PAHLS: Thank you. [LR439]

MICHAELA VALENTIN: ...just so that we can keep things rolling. [LR439]

SENATOR PAHLS: Yeah. [LR439]

MICHAELA VALENTIN: Okay. Our agenda for today is going to be an overview of the law, overview of key provisions, and then I'll take questions. PPACA is the Patient Protection and Affordable Care Act. It's Public Law 111-148, also known as the Senate Bill. HCERA is the Health Care and Education Reform Act. It's Public Law 111-152 and also known as the Reconciliation Bill. I wanted to point that out because a lot of times people think this is one bill but it's actually two pieces of legislation that came together to be what we know as PPACA. If you want more information on PPACA, you can see virtually everything you need to know that's out there thus far on the legislation at healthcare.gov. And I would just like to make the disclaimer, as did Director Frohman, that this is a substantial piece of legislation at 2,400 pages and regulations have not been fully published, so we don't know everything that we need to know. Even though it's very comprehensive and we're hearing about it every day, we are really just still at the very beginning of implementing this legislation, so please keep that in mind. Some key provisions on insurance reform and plan requirements started right away with the enactment of PPACA on March 23, 2010, with a review of unreasonable rates where HHS works with our state Department of Insurance to make sure that insurance carriers that are submitting rate increases can substantiate that information with claims experience so that there is no unreasonable uptick in the rates. In June and July, the

national High Risk Pool came into being, and as Director Frohman explained, that is for folks who have preexisting conditions but they have to be insurance free for six months before they can apply for this particular coverage. And there is a Web site available where folks can go out and see if they're eligible for this coverage and that's at pcip.gov. There's also the HHS Web portal. This is what I kind to refer to is kind of a precursor to the Exchange because it is a...kind of a Web-based library for each state where a person can go out and see what their coverage options are between public or private insurance, whatever they would need or qualify for. By taking just a small survey indicating what state they're in, they can pull up various carrier options as well as Medicaid/Medicare state options, CHIP pool state options, to help them determine what the best coverage is for them and to give them some brief educational pieces on what those various types of insurance mean. There's no pricing information out there and we don't expect it to be out there until October. You cannot buy insurance off of this Web portal. You can just go out there as a consumer or a small business owner and see what's available to you in your state, in your current situation. Then we have the temporary employer reinsurance for early retirees program, which is an application-only program. There's been $5 billion set aside for it and the program is expected to sunset on 1/1/2014 with the advent of the exchange. And this program is for employers to gain 80 percent reimbursement for claims between $15,000 and $90,000, and that money that goes back to the employer has to be used for premiums and cost-sharings to improve plan costs for the participants. For plan years beginning September 23, after September 23 an beyond, which is upcoming, there's going to be these immediate reform provisions that are going to come into play. One that we've heard a lot about is no preexisting exclusion for kids, and that basically means for children under 19 you can't exclude them off of insurance for having preexisting conditions. There's also the dependent coverage to age 26, and that applies to both grandfathered and "nongrandfathered" plans, and what that means is normally when kids would come off insurance at like 19 or 23, depending on the contract language, you're able to extend those kids on insurance under the federal law. And they can be married or unmarried, they don't have to be in school, they can live in other states, but that you still can cover

them to age 26. The only caveat to that right now up to 2014 is if you have a child who works for an employer and they are able to get coverage through that employer, they need to go do that rather than coming on your plan. And then there's also a limit on rescissions, cannot rescind contracts except for circumstances of fraud. And the medical loss ratio, the thresholds have been set for 80 percent for individual and small group and 85 percent for group, and what that means is you have to pay out 80 percent on medical claims and then the rest, the other, you know, 20 percent or 15 percent, is on administrative overhead. And you have to make sure that you meet those thresholds of paying out enough money in claims or in 2011 carriers will have to issue consumer rebates if they don't meet those thresholds. So there's a very complicated formula as to how that works, as Director Frohman indicated, but that's kind of the basics of it. And we are still waiting for the regulations to come down on MLRs, so at this time we don't even know everything we need to know for implementing that particular provision. There's also no lifetime limits on essential benefits. Essential benefits has yet to be defined by HHS, so we've taken our best guess as a carrier on what we think those essential benefits are. But again, we're still waiting for Secretary Sebelius to define those. There's also no preventive cost-sharing. This applies to new policies that go into effect after March 23, and this is...no preventive cost-sharing means everything is paid at 100 percent. So the U.S. Preventative Services Task Force has identified certain, what they call, A and B recommendations, which are services that they feel should be paid at 100 percent. They've handed down those recommendations and those are the ones that are supposed to be paid with no cost-sharing, so no copay, no deductible, no coinsurance. It's just paid across the board at 100 percent. And then there's other patient protections that are involved and most of the carriers already cover these. That would be ER coverage. You don't have to go past one ER when you're in dire need to get to the next emergency room just because the latter one is in-network. It's covered across the board on emergency services. You can go to any ER you want to go to. For women, they can pick their ob-gyn as their primary care physician. For primary care physicians and pediatricians, the consumer has the option to pick whoever they want that is participating within the network to be their primary physician or pediatrician. And that's

what the patient protections are about. And then the next big things that are coming in 2014 is guaranteed issue for everyone, so whether you're an individual or an employer, if you apply for insurance, you get it. That's guaranteed issue. And then community rating, right now we were rating on health status factors and we're going to rate on only certain factors, so you can't rate across the board on health factors. The only things you'll be able to rate on in 2014 are what's called a compressed age band of three to one, which means your youngest, healthiest person might pay, for example, $100 and then your oldest, sickest person would pay three times as much. And that band has actually been compressed to what it is in the current market now, so what you will really have is right now your younger folks that have individual policies are paying not such a high price, and then your oldest, sickest are paying more. With the advent of this compression band, what will happen is you will actually have your young people paying a little bit more to subsidize the older, sicker people paying a little bit less. So that's how the age band works. And then you can also rate on geography and that's, you know, based on where you live. And family composition is individual versus family, if you have an individual policy versus a family policy. And then tobacco is a 50 percent rate up. So if you're a tobacco user, you will be rated up for that. And then the big thing that's coming up also in 2014 is the Exchanges, and I'll talk a little bit more about that in the next few slides. Some key provisions on individual responsibility, there is an individual mandate that comes into effect on 2014 and beyond. All individuals must purchase minimum coverage and that is basically defined as any coverage you have now that's not a limited benefit plan, and it includes TRICARE VA benefits, Medicaid, Medicare. There is a penalty for not purchasing insurance from 2014 and beyond, which is the lower of the national average or the greater of a percentage of income, eventually up to 2.5 percent, or $95 starting in 2014 and all the way up to $695 in 2016, or also in 2016 that could be the percentage of 2.5 percent, whatever the greater is of that. Dependents under 18, for them the penalty is half the adult penalty amount, and if you're a dependent of the taxpayer, taxpayer is liable for your penalty. The penalty is calculated on a monthly basis. It's prorated for partial coverage during the year and it is assessed through the tax code as an additional amount of federal tax owed. As far as individual

subsidies from 2014 and beyond, those are only available through the Exchange and they will be available on a sliding scale, up to 400 percent of the federal poverty level, an example of which is $88,000 a year for a family of four. Some key provisions on employer responsibility, this is called the pay or play requirement and it applies to employers with greater than 50 full-time employees. They have to offer minimum coverage. In the calculation, part-time employees are included on the full-time basis when you're calculating the over 50, and a full-time employee is someone who works 30-plus hours a week. There's no minimum contribution and the employer must provide essential coverage with a 60 percent actuarial value minimum, which we still need to hear a little bit more from the federal government as to what that means. Employers with greater than 50 full-time employees who do not offer coverage and have at least one full-time employee, receive a tax credit through the Exchange. They will pay a penalty of $2,000 times the total number of full-time employees, minus the first 30 full-time employees. If you offer coverage but at least one full-time employee receives a tax credit but the actuarial value of your plan is less than 60 percent or the employee cost is greater than 9.5 percent of household income, you will pay the lesser of $2,000 times the total full-time employees, or $3,000 times the number of employees receiving the tax credit. And again, that employer responsibility pay or play requirement only applies to employers with greater than 50 employees. Some other employer responsibilities that I wanted to talk about is the free choice voucher. This applies across the board to all employers, and an employer must provide a voucher for use in the Exchange if the employee's premium cost-sharing is between 8 and 9.5 percent of their household income and they are below 400 percent of the federal poverty level. And what the free voucher is, is just like it sounds. It's the employer portion of the premium. They would give it to the employee. The employee would go into the Exchange and purchase coverage. If the employee purchased coverage within the Exchange that is cheaper than what the voucher is written for, the employee is allowed to keep that money. So that's how the free choice voucher program works and that starts in 2014. Again, that is across all employers, including small. There is an auto-enrollment provision. It's unclear as to when this actually comes into play, but that pertains to

employers with greater than 200 employees who must auto-enroll their full-time employees into a health plan; however, the employee has the option to opt out of that. There's also a treasury reporting requirement where employers are required to submit annual coverage report of how many employees they have covered, who passed up the insurance, why, so they will have to start submitting that in 2014. In 2011, starts W-2 reporting where an employer must disclose the aggregate value of benefits that the employee is getting. It does not affect tax liability. It's excludable from the employee's income and it is not taxable. And then again, the Early Retiree Reinsurance Program that we discussed earlier starts in 2010. Here's the small employer tax credit that starts 2010 and beyond. It's already in play and this is for employers with less than 25 employees and less than $50,000 a year average annual wages who contribute more than 50 percent of the premium. From 2010 to 2013 there's a sliding scale credit up to 35 percent of employer costs. It's 25 percent if you're tax exempt. That's obviously outside the exchange. And then from 2014 and beyond, when the Exchange is created, the credit moves up to 50 percent of employer costs, 35 percent if you're tax exempt, and that's a two-year credit process and that's limited to the Exchange only after 2014. In 2018 and beyond, the high cost excise tax begins. That's also known as the Cadillac tax. Maybe some of you have heard it referred to as that. It's a 40 percent nondeductible tax and the thresholds that trigger it is the excess amount over $10,200 in premium for an individual plan, over the $27,500 threshold for family coverage. It does exclude dental and vision. For insurance carriers, we will pass that on through premium. For plans that are self-insured, it's the plan administrator that is subject to the 40 percent tax. A little bit about the Exchanges that start in 2014: The states must establish Exchanges for individuals and small employers. If we don't, the feds can do it. A small employer within the Exchange is defined as 1 to 100 workers. The state has the option to define it as 1 to 50 workers until 2016. Employee...there is employee choice within the level of coverage chosen by an employer, so an employer can go into the Exchange and say, I want to choose this coverage, and then the employee can go in and choose within that coverage who they want to have their plan with. And the subsidies in small employer credits from 2014 and beyond are only available through the Exchange.

There's options limited to four actuarial value benefit packages: Bronze is the lowest at 60 percent, Silver at 70, Gold at 80, and Platinum at 90. Insurers must offer the Silver and Gold packages in order to participate within the Exchange. Catastrophic plans will also be offered to individuals under 30 or those who have financial hardship. Going forward, state mandates can be required only if the state pays the added cost of taking care of those mandates. We don't know the exact formula on that. We just know that if we were to put extra benefits on there that were state mandated at some level, the state would have to pick up the cost of those mandates. And then participating plans must meet extensive requirements of having qualified health benefit plans to participate within the Exchange, and we are still waiting for information forthcoming on that. There will be the grants to "navigators" for education and enrollment. "Navigators" are brokers and agents that sell insurance and they would have a place within the Exchange. And you will have some folks come talk to you a bit later about how that's going to affect them and what that means to them. And then outside the Exchange, individual and group coverage can still be sold but you still have to meet the essential benefits requirement, follow cost-sharing limits, and apply state benefit mandates. For benefits in 2014 and beyond, you have to meet three elements. You have to include the essential benefits--again, HHS has to define that; limit cost-sharing; and meet the minimum actuarial values of 60 percent, which is the Bronze level plan within the Exchange. For preventive health from 2010 and beyond, you've got to provide without cost-sharing, so everything that's considered preventive health is paid at 100 percent. And for wellness, that will permit employers to vary their premium by as much as 30 percent for employees who participate in certain wellness and disease management programs. And for grandfathered policies, existing coverage is exempted from many new rules. Certain new benefit mandates do apply to grandfathered policies, such as lifetime limits and "pre-ex." And even though your plan might be grandfathered, you can still add or delete employees or dependents and not lose your grandfather status. In 2014 and beyond there is the opportunity to create co-ops and that's a nonprofit, member-run health insurance company providing insurance in the individual and small group markets, both inside and outside the Exchange. The federal government does provide grants for

start-ups for these entities to be created; however, any of these entities that are created cannot be affiliated with an insurance company. Multistate plans also start in 2014 and beyond. The Office of Personnel Management contracts with insurers to offer at least two multistate plans within the Exchanges, and it allows participation by nationally licensed service marks within the Exchange in different states. And then the state can also create a basic health plan which is non-Medicaid for uninsured individuals between 133 percent and 200 percent of the federal poverty level. It would be in lieu of enrolling them within the exchange and they cannot receive exchange subsidies. Think this is my last slide on how some of this will be financed. There will be taxes on medical devices, which should generate $47 billion in new taxes; 2.3 percent tax on the sale of any taxable medical device moving forward after 2011. There's also an increased Medicare tax for 2013 and beyond. It increases taxes on income and investments for high-income people. There's an additional .9 percent high-income tax for individuals who are considered high-income earners. Those are people making over $200,000 as a single person and then joint filers making over $250,000, and the employer will keep track of that particular tax. And then there's also a new high-income tax that each individual who qualifies for this will have to report on their taxes. It's a 3.8 percent tax on unearned income, which is interest, dividends, annuities, royalties, and rents, and that again is for high-income individuals making over $200,000 and joint filers making over $250,000. There's also an insurance tax that starts in 2014 and beyond. It's an annual tax on insurance products based on your market share and it's estimated in the first year that they will...the government will gain $8 billion in 2014 alone, with an estimate of gaining $60 billion over the next five years. And then again we have the Cadillac tax that starts in 2018 and beyond, which is the tax on the high value plans that we discussed previously. Looking ahead, the passage of reform is really, truly just at the beginning. We are focusing on implementing the new requirements for September 23. Health and Human Services, the Department of Labor, Treasury, and the NAIC still have guidance forthcoming. And we are committed to working closely with the stakeholders to identify and address key issues. That is the end of my presentation. I'd be happy to take any questions you may have. [LR439]

SENATOR PAHLS: Want to thank you for a well-defined concept of what we're supposed to be looking at, one of the better ones I've seen since we've started this. [LR439]

MICHAELA VALENTIN: Thank you. [LR439]

SENATOR PAHLS: Any particular questions? [LR439]

MICHAELA VALENTIN: It's a lot of information to digest... [LR439]

SENATOR PAHLS: Yes. [LR439]

MICHAELA VALENTIN: ...so I would encourage you to please just reach out to me if you have questions after the hearing today. [LR439]

SENATOR PAHLS: I do have one I meant to ask the director. I hear the word of 85 percent and 15 goes...dealing with administration. [LR439]

MICHAELA VALENTIN: Yes. [LR439]

SENATOR PAHLS: Do you...where does your company stand on that issue? [LR439]

MICHAELA VALENTIN: We will have to comply with whatever the regulations are on medical loss ratio. [LR439]

SENATOR PAHLS: Are you pretty close to that now? [LR439]

MICHAELA VALENTIN: Yeah. The last figure that I knew of, we were at 90 percent, or 90 cents on every $1 was put towards medical claim with 9 cents going to administrative

overhead and 1 cent in reserves. But we are a not-for-profit mutual entity so we function differently than other publicly held entities. [LR439]

SENATOR PAHLS: Do you know by chance what the average is in the state of Nebraska? [LR439]

MICHAELA VALENTIN: I don't. [LR439]

SENATOR PAHLS: Okay. [LR439]

MICHAELA VALENTIN: I can look that up, see if I can find it. [LR439]

SENATOR PAHLS: No, I can ask the director. I just was just curious because I...you know, and again there's an awful lot of information. Senator Pankonin. [LR439]

SENATOR PANKONIN: Thank you, Senator Pahls. Michaela, obviously there's been some articles in the paper and with the reform starting, the federal government has kind of taken...acted like they're surprised that insurance rates are going up, that this is going to be maybe a panacea that would start reversing the process. Have...you know, knowing what's coming here in the short term at least, realizing that it could all change with elections and changes in the policy at the federal level, what do you see Blue Cross's stance moving forward in the short term on rate increases? [LR439]

MICHAELA VALENTIN: Well, I think that we've submitted our rate increases to the DOI and they were between like 2 and 6 percent, so they weren't as... [LR439]

SENATOR PANKONIN: Dramatic. [LR439]

MICHAELA VALENTIN: ...even as dramatic as we thought they were going to be. We are tracking each...what is referred to as near-term provision. We have a committee set

aside for each one of those provisions, and within each one of those provisions we're also tracking actuarially how much it costs us or how much it saves us to implement what the federal government has asked us to implement. So we hope to have some figures for you shortly after this gets implemented, be able to share that. We hope it results in cost savings but our fear is that it will increase costs. [LR439]

SENATOR PANKONIN: Thank you. [LR439]

SENATOR PAHLS: Senator Pirsch. [LR439]

SENATOR PIRSCH: Do you feel like at this point in time you pretty well have a handle on what exactly the changes will be comprised of or our definition of, say, essential covered services and other factors make it that there's too much unknown quantity to be able to really accurately predict how this is going to affect Blue Cross Blue Shield? [LR439]

MICHAELA VALENTIN: With that particular example, we've kind of had to put together the pieces of the puzzle with some missing pieces, because we don't exactly know what essential benefits are yet, so we have to speculate. We do the best we can and we try to, you know, be as conservative as we can with our speculation. But it is frustrating when you don't have everything. I mean we're just trying to do the best we can with the information we have to implement. [LR439]

SENATOR PAHLS: Yeah. Within the past six months I've had the opportunity to experience paperwork from the health area. This seems to me that this is just going to multiply for the employer. Am I mistaken there? I mean... [LR439]

MICHAELA VALENTIN: No, the employer does have significant reporting requirements that they did not have on them before, the baseline of which is to make sure that the federal government knows who is being covered and how they're being covered to

make sure that everyone is sticking with the premise of the bill, which was to ensure access for all. [LR439]

SENATOR PAHLS: Okay. Seeing no...but I do entertain your idea of after we adjust to this, just to give you a call, if that's... [LR439]

MICHAELA VALENTIN: Please do. We'll try to be as helpful as we can. [LR439]

SENATOR PAHLS: Okay. Thank you. Thank you, Michaela. [LR439]

MICHAELA VALENTIN: Thank you. [LR439]

SENATOR PAHLS: Good morning. [LR439]

DIANNE BRICKER: Good morning. My name is Dianne Bricker and I'm a regional director in the state advocacy department of America's Health Insurance Plans, AHIP. We are proud that, of our about 1,300 member companies who provide insurance coverage for about 200 million Americans, that many of them are companies that do provide coverage for Nebraskans here. In fact, most of the ones that are licensed in Nebraska are in fact members of AHIP. And AHIP members, just to give you some context, are companies that not only offer a broad range of health insurance products, not just major medical but also disability income and dental and vision and long-term care, but also have demonstrated a strong commitment to providing coverage in the public...in public programs such as Medicare and Medicaid. I want to thank you for holding this hearing. As you have said and as been I think clearly demonstrated here, PPACA or PACA or ACA, whichever group you talk with about it, is an incredibly complex piece of legislation which will have implications for individuals, companies, economies, and governments throughout this country for the years to come, and so the health plan community, both in Nebraska and on a national level, really are committed to sort of a wise and measured approach to the implementation of the law that is, like it

or not, at least at this point, it is the law and so, as you know, that there's movement forward to implement it. But we especially want to ensure that there is minimal disruption for policyholders, for consumers and other sort of unintended consequences that might come about. Really, my one ask of you today is simple and I won't take up much more of your time, but that is to continue, I think as you have done in the past and seem to indicate an interest in doing so today, as you work with...in Nebraska to implement the law, that you see the industry, the health insurance industry, as the huge resource that it really is. Please take advantage of the technical expertise and the...just all the other resources that are available, not only from individual companies such as Blue Cross Blue Shield but also from the Nebraska Insurance Federation--Jan McKenzie seems to be well-known to you all and she is a terrific resource and I...and we enjoy working with her--but also from AHIP as well. One example of what AHIP can offer to you is I think perhaps you've received a copy of this but, if not, we have copies here. It's just an implementation tool kit we're calling. This is really something I've assembled for you all that provides pretty high-level information, time lines, both sort of an executive summary of the whole...the two pieces of legislation but also a pretty detailed review of what the details of the measures are and where they can be found in the statute and kind of what they all mean. But if you need and want kind of a deeper dive into topics of particular interest to you, please let me or please let Jan know and I'll be glad to put together as much information as I can, both information that might be within AHIP but also information from independent sources as well, for example, health insurance premiums, you know, how are they derived, what really contributes to their rise. As you know well, there's a great deal of attention being paid to Exchanges and what's happening in Massachusetts, what's happening in Utah. And as perhaps you know, California just passed a bill that will create an Exchange in California. We have a side-by-side comparison of those to the federal requirements in PPACA. We probably have 40 or 50 charts in terms of what each of the 50 states and the District of Columbia are doing on particular issues, what their statutes say, what their regulations say. So rather than reinventing the wheel, you can kind of look to see what some of your other states are doing as well. So please feel free to ask. I think it makes sense to ask Jan

McKenzie for whatever information you might need and Jan and I will work to forward to you any information that you do require, any answers to questions that you might have. So with that said, I want to again thank you, applaud you for having this hearing to invite public comment about what Nebraska can do. As I said, the health insurance industry really stands ready to work with you to ensure that, you know, sort of the decisions that you make and the actions that you're going to be taking in the months and perhaps even the years ahead are in the best interest of Nebraska and of all Nebraskans. Thank you. [LR439]

SENATOR PAHLS: Any questions? I do appreciate your offering the resources from... [LR439]

DIANNE BRICKER: Absolutely. Please take advantage of them. [LR439]

SENATOR PAHLS: Will do. [LR439]

DIANNE BRICKER: We have... [LR439]

SENATOR PAHLS: And I can assure you we will take advantage of Jan McKenzie. [LR439]

DIANNE BRICKER: Terrific. (Laughter) [LR439]

SENATOR PAHLS: Appreciate it. [LR439]

DIANNE BRICKER: Thank you. [LR439]

SENATOR PAHLS: Thank you. Now this is the opportunity, if we have anybody who would like to come forth, this is your opportunity. [LR439]

CHUCK OLSON: Hi, Senators. [LR439]

SENATOR PAHLS: Good morning, Mr. Olson. [LR439]

CHUCK OLSON: My name is Chuck Olson, C-h-u-c-k O-l-s-o-n, and I'm here to talk a little bit about somebody I think that's being forgotten in this whole mix, and that's the individual that probably knows health insurance the best and that's the local agent who works with a client. In today's world, everything I hear is that it's going to be on the Internet, it's going to be available for them to make a decision. We sell no other insurance without a local agent, licensed and monitored by the state with CE requirements, licensing requirements, and yet everything I'm hearing is that, you know, nobody is really talking about that agent. In my opinion, as you go forward and look at this, is that you continue to require that the state monitor who is selling this. Now I heard earlier something about HHS has already put out a Web site where there's a lot of errors and nobody is monitoring and there's misinformation. The local agent, and I would guess most of you know your local agents, are the ones that know it best, and when it's explained to them by that agent, you learn a lot more about what health insurance is and it doesn't have anything to do really with the end result. What they're talking about is lowering the costs. So with that, I'd be willing to take any questions about agents, but I think you all pretty much know that already, so... [LR439]

SENATOR PAHLS: Do we have any questions? Chuck, I do want to thank you because you do bring a face to, like you say, the person who's out there working. [LR439]

CHUCK OLSON: It's not a very good face but... [LR439]

SENATOR PAHLS: No, no, I didn't say that now. (Laughter) I didn't give you that compliment. But again, every once in awhile we do...a touch of reality has to hit and say what about the person or persons who are actually out there with their feet to the ground, you know, who are actually trying to make things work, and... [LR439]

CHUCK OLSON: Well, and the NAIC did make comments of the value of the agents, but they're also at the same time allowing the MLR to affect possibly how the agent is compensated. And along...if I get one more second here, along the MLR, I would ask this question. You know, it sounds great when you first hear that, you know, you've got to give 80 percent of the premium back as claims, and everybody kind of goes, hey, that's a great idea, until you stop and think about it and it's the end of the year and the carrier has got losses or has paid out claims of 75 percent, let's say, and their choice is to pay back 5 percent to all their policyholders saying, we overcharged you, or to just pay some claims that shouldn't have gotten done. Which one will the carrier do? Logistically, it's going to make a lot more sense to just go ahead and pay some claims, make everybody happy, than to go back and tell your clients, I've overcharged you for the last year. So is that really going to drive down costs? It's not my belief that it will. So again, appreciate your time. [LR439]

SENATOR PAHLS: Yeah, that is an interesting perspective. Thank you. Oh, Senator, yes, go ahead. [LR439]

SENATOR LANGEMEIER: Chairman Pahls, thank you. Sir, are you telling me I need to get sick in December of the year? (Laughter) [LR439]

CHUCK OLSON: Well, I think that's going to be your best bet, especially if you're with a carrier that has a little bit too low of a loss ratio that year. [LR439]

SENATOR LANGEMEIER: Okay. Thanks. [LR439]

CHUCK OLSON: Thank you. [LR439]

SENATOR PAHLS: Thank you. Appreciate it. [LR439]

MICK MINES: Good morning. [LR439]

SENATOR PAHLS: Good morning. [LR439]

MICK MINES: Good morning, Chairman Pahls, members of the Banking, Commerce and Insurance Committee. My name is Mick Mines, M-i-c-k M-i-n-e-s, and I'm a registered lobbyist. Today I'm here representing the National Association of Insurance and Financial Advisors of Nebraska. Our association is comprised of 1,100 agents and financial advisors who help consumers evaluate insurance options, purchase appropriate coverage, and provide service through the life of a policy. In fact, agents are often the human resources department for small businesses, assisting in enrollment, service, and compliance issues. We have been talking at a very high level thus far and I might mention that Mr. Olson is one of our NAIFA members, but we'd like to bring it down to a local level as this process continues, as this committee engages in whether or not to establish a Nebraska Exchange. NAIFA believes the interests of all Nebraskans are best served by a health...state Health Insurance Exchange, similar to the Exchange established in Utah, rather than the Massachusetts model. As you know, a federal Health Insurance Exchange is a nationwide pool of insurance providers and that will facilitate on-line access to coverage for insurers and individuals. Simply, it provides a platform for a government-run public health plan that uses Medicare-style administrative pricing in direct competition with private health insurance. Congressional champions of this idea say that it would increase the range of choice and competition available to Americans. In fact, it does exactly the opposite, resulting in a massive erosion of private health insurance. If we were to engage in a Nebraska Health Insurance Exchange, it will be...it won't be an on-line replacement for existing insurance markets. Indeed, it will foster competition between state and private insurance plans. The exchange will take applications and meet personally with various underwriters to foster competition over each case. Considerations for each individual and their family are wisely handled locally with field underwriters and Nebraska health insurance-based carriers. Understanding and evaluating insurance options is complicated because each

client has different needs with various family options to consider. Personalized professional service from local agents who advise and assist their customers to the best coverage at the best price for their needs is maintained with a Nebraska Exchange. I mean it just does make sense that Nebraskans will get the best deal, the best price, not to mention local service, from their neighborhood insurance representatives rather than as federal Web site that doesn't even office in Nebraska. Competition, accountability, and service have driven the health insurance industry and NAIFA members simply want to continue to compete under a Nebraska Health Exchange plan. I thank you and would be glad to answer any questions. [LR439]

SENATOR PAHLS: Mick, I have a question. So you're saying you are really promoting the Nebraska Exchange, is what... [LR439]

MICK MINES: NAIFA understands that, again, the best service and the best competition will come through a Nebraska Exchange which allows independent insurance agents and NAIFA members to compete on a fair basis. In fact, consumers are best represented because, I mean, they don't rely on a federal Web site for their decision making. They have access through a Nebraska Web site and are then directed to local insurance professionals. [LR439]

SENATOR PAHLS: Okay. I see no more. [LR439]

MICK MINES: Thank you. [LR439]

SENATOR PAHLS: Thank you. Thank you. [LR439]

BRIAN URBAN: Good morning. [LR439]

SENATOR PAHLS: Good morning. Morning. [LR439]

BRIAN URBAN: I'd like to thank the committee for holding this hearing on this dynamic and important topic that touches each and every one of our lives. My name is Brian Urban, B-r-i-a-n U-r-b-a-n. I am a Nebraska registered insurance agent and I am the state legislative committee chairman for the Nebraska Association of Health Underwriters. I'd like to begin by echoing what Mr. Olson and Mr. Mines said in relation to the importance of the agent in this process. When we look at the scope of the presentations that were presented to us previously and all of the new regulations and reporting that's going to be required by small businesses, I can't state enough how important the agent is in assisting those small businesses in remaining compliant as well as, as was indicated earlier, acting as a sort of human resource out...a human resource contractor. I'd like to further state in...relative to the idea of "navigators" stated in the federal reform bill, I would implore this committee to look and to push for the requirements that navigators be licensed agents. If indeed we want to talk about a level playing field, offering insurance information and advice should be monitored and it should be followed through with continuing education and it should be subject to the regulations that current agents are subject to and have to follow. I wanted to touch...I think most everything was said in the prior...the prior presentations, but just to give you some scope or to give you an idea of one piece that is really at the point of contention in this bill, which is the individual mandate and the cost of not complying with the individual mandate, which will be returned to the federal government in the form of a tax. The projections, and this projection, and I'd be happy to make this exhibit available to the committee, this projection assumes a 7 percent annual inflation rate for health insurance cost or healthcare cost. In 2017 the average annualized individual premium is $8,453 per year and the penalty for not complying with that individual mandate is $695 per year. I just want to make the committee aware of the large difference in price for coverage and price for compliance. With the...if we couple that with guarantee issue, which means you can't be turned away, we may very well see a lot of game playing. We see it in Massachusetts already where folks wait until they know that they need to get some things done, buy coverage, and then let the coverage lapse and pay the penalty for the rest of the year because it's a cheaper, more effective way to go. I want the

committee to be cognizant of that. And then secondly, from a cost to the state of Nebraska, this is from Milliman and their August 16 report, and I think that the Governor has been sharing these figures and I just want to share them again with the committee here. The cost of the Medicaid expansion mandated by the PPACA law is, in a midrange, $526 million to a full enrollment range of $765 million. That's over a ten-year period. That's the federal government forcing the Medicaid expansion. That's the cost to Nebraska and I'd be happy to make that exhibit available to the committee also. And I would be more than happy to entertain any questions at this point in time. [LR439]

SENATOR PAHLS: I would just like to have you reinforce, explain again to me about the "navigator" and their...what you said they should do. [LR439]

BRIAN URBAN: I believe the "navigators" should be subject to the same licensing, continuing education, and regulatory requirements that insurance agents are subject to,... [LR439]

SENATOR PAHLS: Okay. [LR439]

BRIAN URBAN: ...just so we're sure that there is a common ground on regulation as well as the information that's being disseminated to the public between a "navigator" and an agent. Those...I think those individuals or those parties should be regulated evenly also. [LR439]

SENATOR PAHLS: Okay. Senator Langemeier. [LR439]

SENATOR LANGEMEIER: Chairman Pahls. And Mr. Urban, thanks for coming to testify. [LR439]

BRIAN URBAN: Absolutely. [LR439]

SENATOR LANGEMEIER: We appreciate it, and same with Mr. Olson. As you talk about being independent insurance agents, and we heard through the Blue Cross presentation and we've been hearing it from health insurance companies for months on end prior to this that they don't quite grasp everything that's within this 2,400 pages, and you talk about being the first line of defense to the individual buying insurance, where are you getting your background to...what's out there for independent agents to try and grasp this if the companies you represent aren't grasping it? [LR439]

BRIAN URBAN: In the form of information? [LR439]

SENATOR LANGEMEIER: Yes. [LR439]

BRIAN URBAN: It comes from a number of sources, including from some of those companies. But my...our sources are collated and disseminated through the National Association of Health Underwriters. Groom Law is a national legal firm that has been providing white papers for us. But I will echo what Director Frohman and Ms. Valentin did say. A 2,400-page bill, at our last check, was rolling off the regulation at about 1,000 pages per page. So the information is still in its early ages and our projections are that we're at the beginning of a seven- to ten-year rollout. But our information does come through our national association. Some of it comes...a lot of it comes directly from the governing body, CMS, CBO, and so I guess the short answer would be a large number of sources. [LR439]

SENATOR LANGEMEIER: Great. Thank you. [LR439]

SENATOR PAHLS: Senator. [LR439]

SENATOR GLOOR: Thank you for your testimony. And I apologize if this question has been asked earlier, but one of the issues with the Milliman report is that it assumes that 100 percent of Medicare-eligible...Medicaid-eligible recipients will drop their employer's

health insurance and move to the Medicaid program, 100 percent. In your experience, are people that quick to drop one insurance carrier--say both spouses have some degree of coverage--that they're that quick to drop and move for a difference in pricing that they understand? [LR439]

BRIAN URBAN: For something...the question is, are people that quick to move for something more expensive to something... [LR439]

SENATOR GLOOR: One plan to another plan. One plan to another. [LR439]

BRIAN URBAN: From one plan to another assuming that the alternative is cheaper to them? I would say absolutely. My experience is that I haven't run across a large number of folks Medicaid-eligible that are in employer-based plans. I believe that number to be somewhat small. And the...I think that the Milliman study does provide a broad range with a midpoint at the $523 million and the full enrollment at the $765 million. But the bigger problem and I guess the wide-angle lens problem with Medicaid in the past is that the barrier of entrance is a large amount of paperwork, background checking, and the eligibility versus the enrollment is still very far off, meaning those that are eligible for Medicaid, be it that they have an employer option or not, aren't taking any options because they don't go through the red tape to get enrolled into Medicaid, that this is different for SCHIP and children's version of Medicaid, but for adults who are eligible for Medicaid, many of them do not enroll until they end up in the provider's office, the hospital, and are forced to do so because of financial concerns. So I think that a bigger question that we have is, with the Medicaid expansion, are we going to get rid of the uninsured problem by simply expanding a program that has had a failed enrollment scenario in the past? And that's, I guess, to be determined. [LR439]

SENATOR GLOOR: Thank you. [LR439]

SENATOR PAHLS: I see no more questions. Thank you, Mr. Urban. [LR439]

BRIAN URBAN: Thank you. [LR439]

SENATOR PAHLS: I feel like I've been in church and I've given a very poor sermon. (Laughter) I'm asking you, if you do, this is a time to give us more input. [LR439]

DENNIS BUTLER: Thanks, Senator. [LR439]

SENATOR PAHLS: Thank you. [LR439]

DENNIS BUTLER: My name is Dennis Butler, D-e-n-n-i-s B-u-t-l-e-r, and I'll be brief. But Senator Langemeier's question kind of brought me up here when asked where we get our information. I am a proud member of the National Association of Health Underwriters and our group provides us with a lot of information, but also on our own. My agency has represented employers in the state of Nebraska for 30 years and we look at it as part of our job to represent those small employers and help keep them in compliance. This past Tuesday and Wednesday, the Department of Labor had two two-hour webinars that you went on and listened to and I don't know if anyone else in the room participated in that but I did. I felt it my responsibility to see how is the government going to disseminate information with compliance for PPACA to small employers. And I have to tell you, I don't know if anyone...I'd love to see hands of anyone else who listened to that. It was four hours long. I don't know what that says about my life that I was...(laughter) but I did listen to it and it was dreadful because I'm a professional and struggled to get through it. And so it takes someone who is a professional to sift through that information and to give it to our clients and clientele across the state and it's just one more measure of the worth of a professional in our business. The regulations that are coming down to us are written by Washington bureaucrats and, not to make a political statement, that most of them are covered by the federal employee health plan. It doesn't have an agent. You know, they don't know what an agent does. If you're a small employer in the state of Nebraska, you do because you

rely on your agent for a lot of things. So the folks writing these regs, who wrote the law in fact, just don't and aren't aware. I don't want to say they're ignorant to it. They just aren't aware. They're not exposed to what we do so we're somewhat left out of much of the language of this. So if we're here in numbers, that's probably why, so my two cents' worth. [LR439]

SENATOR PAHLS: Any? Senator Langemeier. [LR439]

SENATOR LANGEMEIER: Thank you, Chairman Pahls. My comment wasn't to question your knowledge. [LR439]

DENNIS BUTLER: No, no, I understand. [LR439]

SENATOR LANGEMEIER: My point is on the federal level, is they think they can do this through portals on the Web site. I think it's going to take more than that. [LR439]

DENNIS BUTLER: It will take more than that, so... Thank you, Senators. [LR439]

SENATOR LANGEMEIER: I would argue that a third of the state doesn't even have Internet so... (Laughter) [LR439]

SENATOR PAHLS: Thank you. [LR439]

DENNIS BUTLER: Thank you. [LR439]

SENATOR PAHLS: Thank you. It appears we will have more respect for our agents in the future. I mean we can see how difficult this is for some of us just to meander through the work. I'm talking, hopefully I can get another person or two to come forth if they...because I don't want you to leave here not feeling you have not had an opportunity to be heard. Because I have to be honest with you, going into this I hadn't

really thought that much about the effect it has on the agent, because you get so involved in all this other stuff you forget there happens to be a person on the other end. So that's some information that I personally gained. Senator Langemeier. [LR439]

SENATOR LANGEMEIER: Chairman Pahls, would it be safe to say that this is just the first of many meetings... [LR439]

SENATOR PAHLS: Yeah. [LR439]

SENATOR LANGEMEIER: ...and we're going to get to know that crowd pretty well over the next year. (Laughter) [LR439]

SENATOR PAHLS: Probably will, yeah. Yeah. [LR439]

SENATOR LANGEMEIER: Then I'm term limited out so I'm out. (Laughter) [LR439]

SENATOR PAHLS: Yeah, that's true. If I...Director Frohman, would you mind coming forth? I don't know if I have any particular questions for you, but I just thought in case somebody else had something that was left unsaid or needs to be said. Senator Pirsch. [LR439]

SENATOR PIRSCH: Oh. [LR439]

SENATOR PAHLS: Oh, okay. [LR439]

SENATOR PIRSCH: I must have had an inquisitive look on my face, but I'll take advantage of that. Right now, so we're at the point where we are applying for a grant, correct, so that we can use that to kind of reach a sound judgment as to whether and how we want to go about establishing our own Exchange or not. What's the time frame that you kind of anticipate on that, being if we receive the grant then, and what kind of a

time frame is it? [LR439]

ANN FROHMAN: We actually expect that it will be a quick turnaround and we will know hopefully within the next 30 days and it will be funded within 30 thereafter, so it's a fairly quick process. And then the study and the research will commence and we would expect that to probably run through...big project, I don't want to put it out there and hold them to it, but recognizing that it's a one-year grant we would expect that the analysis, research, and recommendations would culminate probably about this time next year. [LR439]

SENATOR PIRSCH: I see. Okay. [LR439]

SENATOR PAHLS: Yes. Senator Langemeier. [LR439]

SENATOR LANGEMEIER: We're killing time. Thank you, Chairman Pahls. Director, as you talk about getting these kind of funds, are you expecting to do that with your current staff load or are you thinking, bringing in some outside consulting type firms to help you crunch numbers or...? [LR439]

ANN FROHMAN: A combination thereof. To the extent we're looking at rate reviews, we will probably engage a consulting actuary, but there are a number of other components that would require us to perhaps on a temporary basis hire a project manager to work on some of the rating trends and putting information out there for the public on some of the rating processes and information and value there that we can maybe enhance in terms of the health insurance arena. [LR439]

SENATOR LANGEMEIER: Then my follow-up question is, do you, as an agency, have any grasp of the money you spent trying to learn what's in these 2,400 pages that hasn't been outside grant money, that's currently in your budget that you've had to reallocate to try and figure this out? [LR439]

ANN FROHMAN: And even that took time. Yes, we've already roughly logged 2,500 hours since this thing was enacted of staff time. [LR439]

SENATOR LANGEMEIER: And we're at the tip of the iceberg. [LR439]

ANN FROHMAN: Pardon? [LR439]

SENATOR LANGEMEIER: And we're at the tip of the iceberg in figuring it out. [LR439]

ANN FROHMAN: At the very tip, yes. [LR439]

SENATOR LANGEMEIER: Thank you very much and wish you the best in your future endeavors as you leave your post as director closer to the end of the year, and we look forward to meeting the new director. [LR439]

ANN FROHMAN: Thank you. [LR439]

SENATOR PAHLS: Yeah, it's one reason...oh, go ahead. [LR439]

SENATOR GLOOR: Go ahead, finish your comment. [LR439]

SENATOR PAHLS: Well, that's one reason I wanted to call you up, because I know we probably won't have too many opportunities to have you in front of us before you go on to another world. And I do want to thank you for all of the things that...the coffees we've had and the discussions and how you tried to enlighten me on certain issues dealing with insurance, and I've always appreciated knowing that when I ask a question, it was answered. And I, as I said in the paper, I don't find that with all of the agency heads that I talk to. Sometimes I feel like I'm being stonewalled and I never did feel that with you. And we are going to miss your experience and your smile and what you've done for us,

and I appreciate that. So I'm going to compliment you but it's also a reprimand. (Laughter) Ann, thank you. [LR439]

ANN FROHMAN: Yeah, thank you. [LR439]

SENATOR GLOOR: Thank you, Mr. Chairman. Obviously, I missed something while I was at another meeting and it appears I'm going to have to give my "healthcare is a utility" speech all over again to somebody new. But let me ask if within your profession or within your position, there is a nationwide group of directors of departments of insurance that not only meets on a regular basis but also shares information, has newsletters, bulletins, etcetera, etcetera. Is there such an arrangement? [LR439]

ANN FROHMAN: The National Association of Insurance Commissioners is actually the oldest organization of government officials in the country and we meet on a triannual basis, addressing a couple hundred issues each time on insurance. We have plugged into that system. We...I think we have 90 conference calls a month, and this is outside of healthcare arena, so we have a very integrated national system of state-based regulation. We have taken the directives out of PPACA that have been the...that association was mentioned in the federal law over 25 times, I believe. [LR439]

SENATOR GLOOR: Good. [LR439]

ANN FROHMAN: And so there are a lot of directives and we have essentially plugged them into that process of reviewing, analyzing issues, considering model legislation for recommendation to you all, and that work is underway in so many areas right now. [LR439]

SENATOR GLOOR: So, I mean I am pleased that we've applied for the grant money, but it's kind of been my assumption that there would be other resources available to you and this clearly, to me, would be one of the best as you and your peers put your heads

together to try and decide what sort of models do people have experience with and what does this reform mean for your departments and for your states. I mean I would think it would be a wonderful source of guidance and help. [LR439]

ANN FROHMAN: You know, it's interesting. I just saw where we have spent exclusively on the healthcare issues $80,000 in conference calls. [LR439]

SENATOR GLOOR: Yeah. Yeah. [LR439]

ANN FROHMAN: That's not our time. That's just...that's just the costs associated with calls. So, yes, it's a very good organization and the value and the expertise there, which is focused, on the end of the day, of getting the most value to the consumers and... [LR439]

SENATOR GLOOR: Is there...is there a specific gem or takeaway that you can share with us that you've taken away from all of these conference calls and interactions so far? [LR439]

ANN FROHMAN: I find, I guess in some respect, I find the organization rather apolitical, which is probably surprising, but I think that's just the nature of trying to, at the end of the day, make a difference for the consumer. But I do think there is a level of frustration. The demand and expectations on the organization are pushed to the limit and yet the organization is not even hesitating to get the work done. So I guess I'm not quite sure... [LR439]

SENATOR GLOOR: That's fine, yeah. [LR439]

ANN FROHMAN: ...but it's...they are a big key and I do hope that the recommendations that come out of that organization are given careful consideration because that's where the expertise lies. It does not lie in Washington. [LR439]

SENATOR GLOOR: And will you then carry what comes from them to us as of our discussions? [LR439]

ANN FROHMAN: I believe...I believe there will be a lot of value there that will be before you all in time. [LR439]

SENATOR GLOOR: Okay. Thank you. [LR439]

SENATOR PAHLS: Again, thank you, Director. [LR439]

ANN FROHMAN: Thank you. I appreciate it. [LR439]

SENATOR PAHLS: That concludes this hearing. Oh. [LR439]

SENATOR PIRSCH: Oh. One more. [LR439]

SENATOR PAHLS: One more. [LR439]

MIKE GRAY: One more. Thank you, Senator Pahls. My name is Mike Gray, M-i-k-e G-r-a-y. I'm an independent agent and I would be remiss if I didn't sit before you and tell you that I have served on a national basis with the health underwriters organization. And we have one of the finest departments of insurance in the country right here in Lincoln, Nebraska. It is unbelievable to me the respect that Director Frohman has across the country and, in fact, is utilized in a lot of my discussions, things that I have talked to her about or learned from her. So they have a great department. Everyone that works there has been very helpful and we just have a great respect for them and all the things that they do for all of us as agents here in Nebraska, so I just wanted to make that comment. I think it's important to do that. [LR439]

SENATOR PAHLS: Good. It's true. [LR439]

MIKE GRAY: So thank you very much for the time. [LR439]

SENATOR PAHLS: Thank you. Thank you. I'm sure we'll see a lot of you because, Senator Gay, some of us serve on his committee that will be dealing with health issues, so I'm sure that I will be looking at some of the same faces. Have a good one. Thank you. [LR439]