[LB220 LB301 LB310 LB341]

The Committee on Health and Human Services met at 1:30 p.m. on Friday, January 30, 2009, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB310, LB341, LB220, and LB301. Senators present: Tim Gay, Chairperson; Dave Pankonin, Vice Chairperson; Kathy Campbell; Mike Gloor; Gwen Howard; Arnie Stuthman; and Norman Wallman. Senators absent: None.

SENATOR PANKONIN: We will start our hearing in a few minutes, but we will go over some of the ground rules. Some of the senators, including Chairman Gay, are introducing bills at other committees, so they may be in and out as your session goes along, as your hearing goes along, so don't be concerned about that. They are going to other committees at times to introduce their own bills. I want to go through some information for everyone this afternoon. Please turn off any cell phones and other electronic devices or put them on manner mode. There are testifier sheets up at the desk or in the corners, and if you could fill those out ahead of time and then when you...if you are going to testify, when you proceed to the chair, would you give them to our committee clerk? We would appreciate that. When you are recognized, please spell your first and last names so that our clerk and the transcribers can have that information accurately. We also have a light system in the Health and Human Services Committee. And this light system that is run by the clerk, there will be a green light for four minutes, then a yellow light will come on for one minute, and then a red light will come on after the five minutes to signify that you should be winding down your testimony if at all possible. We will use some discretion on this, but we do like to stay with this light system because we have long hearings in Health and Human Services often, and people have driven many miles and they've taken their time, and we want to make sure everybody has a fair opportunity to testify. I am Senator Dave Pankonin from District 2. I'm the Vice Chairman of this committee, and I will have the rest of the folks around the table introduce themselves starting with Senator Gloor.

SENATOR GLOOR: Thank you. I am Senator Mike Gloor, District 35, Grand Island.

JEFF SANTEMA: My name is Jeff Santema, I serve as legal counsel to the committee.

SENATOR STUTHMAN: Senator Arnie Stuthman, District 22, which is Platte County.

SENATOR HOWARD: Senator Gwen Howard, Omaha, District 9.

SENATOR WALLMAN: Senator Norm Wallman, District 30.

ERIN MACK: I am Erin Mack, the committee clerk.

SENATOR PANKONIN: Thank you. We will now start with the agenda that's posted with

LB310 and Senator Haar. Go ahead, Senator Haar, when you are ready. [LB310]

SENATOR HAAR: (Exhibit 1) Okay, thank you. Senator Pankonin and members of the committee, my name is Ken Haar, K-e-n H-a-a-r. I've distributed to the committee an amendment which will replace the green copy of LB310. The amendment will limit the licensure requirements to healthcare providers. This is to clarify and narrow the scope of the bill. This bill does not create any new mandate for interpreters where they're required, that is. What it does do is require that interpreters be licensed. It also adds penalties for noncompliance. It's already required in Nebraska that interpreters be licensed in governmental and law enforcement situations. This bill expands that requirement to healthcare settings. Obviously, healthcare language is important to get correct, so that is the reason this bill has been focused on that aspect. There will be testifiers following me that will tell you about specific problems that deaf people have had with unlicensed interpreters in the healthcare setting. I believe you will find the testimony compelling. Thank you. [LB310]

SENATOR PANKONIN: Thank you, Senator Haar. I do want to let everyone know that Senator Kathy Campbell from the Lincoln area has joined us. And is there any questions for Senator Haar? Thank you, Senator Stuthman, he has indicated...I thought Senator Howard was here and introduced herself. [LB310]

SENATOR HOWARD: Oh I did, I was. [LB310]

SENATOR PANKONIN: That's...okay, he said you didn't. So, I... [LB310]

SENATOR HOWARD: Well, he's had a drowsy afternoon, I'm afraid. (Laughter) [LB310]

SENATOR PANKONIN: That was how I remembered, but I was just trying to be courteous to Senator Stuthman. [LB310]

SENATOR HOWARD: Yes, I did. [LB310]

SENATOR PANKONIN: All right, we've had a little disruption with the committee, and we will settle down here. Is there any questions for Senator Haar? Seeing none, thank you, and we'll have our first...our next testifier that is a proponent of the bill come forward. And as we've indicated, we'll have you...as the written material is being passed out, let me remind you that we do need a dozen copies, 12 copies, if possible. And if you don't have that many, our pages can help you, for the record. Go ahead, sir. [LB310]

RAYMOND MEESTER: (Exhibit 2) I am Raymond Meester, R-a-y-m-o-n-d, and the last name is M-e-e-s-t-e-r. I reside in Senator Avery's district here in Lincoln. I'm the chair of the Nebraska Commission for the Deaf and Hard of Hearing, the state agency serving

the needs of the deaf and hard of hearing here in Nebraska. Yes, I am a hearing person, but I grew up in the world of the deaf as both of my parents and four uncles and aunts are deaf. A little over three years ago, we moved my mother to Lincoln. I remain very active in the deaf community, and the church I serve, Heritage Presbyterian Church, has an active deaf ministry. Currently, the legislation for licensure of sign language interpreters is found in Revised Statutes 20-150 through 20-159. The original legislation was signed by Governor Johanns in 2002, and the rules and regulations were established by June 30, 2007. It requires that any interpreters used by state agency's law enforcement personnel must be licensed. The goal of licensure was to ensure that interpreters have the skills required to make communication effective between the deaf and the hearing. The rules and regulations related to this legislation stipulate that to be licensed, interpreters must score a certain level on one of four different certification processes available. The Nebraska Commission for the Deaf and Hard of Hearing administers one of these tests, the Quality Assurance Screening Test or QAST. The changes we are proposing in LB310 would simply add healthcare providers to the list of those required to used licensed interpreters. It is important to have accurate communication in a medical setting. The quality of a person's care cannot rise above the quality of the communication between the doctor and the patient. Other testifiers this afternoon will share their experience of unqualified interpreters in medical settings. In LB310, we are also seeking to include a fine of up to $500 for any interpreter who is not licensed to give the legislation some teeth. The commission currently has the authority to deny, refuse to renew, limit, revoke, suspend or take other disciplinary actions against the license. As a commissioner for the Nebraska Commission for the Deaf and Hard of Hearing, I want to assure you that we intend the fine to be a last resort. I want to reiterate that Revised Statutes 20-150 through 20-159 and LB310 do not create any requirements nor expand any requirements for an interpreter. These rights were required under the Americans with Disabilities Act or ADA. ADA does mention qualified interpreters, and this legislation before you simply defines what a qualified interpreter is. Nothing more. It does not in any way expand the reach of ADA. I can share with you many experiences I've had with unqualified interpreters in medical settings. A few years ago, my mother was to have some x-rays, and we were told an interpreter would be provided. Previously, we had some problems with this facility not using qualified interpreters. I asked about the qualifications of the interpreter and was told she was a Level III, which is a reference to a rating on the QAST. I questioned that because I know this interpreter. After some further questioning, we discovered the interpreter was currently taking her third sign language class. She was far from being a Level III on the QAST, which is the minimal requirement for licensure--and I want to emphasize minimal--for interpreting in a medical setting. We had to reschedule the medical procedure so that my mother would have a qualified interpreter. Most people in organizations are not knowledgeable about sign language interpreting to be able to determine the qualifications of an interpreter. We cannot expect them to be able to determine whether an interpreter is qualified. This bill will help doctors, hospitals, and other medical personnel know that the interpreters they are

using will ensure that their communication with deaf patients is appropriate and effective. And I want to add one more item that's not in my printed report. I'm sure that there are some within the medical profession who are concerned that there are not enough interpreters. My first church was in Coldwater, Kansas, a town of less than 1,000 people, of a county of under 3,000 people out in western Kansas. We had a difficult time getting doctors, but we did not allow anybody to practice medicine simply because there was a shortage of doctors. And I don't think we should allow interpreters to be allowed to interpret if they're not qualified simply because there's a shortage of interpreters. This bill will go a long way to ensure that the deaf of Nebraska can experience the good life. Thank you. [LB310]

SENATOR PANKONIN: Thank you, Mr. Meester, we appreciate your testimony. And if you'll just stay seated for a few minutes in case anyone has any questions from the committee. Senator Gloor. [LB310]

SENATOR GLOOR: Thank you, Mr. Chairman. Mr. Meester, I'm trying to understand that what we're dealing with here is taking out the language that said places of public access which appeared to be too broad, and plugging in the very specific term healthcare providers. So does that, in your mind, include chiropractors? Does it include herbal therapists? Does it include doctors in hospitals? And I should, by way of disclosure, let you know that prior to coming down here I ran a hospital, so I do consider hospitals healthcare providers. But when it suits them, there are an awful lot of people who think they are healthcare providers, and therein lies what I consider to be a very slippery slope on this change in wording. Can you help me understand this? [LB310]

RAYMOND MEESTER: Well, I was on a committee from the commission who originally wrote this up, and we discussed to a great detail about what that is. And we tried to find some definitions of it within Nebraska statutes, and I think we found about four different definitions with healthcare providers. And honestly, according to what we have here, healthcare providers means a physician or other healthcare practitioner that are licensed, accredited or certified to perform specific health services consistent with state law and healthcare facilities or services licensed under the healthcare facility. So we were looking at basically those kind of medical people that already require some kind of certification or some kind of license to practice their particular profession within the state. [LB310]

SENATOR GLOOR: Would you expect, then, every pharmacy in the state to have a certified interpreter? [LB310]

RAYMOND MEESTER: No. The ADA Act talks about reasonable accommodations, so we are not expecting that if a deaf person goes into a pharmacy and wants to get a prescription filled that the pharmacist has to provide an interpreter. [LB310]

SENATOR GLOOR: Physical therapy clinics? [LB310]

RAYMOND MEESTER: Again, in my...in researching the Department of Justice Web site with ADA cases, a lot of it tends to be case by case. But when it's something simple like, you know, just getting your prescription refilled or something like that, we don't expect that to be...sometimes written is adequate but we have to be careful there because a lot of deaf people, including my mother, are not very good with English or with written skills. So, for example, I remember one girl I dated wrote my mother and thanked my mother for the hospitality. And my mother was offended thinking that the woman had said that my mom was in the hospital. So that's some of the confusion between English and sign language. But we, you know, we expect to be reasonable about this. We don't expect every little...every time a deaf person walks in that there has to be an interpreter right there. [LB310]

SENATOR GLOOR: I actually empathize with you. What I'm finding out, now that I'm down here making law, is that the issue of reasonableness just doesn't appear to come up very often when you make laws. There is a degree of specificity that people get real intense about, and so that's the reason for my line of questioning, is it's hard to build reasonableness into a law, I believe. [LB310]

RAYMOND MEESTER: Right. [LB310]

SENATOR GLOOR: And so that's the reason for my concern. I would also say, though, I do understand the seriousness of this issue. At least my institution, when it came to interpreters for language, spent a considerable amount of money because of the concerns that there could be miscommunication that could be life threatening. But certification was something that we forced upon ourself because of our own concerns, it wasn't something that currently is in statute and requires us to follow. Thank you. [LB310]

RAYMOND MEESTER: And like I said with my experiences with my mother, you know, I felt somewhat sorry for the people in the x-ray lab because they were caught in the middle. They didn't know what a qualified interpreter was. So that's why I feel very strongly about this. Here is, within Nebraska Revised Statute 71-143, healthcare facility defined. A healthcare facility means an ambulatory surgical center and assisted living facility, a center or group home for the developmentally disabled, a critical access hospital...I don't know if you want me to go on with this, but that is already spelled out in there, but... [LB310]

SENATOR GLOOR: But the term is healthcare providers. [LB310]

RAYMOND MEESTER: Right. Yeah. [LB310]

SENATOR GLOOR: And so that may be something that needs to be discussed. [LB310]

RAYMOND MEESTER: Yeah, and we may need to tweak that language. [LB310]

SENATOR GLOOR: That's all. Thank you. [LB310]

SENATOR PANKONIN: Thank you, Senator Gloor. Any other questions from the committee? Seeing none, thank you Mr. Meester. [LB310]

RAYMOND MEESTER: Thank you. [LB310]

SENATOR PANKONIN: Next testifier is a proponent. [LB310]

ROY SCHERLING: You know, I may choose to stand if that's okay so that I can sign freely. [LB310]

SENATOR PANKONIN: Yes, that will be fine. You can go ahead and be seated, and the interpreter can stand. He wants to stand. Okay, I'm sorry. [LB310]

ROY SCHERLING: Senators and all members of this committee, I'm happy to be here this afternoon (inaudible) audience members, I welcome you. I am here. I live in DeWitt, Nebraska. My name is Roy Scherling, S-c-h-e-r-l-i-n-g. And I have experienced using interpreters when I was hospitalized in 2001 to have heart surgery. And, of course, this was a very serious medical situation, it was at the point of being a life or death situation. And while I was in the hospital, they provided me with an interpreter. And I was trying to convey something to the physician, and the interpreter was not able to understand what it was that I was saying. And I had to continue to try to repeat myself and change how I was saying what I was saying so that the interpreter could understand it. After multiple attempts, my wife, who is also deaf, wrote a note to the physician explaining to him what I was saying since the interpreter was not able to understand my communication. You know, and there were other times while I was in the hospital that they did provide an interpreter but it was, again, an unqualified interpreter. After I awoke from surgery, I was trying to talk to the doctor and the persons that were there in the recovery room with me. And you know how it is when you are coming out of surgery and you're trying to, you know, just wake up from the anesthesia. It was a very frustrating experience to have to try multiple times to convey a simple thought such as I needed a drink of water or, yes, I was experiencing pain. And that was the primary experience that I have had, and I understand the severity of medical settings and it is very important, it is imperative that we have qualified interpreters that can convey our communication to the physician and the physician to us. Thank you. [LB310]

SENATOR PANKONIN: Thank you. If the testifier could come back forward in case there is questions. Is there any questions? Seeing none, thank you for your... [LB310]

SENATOR GLOOR: Just one. [LB310]

SENATOR PANKONIN: Oh, Senator Gloor. [LB310]

SENATOR GLOOR: Thank you, Mr. Chairman. Mr. Scherling, do you have a regular physician that you go to? [LB310]

ROY SCHERLING: Yes, I do. [LB310]

SENATOR GLOOR: And how does that physician accommodate your need? [LB310]

ROY SCHERLING: Well, I have to go see a heart specialist for checkups, and I do that every six months. And so my family doctor I don't really go to very frequently unless I need to, but my family doctor does not provide an interpreter when I go to him. [LB310]

SENATOR GLOOR: And how do you communicate with your family physician? [LB310]

ROY SCHERLING: He's in a very small town, and so we usually just end up writing notes back and forth to each other with the understanding that we have other deaf members in our family, so we're able to communicate with our doctor in a manner that, you know, is acceptable most of the time. But there are some other deaf persons that live in my community that do not have this same ability in written English that I have, and so those individuals require an interpreter to be able to communicate effectively with a doctor because they can't depend upon their written skills to convey their complex thoughts. So in those cases, that physician does provide an interpreter. [LB310]

SENATOR GLOOR: But would it not bother you that family members, people you trusted, couldn't sign for you with your family physician unless they were licensed? [LB310]

ROY SCHERLING: Could you...I'm sorry I'm not sure I understood what you were... [LB310]

SENATOR GLOOR: If I understand the law, those trusted family members and friends would not be able to sign for you with a physician unless they were licensed. [LB310]

ROY SCHERLING: Well, you know, my whole family is deaf, my wife included and my children. And, you know, because I live in such a small community, we always go into the city to go to any medical appointments because we realize that in the city we'll be served better by interpreters that we would not have in our small community. [LB310]

SENATOR GLOOR: Okay, but I'm still not sure that's answered my question. [LB310]

ROY SCHERLING: So you mean you're asking me whether my family would be able to interpret for me or couldn't interpret for me because this licensure bill would be in place? [LB310]

SENATOR GLOOR: They could not unless they were licensed. [LB310]

ROY SCHERLING: Yeah, and that's fine. That is exactly what I want because I want to have a qualified interpreter come in to communicate so that we can have clear communication in a medical setting. [LB310]

SENATOR GLOOR: Good, that's...thank you. That does answer my question. Thank you. [LB310]

ROY SCHERLING: And the other problem with families communicating for you is, you know, you don't want them to be involved in something that can be very personal and you want to keep private. Thank you. [LB310]

SENATOR PANKONIN: Any other questions from the committee? Seeing none, thank you. [LB310]

ROY SCHERLING: Thank you. [LB310]

SENATOR PANKONIN: Next testifier as a proponent. We'll just wait a little bit while we pass out...okay, you may proceed. [LB310]

JULIE DAHLKE: (Exhibit 3) Good afternoon. My name is Julie Dahlke, D-a-h-l-k-e, and I am from here in Lincoln, Nebraska. And I actually work for the city of Lincoln in the Engineering Services Department. And I am in favor of this bill because of my own personal experience in a medical setting. One afternoon, I had to go see a physician for a regular appointment that I had scheduled, and they had an interpreter there for me. This was an individual that I had never met before. And so the receptionist called me to the desk and was just updating my information. And I looked at the person that was typing and said that, you know what, you're typing the wrong information in there. And so the interpreter had misunderstood my conveying the phone number to the receptionist and entered that information in inaccurately. So that's the beginning of this appointment. So we go into the appointment and the doctor comes in, and I'm not understanding some of the signs that she was using to me. She was using a sign that didn't make any sense, and I later understood only by my ability to lip read her that she was saying cancer, but the interpreter was signing something that was talking about a client or a consumer. So she totally had misunderstood or misconveyed the doctor's information to me. At the end of the visit, I went directly to the Commission for the Deaf

and Hard of Hearing to file a complaint, and when I gave them the name of the interpreter, they said it was not even an interpreter that had met minimal qualifications and was referred by them. And they had hired this interpreter through social services, and I was very upset that they would hire someone that was so unqualified for the nature of my appointment and the seriousness. I think that, you know, social services or physicians offices and doctors should not be permitted to hire individuals that are unqualified. So that is the reason for my being here today to testify in support of this bill. [LB310]

SENATOR PANKONIN: Thank you. Is there any questions for Ms. Dahlke of the committee? Seeing none, thank you for your testimony. Any other proponent testimony? [LB310]

NANCY BRT: (Exhibit 4) Hello, Senators, members of the Health and Human Services Committee. My name is Nancy Brt, N-a-n-c-y B-r-t, no vowels. I serve as a guardian to a 65-year-old woman who is deaf and experiences developmental disabilities. I have worked with her for the past 15 years. I am also a licensed interpreter in the state of Nebraska. Some of my responsibilities as a guardian are to ensure this person receives comprehensive medical care, including managing her medical history, medications, transportation, and ensuring that when she goes to these appointments she has qualified interpreters. I am always concerned about the qualifications of the interpreters who are called to her medical appointments, and I would like to share a couple of those experiences with you today. It was necessary for this person to go to the emergency room. When we arrived at the hospital I let the nurses know that this person was deaf and needed an interpreter. Under the Registry of Interpreters for the Deaf Professional Code of Conduct, I am unable to act as her interpreter so a non-partial third party is required to provide the interpreting services. When the person arrived who the hospital had contacted, I did not recognize her. I began to ask her about her experience and qualifications. I asked her if she knew how to sign in American Sign Language, as the person that I'm a guardian for does not understand signed exact English. The woman responded that she had not had any formal training, only what she had learned from her son, who is deaf. She said that she did not know ASL, she only knew ESL. Well, that statement alone proved to me that she was not qualified as in the interpreting field there is no such language as ESL. I watched her try to communicate with this person and knew immediately she could not be trusted to interpret accurately what the deaf person said or what the medical staff wanted to say to her. I demanded the hospital find a qualified interpreter through the Nebraska Commission for the Deaf and Hard of Hearing's referral list. A qualified person did show up then. That person ended up spending most of the evening there facilitating communication so appropriate treatment could be administered. It turns out it was quite serious, and this person had to be admitted to the hospital. Recently, I took this same person to a follow-up appointment with her physician that she has been with for the last 15 years. I have had to advocate over and over again that this medical office...to provide qualified interpreters. I thought

the battle had been won until this appointment when another person showed up who apparently had been there before. I found out that she was the interpreter of the previous appointment when a lump had been removed from this person's neck. In the interest of time, let me say that I have found her to be unqualified as well. Because of inaccurate interpreting services, her physician had already scheduled an appointment with a specialist which was found to be unnecessary as...after I repeated the question in American Sign Language. I believe the medical community mostly wants to provide accurately interpreted medical services but has no means to verify a person's qualifications. Licensing of interpreters would be a fast and effective way to protect themselves and the deaf patient. Thank you for your time and your full consideration of LB310, and I'd be happy to answer any questions. [LB310]

SENATOR PANKONIN: Thank you, Ms. Brt. Are there questions? Yes, Senator Wallman. [LB310]

SENATOR WALLMAN: Thank you, Chairman Pankonin. Yes, say I wanted to become a certified interpreter. Do I have school to go to here in Lincoln or... [LB310]

NANCY BRT: Omaha has an interpreter program, I believe. [LB310]

SENATOR WALLMAN: And what would that cost me? [LB310]

NANCY BRT: I couldn't tell you. [LB310]

SENATOR WALLMAN: Okay, thank you. [LB310]

SENATOR PANKONIN: Ms. Brt, let me...I'm going to ask a question of my own that's kind of a follow-up to Senator Gloor's earlier question. [LB310]

NANCY BRT: Um-hum. [LB310]

SENATOR PANKONIN: I think what he was getting at is that now when you're making laws, we have to think about unintended consequences. And if this is too broad, it may require some facilities to have this service available that would make it burdensome and almost impossible to do. And when we talk about reasonableness of having the services, that obviously can be interpreted many different ways. How, from a practical standpoint...I think we can all see the need, how do you think this could work? Is there enough people available even to do this type of service? [LB310]

NANCY BRT: Well, like what was said earlier, there's, you know, whether there were enough people everywhere doesn't mean you lower the standards, you know. People may have to rearrange appointments, they may have to call an interpreter from another community, but it's certainly possible to get things interpreted. And I think it would be

better to err on the side of the deaf person being over-covered than under-covered. And as far as things like physical therapy, some deaf people would not need an interpreter, and they will go in and say that, I don't need an interpreter for this. But there are other people who truly do need an interpreter for things like physical therapy, chiropractors, and any number of those kind of appointments. And also, earlier, you'd asked a question, Senator Gloor, about family members could not then interpret for you. Well, the Americans with Disabilities Act already states very clearly that family members should not be interpreting for you. And that, I think, is one of the major reasons that it had become a law to begin with is because people would always depend on children to interpret for their parents. And we're not just talking adult children, we're talking children children. [LB310]

SENATOR GLOOR: Can I respond? [LB310]

SENATOR PANKONIN: Yes, Senator Gloor. [LB310]

SENATOR GLOOR: Thank you, Mr. Chairperson. Actually, my question would be more one of, if you would like to have your family member or a close friend who you trust, who you think can sign accurately, unless they are licensed, it would appear to me they could not perform in this capacity or you would be in violation of this law, if passed. [LB310]

NANCY BRT: There's two parties involved in any kind of situation where interpreters are involved. There's the medical facility, and there's the deaf person. If I was a medical facility, I would want to protect myself by having a licensed, impartial third party there to interpret. I wouldn't want somebody's family member. There's been many instanced over the years where a family member really wasn't qualified, gave inaccurate information or withheld information or was embarrassed by the information. I mean, there's just a lot of reasons why family members really should not and are very, you know...most deaf people do not prefer to have their family members. [LB310]

SENATOR GLOOR: Thank you. [LB310]

SENATOR PANKONIN: Any other questions? Thank you for your testimony. Any other proponent testimony? Okay, Ms. Richardson-Nelson, you can go ahead and testify. [LB310]

TAMI RICHARDSON-NELSON: (Exhibit 5) Good afternoon, my name is Tami, T-a-m-i, Richardson-Nelson, N-e-l-s-o-n. Members of the Health and Human Services Committee and all of the members in the audience, I am a member of the deaf community and a member of the Nebraska State Licensure Board. And thank you this afternoon for giving me the opportunity to come and testify. I'm going to share with you some of my personal experiences that will help you understand why passing LB310 is

very important to the deaf community. Two years ago, I wanted to attend a medical conference at Creighton University Medical Center, and the presenter was from Johns Hopkins University and was going to be talking about cochlear implant surgery. And I was excited, being deaf myself, I wanted to know what new technology was being developed as it relates to cochlear implants for deaf individuals. So I contacted the person prior to the conference that would be responsible for making the arrangements to hire an interpreter. They indicated to me they would do that, and I just, you know, assumed that they would take care of this and do it in the proper manner. When I showed up at the conference that afternoon, I went to the person that had said they would provide the interpreter, and they said, yes, we have someone. And this person stood up in front of the room, and it was not anyone I had recognized. And so I asked her who she was, and she said, well, I am actually a lab tech in the lab. And she said, but my husband is deaf, so I'll be interpreting for you today. And I thought to myself, okay. So once the speaker began to speak, she really started to fumble, and I'm sitting here, you know, wondering what this person from Johns Hopkins is talking about. And because the presenter was discussing a topic of technicalities that were, you know, foreign to her, she was overwhelmed and unable to interpret the information. I actually asked her why she had accepted this assignment to do this, so it was very obvious to me. And then afterwards it was conveyed to me that she did not have a license, she did not have any type of qualifications, and she actually stopped interpreting after a few minutes and left the room. So immediately afterwards I filed a complaint with the Nebraska Commission for the Deaf and Hard of Hearing because this was totally unacceptable to me that I did not have access to information that I wanted to understand. Every deaf and hard of hearing person has a right to have and select a qualified...or expect a qualified interpreter so that they can communicate without having to worry about what's being conveyed, and that that information will be maintained in a confidential manner because that is very important to us. I am sure that each one of you here today when you have a third party in the room with you and you are talking to a physician, you want to ensure that that person will keep the information that they overhear confidential. Later, I had an opportunity to have a presenter come to CU, where I work, and this person was here to talk to young physicians that were going through their residency or their training to help them understand why it's important to have a qualified interpreter. All of the residents were very thrilled to have this kind of information made available to them. This presenter, he's a national presenter, shared a story about a mother that had taken her doctor (sic) to the emergency room. The mother...the daughter was in a lot of pain, and she was pregnant, and she was having complications with her pregnancy. The mother misinterpreted on purpose to her daughter because she did not want to tell her daughter that she was pregnant. She told her that she was having appendicitis and said that, yes, you just have appendicitis. The doctor asked her if she wanted to have an abortion. The mother interpreted it to her, do you want to have your appendix removed? And what happened was the girl ended up having an abortion without knowing it at that time. Later on in life the girl went to the emergency room, and the doctor told her that she had appendicitis, and she said, well

that's not possible because I've had my appendix taken out. And he said that's not true, and that's when she discovered that she had had an abortion. So if...for all medical purposes, appointments, et cetera, any healthcare provider that's providing information to a deaf individual, they should have a qualified interpreter in that setting. So I want you to have no doubt that you will be doing the right thing by passing this legislation to support the needs of deaf and hard of hearing persons in the state of Nebraska. Thank you for your time. [LB310]

SENATOR PANKONIN: Thank you. Are there questions? Seeing no questions, thank you for your testimony. I'm just going to ask if there are any other proponent testifiers? We don't have any other proponent testifiers? Okay, we will now have any opponent testifiers. Good afternoon. [LB310]

BRUCE RIEKER: (Exhibit 6) Good afternoon, Chairman Pankonin, members of the Health and Human Services Committee. My name is Bruce Rieker. I'm vice president of Advocacy for the Nebraska Hospital Association. Rieker is spelled R-i-e-k-e-r. On behalf of the 85-member hospitals that we represent, the Nebraska Hospital Association opposes LB310. Even though our hospitals are not included in the definition of healthcare provider as LB310 is written, our hospitals employ those providers, and we believe that we have a vested interest in this discussion. It is a precarious position to oppose something when the intent is pure. However, that is the position that the NHA must take on LB310. Nebraska's hospitals are in the business of providing some of the most critical services individuals may ever need--healthcare services. Clear communication between healthcare providers and the person seeking those services is paramount to delivering the best possible healthcare. The amended version of LB310 mandates that the healthcare providers must provide people that are deaf and hard of hearing and who communicate by means of sign language or manual language with licensed interpreters. Many of our larger member hospitals already have people on staff to provide such services. Other hospitals have made arrangements to provide those services when they are necessary. Some of our smallest hospitals would find this a very difficult situation to provide such services. A similar scenario presents itself to many of our hospitals each and every day, and that is the dilemma about how to handle the growing diversity of languages spoken by those seeking services in our hospitals, clinics, nursing, and long-term care facilities, among the other allied or affiliated healthcare providers or organizations that we work with. The Nebraska Hospital Association contends that the mandate imposed on healthcare providers by LB310 is unworkable and unnecessary. There is not a day that goes by where the rising cost of healthcare is not a topic of conversation or debate. Many of those increased costs are the result of well-intentioned mandates handled down from federal and state legislative bodies. Rather than mandate such a requirement, the NHA or the Nebraska Hospital Association contends that handling the situation in each of our facilities should remain in the hands of our medical staff and other professionals charged with meeting the healthcare needs of those we serve. For those reasons, we oppose LB310 and thank

you for your consideration of this important matter. [LB310]

SENATOR PANKONIN: Thank you. Are there questions for the testifier? Yes, Senator Gloor. [LB310]

SENATOR GLOOR: Thank you, Chairman Pankonin. Mr. Rieker, you've just made a comment that hospitals were not covered under the definition. I thought, in fact, I read that...I'm sorry I have lost the spot but I will find it. Healthcare facility or healthcare service licensed under the Healthcare Facility Licensure Act, does that not cover hospitals? [LB310]

BRUCE RIEKER: Is that in the original version of LB310? [LB310]

SENATOR GLOOR: No, this is... [LB310]

SENATOR PANKONIN: It's in the amended... [LB310]

SENATOR GLOOR: This is the amended. [LB310]

BRUCE RIEKER: Oh, it's in the amended version? I thought...okay, if that's in there then that is an error in my statement. [LB310]

SENATOR GLOOR: I'm trying, in my own mind, having read that, knowing that there are federal regulations, such as EMTALA, that require hospitals to see all patients who present for urgent or emergent services versus a state statute that would provide penalty if you didn't provide that care with a licensed interpreter. I'm trying to see if we're setting ourselves up for a battle between state law and federal statute, and I've tried to work that through in my mind. I don't know that you can answer the question, but once I read that amendment, I thought, I know that this might set up an inevitable conflict. [LB310]

BRUCE RIEKER: I appreciate you letting me off the hook with that last statement about. I may not be able to answer the question. But I think that it definitely proposes the conflict between federal EMTALA law and what may be created by this particular law if it were enacted. Yes, I believe so. [LB310]

SENATOR PANKONIN: Any other questions? Seeing none, Mr. Rieker, thank you for coming today and testifying. Next opponent testifier. Mr. Buntain, welcome. [LB310]

DAVID BUNTAIN: Thank you. Thank you very much, Senator Pankonin, members of the committee. I am David Buntain, B-u-n-t-a-i-n. I am the registered lobbyist for the Nebraska Medical Association, and we also are appearing in opposition to LB310. Mr. Rieker's comments are essentially the same that we have. Obviously, it's in everyone's

best interest throughout the healthcare delivery system to have good communication between patients and physicians, and this is an issue not just with hearing impaired community, but with a number of other communities in our state who have language difficulties, and it's a huge issue in many areas of the state. Mandating a licensed interpreter will not solve the problem. I...listen, I don't believe I heard anyone say how many licensed interpreters we have in this state nor do we have information that I've seen concerning what their distribution is. We know that we have hearing impaired patients across the state who are seeking to access providers across the state, not just physicians, but optometrists, chiropractors, physical therapists. I think we have roughly 30 healthcare professions that would be governed by this in addition to healthcare facilities. And it would be extremely difficult from an access standpoint to have those licensed interpreters available. And you have the further issue as to who bears the cost of that. That is not a reimbursable cost for providers, which can be an issue as well. I also want to just raise the question as to whether this really makes sense to try to do this in the manner in which it's being done. What you have in front of you as far as the bill, and I guess the amendment becomes the bill now, are several sections of statute, but they basically define terms that relate to other parts of the statute. And basically the statute that this language appears in was a law that was passed to give the deaf or hearing impaired persons access to our court proceedings and our state agencies. And you'll notice that what you are doing or being asked to do is to change the definition of appointing authority. And if you look at the operative section of the statute, what it says is that an appointing authority has to have a licensed interpreter in a proceeding, including any court proceeding at which a deaf person is subpoenaed or required to attend. So basically this statute is aimed at, I think, a different issue than a healthcare issue. And, obviously, this could be rewritten in a way that applied only to healthcare providers, and it would have the basic problem with it. But I do want to draw that to your attention because as with many bills, you have to read the rest of the law that this plugs back into in order to see what's intended. So with that, I will take any questions. [LB310]

SENATOR PANKONIN: Thank you, Mr. Buntain. Questions of the committee? I may ask one. Mr. Buntain, obviously, I mean, I think we would all realize that the potential problems and concerns that this bill raises that are legitimate, and you have expressed some of your concerns as well. What do you see as a potential solution here that would help that maybe isn't this bill, but another method that we could make the system better? [LB310]

DAVID BUNTAIN: Well, I think part of it would be...would involve communication between the parties. Not every problem we have can be solved by law, and I don't think this is a one-size-fits-all issue. It is going to depend on the type of provider, what resources are available. I think it has to be worked out on a more local level than just having a state law imposed that will be very impractical to administer. But obviously the physician community has a strong interest in being able to communicate with their patients, so I'm not minimizing the problem. But I don't think the law can mandate the

way that that occurs. [LB310]

SENATOR PANKONIN: Well, I thank you for your comments. And I could even see from a scheduling issue as well so that that can line up, and people are usually busy in the healthcare professions. And then to waste an appointment when they don't have the proper way to interpret is...I can see is a waste of resources as well. But hopefully people in your association will be thinking about this as how we could then do something if possible. [LB310]

DAVID BUNTAIN: Definitely. [LB310]

SENATOR PANKONIN: Thank you for your testimony. [LB310]

DAVID BUNTAIN: Thank you. [LB310]

SENATOR PANKONIN: Any other opponent testimony? [LB310]

BRENDON POLT: Good afternoon, Senator and members of the committee. I'm Brendon Polt, that's P-o-l-t, and I'm here representing the state's nursing homes and assisted living facility members of the Nebraska Healthcare Association and Assisted Living Association. That's about 200 facilities, proprietary and nonproprietary, statewide. I do apologize because until 11:45 today I thought this bill applied to places of public accommodation, and it was unclear whether Joe Public can't necessarily walk into a nursing facility and expect full benefits of the facility. We're clearly a healthcare provider, so now I've seen the amendment and so I am testifying on the amendment as I have received it, AM112. That being said, first of all, you know, I was reading the amendment, and then I took another look at it. You know, nursing facilities and assisted living facilities have been running in the state of Nebraska for I don't know how long but, you know, a hundred...hundreds of years and we've been operating fine. And this language says that the intent of the state is to ensure that language be provided when someone can only benefit from the programs of healthcare providers if they have an interpreter. Well, we've been operating for over 100 years, and we've been serving people that are deaf and hard of hearing, so it makes me wonder. If it ain't broke, don't fix it? And if whether or not in nursing facilities, since CMS, the Centers for Medicare and Medicaid Services, has never created this requirement, and they have 400 other pages of requirements that effect nursing facilities and really do very rigorously ensure patent safety, ensure resident rights protection, ensure a whole host of clearly the medical aspects that occur in nursing facilities. They've never identified this as something that's required to effectively participate in the services that are administered at a nursing home. So I almost wonder with this language it almost is contrary to the language of what a healthcare...on one side, I would almost say with the intent of the Legislature maybe isn't to cover nursing facilities because we've been effectively serving residents all along. But under the definitions, we are covered under the

Healthcare Facilities Licensure Act. So I'd just point that out. Some of the other problems we see with the bill, obviously, is a cost benefit. Clearly, there are people that are deaf and hard of hearing working or residing in nursing homes. And I'm going to take a step back. The way the bill is written, as I see it, it's not just the residents of a healthcare facility, it's anyone who walks into a healthcare facility, would get translation services to participate in any of the activities of that facility is the way I read the bill, so. So I think the bill is overly vague and that it's not just about the safety of the residents. This bill is about the brother of a resident playing bingo with the other players of bingo by a licensed interpreter. So I'm not sure how far the bill goes. But the benefit...currently, in a community in rural Nebraska, there are no licensed interpreters for hearing impaired people. So what you often do is use a member of staff who can communicate, they use sign boards, they write on white boards. Usually it's, you know, something that's fairly easy to be communicated or oftentimes there's family there. And the things that are communicated are, you know, my side hurts. It's not something that requires technical knowledge of a licensed interpreter that might have to be brought from Omaha to Sidney or something like that where there aren't lots of licensed interpreters around. The cost, then, gets borne by the government supposedly, even though healthcare facilities are supposed to be reimbursed under the Medicaid system and Medicare system for the cost of interpreters. We know the way the rate is devised really becomes aggregated into the total cost of care, and then you divide...you go through the rate methodology. And so there really isn't a dollar-for-dollar reimbursement for this. So you take our healthcare facilities that are already underfunded by $12-a-resident day and add a quite significant cost. And the benefit...I haven't heard any of the previous testifiers in support talk about the long-term care setting nor did I see how it would really relate in terms of the types of items they were talking about and the seriousness that you would need a very technical...someone able to communicate technically through sign language. Also, the bill as written says that an interpreter must be available. So currently if an interpreter is needed, you might have someone come from down the street, someone that's able to communicate using sign language to be available under this bill. Now, I'm not sure if that means at all times. So is that a 24-7 staffing requirement in case someone walks in off the street? So those are some of the things that I see in the amended bill, and I have a feeling maybe not all of them were intended. And so the late-breaking nature of this bill has prevented our members from taking a look at it and has prevented the ability to really analyze what this means because there is a great difference between public accommodation and healthcare facility. So anyway, with that, I'd be happy to answer any questions. [LB310]

SENATOR PANKONIN: Thank you, are there any questions? Seeing none, thank you, Mr. Polt. [LB310]

JONI COVER: Good afternoon, Senator Pankonin, members of the committee. My name is Joni Cover, it's J-o-n-i C-o-v-e-r. I'm the executive vice president of the Nebraska Pharmacists Association, and I am here in opposition to LB310. I am going to

concur with the previous testimony of the opponents on the hospital and healthcare and medical side. The pharmacists are, of course, required to follow ADA requirements. One of the concerns we have is the cost of this new mandate. And the second thing would be primarily, are there enough interpreters across the state to accommodate all the healthcare providers that would need to have this sort of service provided? So, I guess if there is an opportunity to work this out, we'd be happy to be at the table. And with that, if there are any questions, I'd be happy to answer them. [LB310]

SENATOR PANKONIN: Are there any questions for Ms. Cover this afternoon? Seeing none... [LB310]

JONI COVER: Thank you. [LB310]

SENATOR PANKONIN: Thank you, Ms. Cover, for your testimony. Welcome, Mr. Otto. [LB310]

JIM OTTO: Senator... [LB310]

SENATOR PANKONIN: I assume you're an opposition testifier? [LB310]

JIM OTTO: Yes, I am. [LB310]

SENATOR PANKONIN: Okay, we're still taking opposition testimony. [LB310]

JIM OTTO: Senator Pankonin and members of the committee, my name is Jim Otto, last name is spelled O-t-t-o. I am a registered lobbyist for the Nebraska Retail Federation and the Nebraska Restaurant Association and am here in opposition on behalf of both organizations. First of all, I want to apologize to Senator Haar because it is my policy to try to inform a Senator if I am going to appear in opposition, and I tried to do that today but I tried too late after he had left the office to come here, so my apologies for that. Really the only thing I need to communicate is that we are against the bill as introduced, the green copy. We may not be against the bill after the amendment becomes the bill, but we, I guess, reserved the right to make that decision later. The biggest concern that retailers would have is many of our retailers also are pharmacists and have pharmacists within their stores. And are they exempt? Are they not exempt? Are they in? Are they out? So that is the main thing. Also, Mr. Sedlacek and Mr. Hallstrom of the Nebraska State Chamber and NFIB also asked me to communicate their opposition of their organizations. They're running back and forth between different committee hearings. [LB310]

SENATOR PANKONIN: Thank you, Mr. Otto. Are there any questions for the testifier? Seeing none, thank you. Is there any other opposition testimony? Is there any testifiers in the neutral capacity? Okay, you may begin. [LB310]

DIANNE DeLAIR: (Exhibit 7) Thank you. Good afternoon members of the Health and Human Services Committee. My name is Dianne DeLair, D-i-a-n-n-e D-e-L-a-i-r, and I'm a staff attorney at Nebraska Advocacy Services, Inc., the Center for Disability Rights, Law, and Advocacy. Nebraska Advocacy Services, Inc. takes a neutral position on LB310. I am here today to provide testimony on Title III of the Americans with Disabilities Act. This information may be helpful to the committee as it examines the proposed legislation contained in LB310. Title III of the ADA gives rights of equal access to places of public accommodation. The ADA applies to all hospital programs and services, such as: emergency room care, inpatient and outpatient services, surgery, clinics, educational classes, and cafeteria and gift shop services. Wherever patients, their family members, companions or members of the public are interacting with hospital staff, the hospital is obligated to provide effective communication. Effective communication is particularly critical in healthcare settings where miscommunication may lead to misdiagnosis and improper or delayed medical treatment. Under the ADA, hospitals must provide effective means of communication for patients, family members, and hospital visitors who are deaf or hard of hearing. A qualified interpreter may be required for effective communication. Examples of situations where an interpreter may be needed include: discussing a patient's symptoms, medical condition and history, obtaining informed consent for treatment, providing mental health services including counseling for patients and family members, making educational presentations such as birthing and new parent classes, CPR, and first aid training. Under the ADA, sign language or other interpreters must be qualified. An interpreter is qualified if he or she can interpret competently, accurately, and impartially. In the hospital setting, the interpreter must be familiar with any specialized vocabulary used and must be able to interpret medical terms and concepts. In order to ensure sign language interpreters possess these skills, precedent has been established that requires the use of licensed or certified interpreters. The United States Department of Justice conducted several investigations involving violations of Title III of the ADA in hospital settings. The hospitals in violation entered into settlement agreements with the Department of Justice, agreeing to make changes in its practices and policies. Following its investigation at one hospital, the United States found reasonable cause to believe the hospital failed to provide a sign language interpreter in a timely manner, did not have effective protocol for arranging interpreters for emergency room admissions after hours, and the hospital failed to provide an interpreter for important meetings like discharge conferences. As part of the settlement, all parties agreed that in order to be a qualified sign language interpreter, a person must possess minimum certificate qualifications which are current and up-to-date. In a similar case, a hospital agreed to use interpreters who were licensed by the state or who possessed similar national certifications. The hospital agreed to give first consideration to persons who attained certification by the Registry of Interpreters for the Deaf, Inc., a national credentialing organization. In conclusion, the Americans with Disabilities Act prohibits discrimination against people with disabilities. People who are deaf, hard of hearing or have speech disabilities have the right, under

the ADA, to request auxiliary aids and services. To ensure communication is effective, a qualified sign language interpreter may be needed. In determining who is qualified, the reliance on interpreters who are certified and licensed is well established. I appreciate the opportunity to provide information regarding Title III of the ADA and would be pleased to answer any questions at this time. [LB310]

SENATOR PANKONIN: Thank you. Are there any questions? Okay. Senator Campbell. [LB310]

SENATOR CAMPBELL: Thank you, Chairman. And Ms. DeLair, would you say that in the instances that have been illustrated today, would there be anywhere this would not apply and we would need to take action, as you listened to the testimony? [LB310]

DIANNE DeLAIR: Could you rephrase the question, be a little bit more specific? [LB310]

SENATOR CAMPBELL: Sure. I mean, I'm looking for any situation in which this would not be covered in the examples that we were given today, with the physician or going into...an individual with a pharmacist. In other words, what you're telling us is that any place this act can be invoked they would need to have a qualified interpreter? [LB310]

DIANNE DeLAIR: Well, under the ADA Title III, all places of public accommodation cannot discriminate. And I think the key operative word here is effective communication, and that may include a qualified interpreter. So let's say in the instance of the pharmacy, that may be a situation where the individual does not need an interpreter and they can understand the information that's given to them. However, you also want to look at the complexity of the communication that's involved. If I can give an example from one of the Americans with Disabilities Technical Assistance Manuals, they give an example of an individual who goes into the doctor's office, their family physician, for an annual physical. It would be permissible to possibly exchange notes as far as what the individual's blood pressure is, that type of thing. But now when we are getting into more complex discussions, it may necessitate a qualified sign language interpreter. When you're talking about treatment or diagnosis, very complex medical terminology. [LB310]

SENATOR CAMPBELL: Thank you. [LB310]

SENATOR PANKONIN: Any other questions? Senator Gloor. [LB310]

SENATOR GLOOR: Thank you, Chairman Pankonin. Ms. DeLair, I'm sorry, I'm still worried about federal regulation statute banging its head against state regulation statute if this is passed. Let's take a...we've talked about hospitals, let's take a rural clinic that's out in the Sandhills staffed by a mid-level practitioner, a nurse practitioner, a PA or whatnot, that drops into town twice a week and for whom there are limited resources to begin with. And they get a call to schedule an appointment with a patient who would fall

under this particular statute. Are they within their rights to turn that patient away under Title III because they can't provide that service even though it is now state law they are supposed to provide that service? [LB310]

DIANNE DeLAIR: Under the Americans with Disabilities Act, the place of public accommodation in the example that you've given would be required to provide that interpreter. Now, it is a case specific situation that's examined, and no one can be denied a service because of their disability. [LB310]

SENATOR GLOOR: Yes, I understand, but... [LB310]

DIANNE DeLAIR: Now, there may be other individuals here today who could comment on other options besides having a live individual present to provide that qualified interpreter service. I think there are other means, but the ADA covers places of public accommodation and they are required to provide effective communication. And the way that's been determined in some of these hospital settings when hospitals have been in violation, they need to go to interpreters who are certified or licensed. That is one way they can ensure that those interpreters are qualified and can provide that effective communication. [LB310]

SENATOR GLOOR: And the reason I use the term...I believe I used the term, accommodation, and the reason I used the Sandhill clinic was that I know that there would appear to be accommodations that can be made by video teleconferencing. But we have broadband problems in this state in terms of access statewide, and the Sandhills, not surprisingly, are one of the areas where there are significant limitations. And so I am trying to look at whether we set ourselves up to put those two components playing against each other here, even though people might want to make that accommodation, you don't have the access. They're expected to make that appointment. They don't want to run afoul of Title III. By the same token, they don't want to run afoul of state statute. So I'm trying to work through what we might want to try and avoid if we are going to approve this as a state law. Thank you. [LB310]

SENATOR PANKONIN: Thank you, Senator Gloor. Any other questions? Thank you for testifying today. Is there any other testifiers in a neutral capacity? Seeing none, Senator Haar, would you like to close? Oh, excuse me. We do have another. [LB310]

BARBARA WOODHEAD: Sorry. [LB310]

SENATOR PANKONIN: Sorry. [LB310]

BARBARA WOODHEAD: My name is Barbara Woodhead, B-a-r-b-a-r-a W-o-o-d-h-e-a-d. And just to give you a little background on who I am, I currently serve on the Interpreter Review Board that is identified in this...in the previous bill that had to

be established to create the rules and regs for the license that applies to state entities and law enforcement. I'm also a licensed interpreter in this state. I also am an interpreter trainer, and I also have experience evaluating interpreters around the country. So that's my background. One thing as I have listened to the testimony is the Interpreting Review Board and as a professional interpreter, there is a general thought that any interpreter who puts him or herself out there as an interpreter should be licensed in that they have entry-level skills to practice, just like psychologists, psychiatrists, physicians. They should have because everything in those settings stops the minute communication is not effective. And as a person who evaluates interpreters, I know that if you get below this minimal level, you're saying that a person is maybe capturing, could be 10 percent of the communication, 15 percent. It's...in other words, in some cases, something is not better than nothing. And what the right is in ADA is they have to try to provide this accommodation. So really what we're talking about is not new circumstances to provide interpreters because ADA already says these settings should provide or attempt to provide qualified interpreters. This bill is limited to medical. In my mind, it should be all-encompassing, any practitioner should have a minimal level of skill. But in this case, in the rural settings and the other examples that have come up today in the hospitals, it is necessary for the hospitals and the physician to know that they are getting what they are paying for, that they have a qualified person in that room exchanging information between two parties. So really what this does is it defines qualified. It doesn't say get interpreters that you are not getting now. So I would say for the situations in the nursing home that require or where a deaf person has right to an interpreter under ADA right now, just make sure that person is qualified to do that and be paid for that because the practice we have happening in Nebraska is that we have people who are presenting themselves out there in the hospitals, as you've heard in the testimony, who are not qualified. They have taken a couple of classes and they're going in a hospital and saying, I'm an interpreter. And there's nobody there who's qualified to determine whether or not they are qualified or not. The physicians have to trust that. The surgeons have to trust that. An example of a situation that could happen in a medical environment, and I have done medical interpreting, is there are occasions where during surgery a patient is awake, is alert, and for during that procedure, they're asking the patient their level of pain as they continue. The patient's hands are under the sterile covering, so they can't communicate by sign. If that interpreter is working in a hospital, they have got to have the skills to have some kind of a system set up with the information on the face. The grammar is here, the adverbs, the adjectives, the rest of the grammar is up here in the eyebrow region. They have to have a system and know how to set up a system when the surgeon says what is your pain level? Do you need more anesthesia? Considering the fact that we have persons working in the hospitals in medical environments for doctors now, they're already being hired, so we're just saying, have them be qualified. That could be a life threatening situation. And that's happening in Nebraska now. We have individuals who are simply saying we're qualified and we're presenting ourselves as such. So we're not saying, get more interpreters. And since we established licensure last year, I think there's been an increase of licensure by 64

percent. Interpreters are getting training in Omaha, they're going to Council Bluffs, they're going to Denver, which is what I did. I went to Kansas City, I went to Minnesota, anywhere where I needed to pass the certification level that I needed. You brought up the issue of video remote interpreting. As more areas get broadband, that is exactly how we're increasing the presence of interpreters in emergency situations where we don't have a person. And Nebraska is already using that. There's a small laptop connected in that room and they open it up and they communicate with the deaf person, and they're only billed for the time that that service is used. And so where we don't have bodies, what we have are we have qualified people on those video remote interpreting services. So if all of the opponents today are hiring interpreters according to ADA, then the question is, don't you need to be protected to know that you have hired someone who knows what they're doing? That's really what this is about. And the last thing I'll say about qualifications is the licensing level in here, which I know probably no one here could interpret, but as an evaluator I can, and I can tell you, I can promise you it is a minimal level. It is minimal. This does not create a hardship. It doesn't create an additional burden financially because they should be hiring interpreters anyway in those situations. So I'll just open...thank you for your time, and I'll just leave it for questions. [LB310]

SENATOR PANKONIN: Thank you. Is there any questions? Seeing none, thank you. [LB310]

BARBARA WOODHEAD: Thank you. [LB310]

SENATOR PANKONIN: And is there anyone else in a neutral capacity that I might have missed? Seeing none, Senator Haar, go ahead and close if you'd like. [LB310]

SENATOR HAAR: Okay, sure. That's the first part of my testimony. I don't know if Tami Richardson-Nelson was entitled to a qualified interpreter. She talked about being at a conference. But I don't think this bill talks about that at all because it's where the ADA requires interpretation to begin with. We're talking about interpreters that are used being licensed. That's the issue, not where they're required, but their licensure. The comment came up, if it ain't broke, don't fix it. I think we've heard that it is broke, and the argument that these people aren't available would be like saying that you could build a building in Scottsbluff without a civil engineer because there weren't any in Scottsbluff. I mean, that...we require licensure of engineers, doctors, lawyers, veterinarians, dentists, and even teachers. You know, it's not an excuse in someplace where there's a shortage of teachers to say, oh, okay, well, you know, that's okay, we just can't supply them. I think that's a very poor argument. And I'm sure this group...part of it, I guess, is, you know, coming to a new senator where we didn't work through this legislation for a whole summer, that sort of thing. But I'm quite sure that they'd be more than willing to work with legal counsel to tighten up some definitions because I think we've seen that. And references and those kind of technicalities, and probably I suspect this group will be in

touch with Ms. DeLair to get her help in this area. But to kill this bill because of technicalities would be the easy way out. I think that we need to modify this appropriately so that it makes sense. And my last point is, without...just using the acronym here and not saying the words, I think this is a CYA kind of bill because already the ADA requires people in certain places. This will ensure that the people that are used in those situations are qualified and certified. It just...from the last thing we heard it just seems to me that people are open to all kinds of legal ramifications if they don't do this. And then it really becomes up...I guess, if you chose not to do this currently, it's going to be up to the doctor, a medical doctor, to decide if their interpreter is signing correctly. Now, that just doesn't make any sense. This would give a mechanism for certifying that those who are required to use interpreters have certified interpreters. So, thank you very much. [LB310]

SENATOR PANKONIN: Thank you, Senator Haar. Are there any final questions? Senator Howard. [LB310]

SENATOR HAAR: Yes? [LB310]

SENATOR HOWARD: Well, I don't know if this is...thank you. I don't know if this is so much of a question, but I think it's really critical that we have accurate information conveyed. I know that when you get inaccurate information in a medical file, it's very hard to get that changed. If there was a notation regarding a cancer and that wasn't the correct terminology, it should have been client, I think you've got a serious problem there. And I think we need to really think that through and see what we need to do. [LB310]

SENATOR HAAR: Well, you know, going back to, if it ain't broke, don't fix it, if somebody gets an abortion and they thought they were giving, you know, acceptance to having an appendicitis or an appendix removed, it's broke. You know, it's broke. And I tried to put myself in the position listening to this testimony. When you have to work through an interpreter, I mean, communicating between us is hard enough. When you think that you have to depend on a middle person to translate or to communicate, to effectively communicate those things which are most important to you, I can't imagine what kind of situation that must be in. So I would request that the committee work with us to maybe firm this up a little bit, and it sounds to me like it's broke, we ought to fix it, and we may also be saving some institutions from major lawsuits. So thank you very much. [LB310]

SENATOR PANKONIN: Thank you, Senator Haar. This concludes the hearing on LB310. Senator Gay, our committee Chairman, has rejoined us from giving an opening on a bill, and so he will take it over from here. [LB310]

SENATOR GAY: Thank you, Senator Pankonin, for covering there. Welcome, Senator

Cook. [LB341]

SENATOR COOK: (Exhibit 1) Thank you very much, Senator Gay and members of the committee. Good afternoon. My name is Tanya Cook, that's T-a-n-y-a C-o-o-k. I am the Nebraska state senator representing Legislative District 13. Today, I appear before the committee as the introducer of LB341. I introduce LB341 on behalf of the Department of Health and Human Services. Importantly, LB341 enhances tuberculosis detection and prevention in our state while having no fiscal impact. The reemergence of TB in traditional and new multidrug-resistance forms requires public health agencies at all levels to develop and apply new tools to address the threat. LB341 directly addresses that threat. LB341 has two components: First, LB341 provides a change to the Nurse Practice Act and the Uniform Credentialing Act. Secondly, LB341 provides changes to the Tuberculosis Detection and Prevention Act. Specifically, LB341 will allow nurse practitioners to dispense TB medications at no charge when those medications are provided through the Department of Health and Human Services. This bill also allows for directed health measures, which are means to prevent the spread of communicable tuberculosis. Both of these changes will enhance community health and protect frontline caregivers in the fight against TB. In conclusion, I have passed around some letters of support. You may already have a copy of the letter of support from the Douglas County Health Department signed by its director, Dr. Adi Pour. We also have a letter that's been circulated from the Nebraska Nurses Association. And there are two additional letters of support, one from the Public Health Association of Nebraska, also known as PHAN, and Friends of Public Health in Nebraska. Also submitted, and will elaborate this on later in the testimony, to this bill will be an amendment addressing concerns recently brought to our attention by the Nebraska Pharmacists Association. I thank the committee for your thoughtful attention to LB341. I will try to answer any questions that you may have. However, Dr. Joann Schaefer, director of the Division of Public Health, will provide detailed testimony on this bill. I would respectfully defer technical questions regarding the impact of LB341 to her expertise. I ask that you advance LB341 from this committee and thank you again for your time. [LB341]

SENATOR GAY: Thank you, Senator Cook. Any questions from the committee? I don't see any at this time. Thank you. [LB341]

SENATOR COOK: Thanks a lot. I'm going to waive closing, Senator, so I can... [LB341]

SENATOR GAY: Okay. Are you going to stick around for a little bit? [LB341]

SENATOR COOK: Oh sure, for a little bit. Absolutely. [LB341]

SENATOR GAY: All right, proponents? How many proponents will be speaking on this? Any...okay. Any opponents to this? Okay. I caught you. [LB341]

JOANN SCHAEFER: (Exhibit 3) Good afternoon, senators and members of the Health and Human Services Committee. My name is Dr. Joann Schaefer, that's J-o-a-n-n S-c-h-a-e-f-e-r. I'm the Chief Medical Officer and the Director of the Division of Public Health and the Department of Health and Human Services and the Chief Medical Officer. I want to thank Senator Cook for introducing this bill on behalf of the department. I am here to testify in support of LB341. First, this bill updates the Uniform Credentialing Act to allow nurse practitioners to dispense medications without charge if the medications are obtained from a public health agency. Currently, nurse practitioners are only allowed to dispense sample medications obtained from a manufacturer for no charge without having to obtain a pharmacy license and be a licensed pharmacist. In 2005, the Tuberculosis Program operated by DHHS joined a multistate contract to purchase certain drugs for the treatment of tuberculosis. The contract allows us to purchase these at a much, much lower cost than a patient could. So because we are not a licensed drug distributor such as...well, or a drug company such as Pfizer that would handout a free sample which nurse practitioners are allowed to do, we are paying a low cost for these medications. And because we pay for the drug, they view that medication differently and, although doctors and physicians assistants are currently exempted from that and they are allowed to do this, nurse practitioners are not. So the bill is written so that they would be able to do this. Within the past several years, the epidemiology of tuberculosis has changed in Nebraska. This reflects the changes occurring nationally, and among those and the most concerning is that of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis, two different criteria there. In one of the cases, causes for these changes is the failure of individuals to receive treatment or finish treatment completely. We believe the addition to the access at a low or no cost to the medication for treatment through nurse practitioners will cause more individuals to seek treatment and complete it. Second, the bill makes changes to Tuberculosis Detection and Prevention Act, the addition of the authority to require an evaluation of individuals for diagnosis and treatment as needed, and additional method to deal with these issues of which we are funded federally to do and through some state dollars already. That's why there is no fiscal impact. The use of directed health measures allow us to use the least restricted method to ensure the evaluation and treatment is received by individuals. Currently, the only thing we can do is commit somebody to a facility for the duration of their treatment, which could be six to nine months in length if they do not want to seek the treatment. This would allow us to obtain a court order for a direct observation of therapy where people can be placed in their home, and it would be more cost-effective and is currently done by many other states. Since 2003, three individuals have been committed under this act. The ability to require other measures such as outpatient treatment to be obtained may help avoid extensive alternative treatment in an institution. The bill makes it clear that DHHS can provide payment for the medications and the medical care and evaluations. We currently do. But you should know, we currently do not have the explicit authority to do that, it just barely dusts on the issue. This will make it easier for individuals to obtain the necessary care for tuberculosis. In the past, the inability of individuals to pay for the

care has been a major barrier to stop the spread of tuberculosis. When treatment is not obtained because of the cost, it permits the transmission of the disease and the multidrug-resistant tuberculosis and its extensively drug-resistant tuberculosis are on the rise and are of great concern to us. We have a friendly amendment which I have offered up to you with our conversations with the Nebraska Pharmacy Association because of their concerns. I want to make it very clear to you that the bill, as written, does not expand the scope of a nurse practitioner. That is their concern, so we have drafted up very tight language and put it in the amendment form and offered that as an amendment, and we are okay with it. Currently, again, physician assistants and physicians are already allowed to do this, but nurse practitioners are not on the list. This allows us to eliminate any potential barrier, so we really want to move forward with the bill if possible. I'd be happy to answer any questions. [LB341]

SENATOR GAY: Thank you, Dr. Schaefer. Any questions? Senator Campbell. [LB341]

SENATOR CAMPBELL: Thank you, Chairman Gay. Dr. Schaefer, I just want to be really clear in the second paragraph of your testimony is that nurse practitioners are presently allowed to dispense medications from the manufacturer for no charge? [LB341]

JOANN SCHAEFER: Yes. [LB341]

SENATOR CAMPBELL: Is that right? [LB341]

JOANN SCHAEFER: Um-hum. So sample medications. If you go in and see a... [LB341]

SENATOR CAMPBELL: So, sample medications? [LB341]

JOANN SCHAEFER: Yeah. And this is like a sample because they aren't charging the patient, but because we paid for it, it is viewed as dispensing a drug in a different light. We're not a drug manufacturer, so they're allowed to get a medication sample from Pfizer and hand that medication sample out, which is currently done all across the state today, but because we pay for it, that's an issue. And we pay for it for pennies, pennies on the dollar of what a patient would normally have to pay for it. We're approximately 25 cases of tuberculosis a year, not a high incidence state, not that many cases out there, but when we have them, we want to be able to treat the families and people who are exposed to them very cost-effectively and get on top of it. [LB341]

SENATOR GAY: Any other questions? Senator Howard. [LB341]

SENATOR HOWARD: Thank you, Mr. Chairman. There's some terminology in here that I just want to make sure that everybody understands, if I could ask you about this.

[LB341]

JOANN SCHAEFER: Um-hum. [LB341]

SENATOR HOWARD: It says, when there are reasonable grounds to believe that a person has a communicable tuberculosis, so that doesn't imply that there has to be a diagnosis. It sounds as if there has to be... [LB341]

JOANN SCHAEFER: There...reasonable grounds that it's...yes, it does. So it could be...the chest x-ray could look positive. You could have the history of the disease and some of...another family member, they're reasonable grounds to believe that they're infectious, but you may not be able to capture it on a culture that comes out of the patient. It's very difficult at times to culture and...but somebody who looks like they're positive on a chest x-ray will get the treatment, but not... [LB341]

SENATOR HOWARD: So the doctor would forward this information to you? [LB341]

JOANN SCHAEFER: Yes. [LB341]

SENATOR HOWARD: And you would see this, but the doctor wouldn't give a confirmation of the diagnosis? [LB341]

JOANN SCHAEFER: Well, that would be...that's possible. That would be in a different situation when they're already within the hands of a physician that's treating that's going to write the...that will write the prescription for the patient. But we'll facilitate if the patient doesn't have the coverage for it through those means of getting the medications out. But if there's a positive test on a patient and they are believed to have tuberculosis, and/or they have been exposed to someone who is...I need to make sure we are not talking about the act or the expansion portion. I think if we are talking about the act, you're talking about whether or not we commit someone or do extra treatment when they... [LB341]

SENATOR HOWARD: How would you receive an x-ray or a test result if they weren't under a doctor, if they hadn't gone to a physician? [LB341]

JOANN SCHAEFER: If they are in the screening clinic. The screening clinic information from another state that , you know, frequently we have people that will travel here and they're known positive or they were diagnosed. We've had that happen this past year where they were diagnosed in another state and came to our state. [LB341]

SENATOR HOWARD: Okay. The other concern I have is that the state health officer or local health officer may order such a person to submit to directed health measures as necessary. It makes me think back to years ago when people who demonstrated mental

illness could be apprehended and could be placed in the hospital. And now we have a Board of Mental Health, there has to be a hearing prior to someone being placed in a facility. I wonder if this really gives the person who is suspected of being ill... [LB341]

JOANN SCHAEFER: Sure. [LB341]

SENATOR HOWARD: ...the opportunity to... [LB341]

JOANN SCHAEFER: They have all rights to due process with this and appealable and the full ability to do that, and we've complied with that all each time. [LB341]

SENATOR HOWARD: If the determination was made that this was somebody that should receive treatment, how would that come about? What would happen? [LB341]

JOANN SCHAEFER: How the treatment would be given? [LB341]

SENATOR HOWARD: Well, how would the state health officer put that into effect? How would this...would this individual be picked up by the sheriff? [LB341]

JOANN SCHAEFER: Yes. Currently, that's exactly how we can do it. This is a person that does not want to receive treatment, who is saying they refuse treatment, and we have exhausted all of our means of trying to get the person into treatment. Currently, the law is written now that we can put them into any care that we need to to get them treated, and we've had to do that three times. [LB341]

SENATOR HOWARD: Okay, so it is very reminiscent of the old mental health method of committing. [LB341]

JOANN SCHAEFER: Yeah, it is. But they have the right to appeal. We provide a lot of things for them, and in many times they can even get out early if they can give us reasonable assurance that they're going to continue to take their meds. It's a protection to everybody else. It's a longstanding law that's been upgraded throughout the years to meet the demands. [LB341]

SENATOR HOWARD: Okay. Well, thanks for explaining that. [LB341]

JOANN SCHAEFER: Sure. [LB341]

SENATOR GAY: Senator Wallman. [LB341]

SENATOR WALLMAN: Thank you, Chairman Gay. Thank you, Doctor, for testifying here. [LB341]

JOANN SCHAEFER: You're welcome. [LB341]

SENATOR WALLMAN: This is or can be a big deal. And how are we dealing with immigrants that gets...are we automatically checking those when they get hospitalized for TB? [LB341]

JOANN SCHAEFER: I don't think that there's any automatic checking by any race. It's spun by clinical suspicion and some of our immigrants have been vaccinated for tuberculosis, which is a vaccine which we don't currently offer in our country. So that's why it's an issue here more often with spreading and getting people caught early when they have it so we can treat those who are surrounded by them. Immigrants from anywhere within the world, though, can...it can be a possibility that they come in with tuberculosis. So that's part of the reason, not all of the reason why a resurgence. Some of our resurgence has been associated with HIV and the fact that once somebody has gotten it, the immunosuppression has brought back multidrug-resistance or brought back or brought to our current day multidrug-resistant tuberculosis, so. [LB341]

SENATOR WALLMAN: Thank you, doctor. [LB341]

SENATOR GAY: Any other questions? I have one, Dr. Schaefer... [LB341]

JOANN SCHAEFER: Sure. [LB341]

SENATOR GAY: ...on the public health. I know several of us have been on public health agencies. How do you go about informing them? Did you say there's 25 cases last year? [LB341]

JOANN SCHAEFER: Um-hum. Right. [LB341]

SENATOR GAY: How do you go about informing them and keeping them...that network that they all know how this would work? [LB341]

JOANN SCHAEFER: Absolutely. [LB341]

SENATOR GAY: How do you go about doing that? [LB341]

JOANN SCHAEFER: Well, they are our biggest partners out across the state, so this is exactly how we interact with them on this basis. It depends on if...in Douglas County, for example, has the ability to know...they know their public health data on their labs as soon as the labs come up, so they know anybody who's turned positive. If we identify them by other means, we let that local health director know because it's within their district, and they help us adjust to whatever we need to do to treat the patient, contacting the patient, doing the contact tracing of the patient. We are kind of the

coordinators at our level, but they are doing a lot of the footwork. In other counties where that information is not brought at the lab, is not electronically reported at the local level, it comes only to the state, we get it first and we push it right back down to them and make sure that they know because they need to be involved with the care of the patient. And it works extremely well. We have a really tight relationship with the folks to take care of these cases when they come up because they're really intensive. [LB341]

SENATOR GAY: So, well, I guess the situation...so those cases are spread out. But I guess what I am saying, when we had...we just had formed a public health agency and all this, but on the quarantine, we had to work with the sheriff, and it was quite a process quite honestly. [LB341]

JOANN SCHAEFER: Yeah, it is. [LB341]

SENATOR GAY: It took some time because it's just not something you do. This, to me, sounds like some involuntary things, pretty drastic things you have to do. So what I'm saying, though, is in a county...and this isn't Sarpy County, but in another county, so they have plans in place if this were to happen and they've talked to the local law enforcement if you have to, I mean, you have to keep them on this regimen, right? [LB341]

JOANN SCHAEFER: Yes. Yeah, we already have that now. [LB341]

SENATOR GAY: So that's all set up and you feel confident... [LB341]

JOANN SCHAEFER: Yes. [LB341]

SENATOR GAY: ...that any county in the state is ready if something were to happen? [LB341]

JOANN SCHAEFER: We already have that current capability within the law to do that. What this allows us to do is do something actually lesser than actually commit somebody. [LB341]

SENATOR GAY: Yeah. Your option is... [LB341]

JOANN SCHAEFER: Is better, is friendlier, and we only...and that allows commitment as the last resort. [LB341]

SENATOR GAY: I commend you. That's a... [LB341]

JOANN SCHAEFER: Which, because as you can see, quite draconian. [LB341]

SENATOR GAY: That's a big job to keep them all informed and get them on the same game plan. [LB341]

JOANN SCHAEFER: It is. Well, fortunately we're a low-incident state. [LB341]

SENATOR GAY: Yeah. [LB341]

JOANN SCHAEFER: You know, California and New York and Florida have much bigger issues than we do. [LB341]

SENATOR GAY: The only reason...yeah, Senator Howard. [LB341]

SENATOR HOWARD: Well, thank you. I was just going to say I appreciate your reflecting on that as being draconian. [LB341]

JOANN SCHAEFER: Draconian. [LB341]

SENATOR HOWARD: That's a good definition of it. [LB341]

JOANN SCHAEFER: Yes, it is, it is. We don't like to use it. [LB341]

SENATOR HOWARD: Because I remember years ago when I originally started out doing social services and we would make commitments of parents that...and there were valid reasons to suspect that they were mentally ill, but they really had no recourse. They were picked up by the sheriff and they were committed. So I'm always leery of things that would be so... [LB341]

JOANN SCHAEFER: Yeah. They have a right to appeal and they're given a hearing. The hearing is done wherever they're at, so they have those... [LB341]

SENATOR HOWARD: Okay, and that's kind of the same thing you're looking at. [LB341]

JOANN SCHAEFER: Yeah. [LB341]

SENATOR HOWARD: So thank you. [LB341]

SENATOR GAY: Any other questions? Senator Campbell. [LB341]

SENATOR CAMPBELL: Thank you, Chairman Gay. Dr. Schaefer, in the...and we're dealing with 25 individuals here, with those...in those cases when they would go to a public agency, would there be someone, a physician, that might administer these in some cases? [LB341]

JOANN SCHAEFER: Actually, they may not have one of those agencies out there, so we take over a person to treat and send the patient to. They may not have a place for them to go, and we perceive that as a barrier sometimes. So we find out about the test. We contact the patient. We work with the local health department, but then we're out with the provider. We may not have a physician or a PA that can do that for us. So we would contract with a nurse practitioner or currently we can do it with a PA to go out and get the medication to the patient, patient's families. [LB341]

SENATOR CAMPBELL: So then do we...then does your department pay the nurse practitioner to administer it? [LB341]

JOANN SCHAEFER: Yes. Yes. Yeah, we have the ability with our funds to pay that now, and do do that. This allows us to use...since we already have PAs that can do it and physicians that can do it, this allows nurse practitioners which are more readily available in rural Nebraska. [LB341]

SENATOR CAMPBELL: Okay. [LB341]

SENATOR GAY: Yeah, and the reason why I asked that is, too, if this were to go to the full Legislature and, you know, you got to explain this, you want to be able that they'd know this could be done in my county because, like I say, that was a process, took a year and a half for us to get it quarantined. I mean, we had lawyers back and forth and working with the sheriff, but it sounds like you've done a lot of legwork on this to get...which commendable to you and your department, do a great job. [LB341]

JOANN SCHAEFER: Thank you. We have very hard working staff on this. [LB341]

SENATOR GAY: Yeah. Very good. All right. Any other questions? No, don't see any. Thank you, Dr. Schaefer. [LB341]

JOANN SCHAEFER: Great. Thank you. [LB341]

SENATOR GAY: Other proponents? [LB341]

DAVID BUNTAIN: Senator Gay, members of the committee, I'm David Buntain, B-u-n-t-a-i-n. I'm the registered lobbyist for the Nebraska Medical Association. We are appearing in support of LB341 and are supportive of the public health aspects of this and commend the department for pursuing this. We did have a concern with the original draft of LB341 that's similar to that that the pharmacists had. I have not seen the amendment. I was aware that there were discussions going on, and I just wanted to say for the record what our concerns were. On page 2 of the bill, where there is reference to the nurse practitioner's Scope of Practice Agreement, the original intent was to amend

the section that allows dispensing incident to practice, sample medications. And the way this was originally drafted, it would allow dispensing of all types of drugs that are provided through public health agencies, which are dispensed at no charge. We understand that that is going to be changed to say, tuberculosis drugs. In other words, the ones that are needed for this program. I do think that is a small increase in the scope of practice, but it's kind of moot at this point. We do in part, rely on the testimony we gave yesterday about the fact that we have the nurse practitioners are under Integrated Practice Agreements with physicians and we understand the necessity of having this in order to allow additional access to these drugs. On page 4, similarly, the original proposal was to change the definition of the practice of pharmacy to allow not just nurse practitioners, but also certified nurse midwives and certified registered nurse anesthetists to dispense not just tuberculosis drugs, but all kinds of drugs through public health agencies at no charge. Again, my understanding is the amendment would limit that. So, with that understanding we're in full support of the bill. [LB341]

SENATOR GAY: Thank you. Any questions from the committee? I don't see any. While you're here, it reads, that amendment: And drugs for the treatment and prevention of tuberculosis which are provided through the department and are dispensed at no charge to the patient. Then on four it's, nurse practitioners who dispense drugs for the treatment and prevention of tuberculosis which are provided through the department and are dispensed at no charge to the patient with proper labeling and patient counseling. That's what we have in front of us, so. [LB341]

DAVID BUNTAIN: From our standpoint, I think that satisfies us. [LB341]

SENATOR GAY: For anyone else that might be interested. [LB341]

DAVID BUNTAIN: I can't speak for the pharmacists. [LB341]

SENATOR GAY: I don't see any questions. Thank you. [LB341]

DAVID BUNTAIN: Thank you. [LB341]

SENATOR GAY: Any other proponents? Any opponents would like to speak? [LB341]

JONI COVER: Good afternoon. My name is Joni Cover, it's J-o-n-i C-o-v-e-r, and I am here in opposition to LB341. I would first like to commit to that we are not opposed to the entire bill, from page 5 going on, we support that provision. We do, however, have large reservations with the language on page 2 and page 4. As Dr. Schaefer said, she and I have been in communication all morning trying to work out an amendment that is appeasable to her and to my membership. At this point I haven't had directives from the pharmacists to support the amendment, but I will explain to you why we have concerns with that. In our opinion it is a broad scope, the expansion of the scope of practice for

nurse practitioners. David Buntain pointed out that certified nurse midwives and CRNAs, in the section on page 4, CRNAs are allowed to dispense or to prescribe preop and postop. Certified Nurse Midwives have a...do not have independent prescribing authority. The nurse practitioner piece, there is independent prescribing, and so they'd possibly could dispense. However, the issue that we have with giving out sample medications, if you've ever noticed when you've received a sample medication from your prescriber, it is labeled as: Sample Not For Sale. The medications that would be provided free of charge from Health and Human Services would not be samples. They are not labeled that way. We have concerns with proper labeling and proper counseling that is required of a pharmacist when they practice pharmacy. In our opinion, we are asking nurse practitioners to practice pharmacy without having those same requirements. It doesn't matter where the drugs came from, the fact is, is they're still medications. And tuberculosis medications do have interaction with other drugs. And so we would hope that if we can work out a compromise and move this bill forward, that those considerations would be taken into place. I am a little bit confused here because I thought that the bill was for public health clinics, and then I realized that maybe it was for physician and nurse practitioner offices, and now I am hearing that it could possibly be given out both ways. I believe public health clinics have a formulary right now that they have to work off of with the delegated dispensing permit with the pharmacist. And so if those drugs were to be dispensed through public health clinics, I believe they would have to be added to the formulary and that's the route they would go through because we would have an agreement with the pharmacist. On the clinic side, again, I thought that that's where we were going. So maybe some clarification on exactly how this program was going to be run, whether it's through private clinics or through public health clinics, how that's all going to work. The other thing I would offer up in discussion with my members on this issue, I pointed out that at Health and Human Services was able to purchase these drugs very inexpensively and provide them to patients, which is great for them. I did have a couple of pharmacies say to me that they would be happy to participate in the program pro bono. And I don't believe that we've ever been approached to participate. So I just wanted to make that offer, and to let you know that we are willing to work with the department and continue to get this all worked out. But in our opinion, it is the scope of practice expansion, and we do not support that, so. Page 5 and on we're good. One, two, three, and four we have some issues. [LB341]

SENATOR GAY: All right. Thank you, Ms. Cover. Any questions? I don't see any questions for you. Thank you. [LB341]

JONI COVER: Thank you. [LB341]

SENATOR GAY: (Exhibit 2) Other opponents? All right. No other opponents. Anyone neutral on this issue that would like to speak? No neutral? I would...Senator Cook, you mentioned some letters of support, we've...I'm just going to read these a little bit for the record. We have the Friends of Public Health in Nebraska, Douglas County Health

Department, Public Health Association of Nebraska, the Iowa-Nebraska Primary Care Association, and Nebraska Nurses Association is what we have, so. Would you like to close or no? [LB341]

SENATOR COOK: Sure, why not. [LB341]

SENATOR GAY: Okay. You're here, what the heck. [LB341]

SENATOR COOK: Thank you very much, Mr. Chairman and members of the committee. I'd like to emphasize that the goal of the bill is to be able to offer drug therapy in treatment and prevention of tuberculosis. And just to...as you are considering moving it out of committee, which I would, again, ask your consideration to do, that that be your overarching factor in your decision making. Thank you very much, again, for your time and consideration. [LB341]

SENATOR GAY: Thank you, Senator Cook. Are there any questions? Nope. Thank you very much. All right, we'll close the public hearing on LB341 and go to LB220. Senator Gloor. [LB341]

SENATOR GAY: Senator Gay, could I ask for a five minute recess?

SENATOR GAY: Yeah, you bet. Let's do that. All right. Let's just make it 3:30 we'll come back. How about that?

RECESS

SENATOR GAY: (Recorder malfunction)... on LB220. [LB220]

SENATOR GLOOR: (Exhibit 1) Thank you and good afternoon, Senator Gay and members of the committee. My name is Senator Mike Gloor. (Cough) Excuse me. I'm District 35, Grand Island. My last name is spelled G-l-o-o-r. LB220 was brought to me for introduction by the Pharmacy Association as a result of some work that began last year with my predecessor, Senator Ray Aguilar, who worked on this issue last year with Dr. Jennifer King who was the medical director at the Grand Island Veterans Home, had to do with regarding services to veterans and their pharmacy. It's expanded somewhat beyond that in very positive ways. And as a result, this bill is the collection of a collaborative effort, I am proud to say, by the Pharmacy Association, the Nebraska Hospital Association, the Nebraska Health Care Association who worked on this over the past year. And I believe a letter has been circulated that we were given today by the Nebraska Department of Health and Human Services who have also issued a letter of support. So we have a wonderful collaborative effort on this particular bill. The purpose: To address the pharmacy needs of long-term care facilities. Long-term care facility practice has been forced into a retail model like your corner drugstore over the years.

Over the years, it's evolved into something more like a hospital model of practice. This dichotomy means that the current statutes in place don't address needs adequately of the patients, the pharmacies, and the pharmacists. This bill proposes to add a definition of long-term care facility in three different places in statute in the Controlled Substance Act, the Pharmacy Practice Act, and the Automated--and this is important--the Automated Medication Systems Act. The definition of a long-term care facility includes: an intermediate care facility; and intermediate care facility for the mentally retarded; a mental health center; a long-term care hospital; a nursing facility; a skilled nursing facility; all of which are already defined in Nebraska statute. The proposed changes in this bill will simply give us a set of statutes that are more appropriate for long-term care facilities in meeting the drug needs of their residents, give appropriate oversights still, and take technological advances into consideration which will improve both quality as well as realize efficiencies and cost savings in some cases to the state of Nebraska. To do that, it proposes changes in how these facilities deal with prescriptions, use emergency drug boxes, the oversight of the disposal of unused drugs, and allows automated medication systems to used. I see this as a way to improve efficiency in all long-term care facilities, and most importantly, an improvement in the care of residents in those facilities. I ask you for your support. I'd be glad to answer questions, but there will be other people giving testimony who can do that also. Thank you. [LB220]

SENATOR GAY: (Exhibits 4, 5, 9) Thank you, Senator Gloor. Any questions? I don't see any. Thank you. Other proponents? While the proponents are coming up, we've received three letters of support: One from the Nebraska Hospital Association; the Department of Health and Human Services; and from Golden Living. So we did receive those and have those on file. Go ahead. [LB220]

ROBERT LASSEN: (Exhibit 2) Okay. Senator Gay, members of the committee, my name is Bob Lassen. I'm a registered pharmacist and a member of the Nebraska Pharmacist Association board of directors. I appear here today before you on behalf of the NPA to support LB220. I would like to thank Senator Gloor for introducing this legislation on our behalf. I've been a pharmacist in a long-term care for over 20 years, and am currently the cochair for the committee that worked to develop LB220. The NPA in conjunction with, as mentioned earlier, the Nebraska Health Care Association, the Nebraska Hospital Association, and the Nebraska Health and Human Services came together and drafted this legislation that updates the practice of pharmacy for residents residing in long-term care facilities. For many years, the pharmacies were...long-term care practice has been required from the pharmacy point of view to fit the retail mode, and that means prescription blanks rather than certain other types of orders. So we had to meet the same protocols as you would or I would if we had to go to the neighborhood pharmacy to pick up our medications. Over the years, the long-term care has transitioned into more of a hospital model in which individuals living in long-term care facilities are treated more like patients in a hospital, and having their medications orders come from medication charts rather than a traditional prescription form. Our group has

worked collaboratively to update the Pharmacy Practice Act to ease the burden of long-term care facilities and the pharmacists while prioritizing the care of the patient. We have also updated the emergency drug box provisions, and will now allow long-term care facility medical directors, pharmacists, and facility quality assurance officers who are normally nurses to decide what medications can be stored in the emergency box in a limited quantity. Other important provisions contained in LB220 that our committee recommends is that we change from requiring a pharmacist to destroy medications to allowing two credentialed individuals to destroy medications. We are also changing the Nebraska prescription filing system to mirror language in the federal law that allows a readily retrievable storage and, in doing this, will allow us the capability of utilizing electronic prescriptions or medical orders in the era of e-health initiatives via CMS. In addition, LTC facilities have also been included in the Automated Medication Systems Act, and this will allow us to utilize automation which should reduce the wasted medications in long-term care. LB220 also has numerous cleanup provisions that I've listed on the attachment summary. In addition, the NPA is offering an amendment that is technical in nature, except for the section that limits the number of doses of medications contained in the emergency box. The terminology in the box, doses should say drugs to accommodate such medications as nitroglycerin, which is actually packaged in bottles of 30 and inhalers. I would be happy to discuss any of these with you, but as far as the time is a little bit limited, so I tried to hit the major points of legislation. And so if you have any other questions, I'd be happy to answer those. [LB220]

SENATOR GAY: (Exhibit 3) Thank you. We'll see if any questions. I don't see any. Thank you. How many proponents will be speaking on this? All right. We've got three it looks like. Is there any opponents to this? No opponents. And anybody neutral? No one is neutral. Okay. You can come on up. Excuse me one minute. We do have a letter, though. Nebraska Information Technology Committee (sic) has a letter. They are neutral. That's in the record. Go ahead. [LB220]

LINDA STONES: (Exhibit 6) Good afternoon. My name is Linda Stones, L-i-n-d-a S-t-o-n-e-s. I'm a registered nurse in the state of Nebraska. I reside in District 30, Senator Wallman's district. And I'm here today in behalf of the Nebraska Nurses Association to speak in support of LB220. The Nebraska Nurses Association believes passing LB220 and allowing the use specifically of automated medication dispensing units in long-term care facilities would improve patient safety and assist nurses in performing their jobs. A report established in 2004 by AARP suggested there were about 14,000 Nebraskans residing in nursing homes. The average number of prescriptions that a nursing home resident has is approximately nine medications per day. And 25 percent of all nursing home residents take more than 12 medications per day. Thus, in an average 100-bed nursing home, over 25,000 medications can be administered in a month period. In 2006, the Institute of Medicine suggested that about 800,000 drug-related injuries occurred in long-term care settings across the United States. Medication errors are very common. Approximately 96 percent of medication

errors though, however, can be prevented. The Institute of Medicine as well as the Institute for Safe Patient (sic) Practices recommends technology is the key to improving patient safety and reducing medication errors. The automated dispensing units, which I've provided you a picture of one in the back of my testimony, are machines that allow a technological backup to a manual process. ADMs are similar to a vending machine. A nurse enters a code that identifies her specifically, chooses a patient's name, and the specific medication that they want to dispense. That then triggers one drawer to open with that medication in that drawer. So it prevents a nurse from inadvertently picking up a medication that was not prescribed to that patient. It provides a secondary check. In hospital units, in hospital facilities, acute care facilities, we've seen results of up to a 75 percent reduction in medication errors after implementing similar technology. As a nurse, I can personally tell you that one of the most devastating things that can happen during your career is to know that you have made an error that may be potentially harmful to a patient. I remember vividly my first medication error. I was working at a hospital in Omaha. It was in about 1989 and we did not have this technology. A gentleman was admitted to our step-down unit with a GI...following a GI surgery, and I had inadvertently gave him a dose of Hydrocodone versus Oxycodone that was prescribed. Fortunately for me, my error did not result in any harmful consequences to this patient. A little extra monitoring and he was fine. However, my patient was 28 years old and otherwise healthy. For our geriatric patients, for example, if this was an 85-year-old with kidney problems and maybe blood pressure issues, there could have been an issue, and an ADM would have made...an automated dispensing unit would have helped prevent me from making that error. With the shortage of nurses that we're facing, the increase complexity of patient conditions, the longer longevity of the patients, healthcare providers need technology to keep pace with the increasing demands. While we put antilock breaks in cars to help prevent accidents, we should have the availability to have technology in our long-term care settings to safeguard Nebraskans from accidents as well. Today, I ask for you to help us, the nurses of Nebraska, to care for our patients and to help keep them safe. Please support the adoption of LB220. I'll take any questions if anybody has any. [LB220]

SENATOR GAY: Thank you. Senator Wallman. [LB220]

SENATOR WALLMAN: Thank you, Chairman Gay. Welcome. [LB220]

LINDA STONES: Thank you. [LB220]

SENATOR WALLMAN: Thanks for testifying. I can sympathize with your error. My mom used to be in a nursing home. And whenever they made a mistake they did call, so I appreciate the nurses actually, you know, making a mistake. If something would have happened, we wouldn't have pressed charges. But thank you. [LB220]

LINDA STONES: Thanks. [LB220]

SENATOR GAY: Any other questions? I don't see any. Thank you for your testimony. [LB220]

LINDA STONES: Thank you. [LB220]

SENATOR GAY: Other proponents. [LB220]

MARSHA WAGNER: (Exhibit 7) Good afternoon. My name is Marsha Wagner. I'm the director of pharmacy at Madonna Rehabilitation Hospital, and I'm here for the hospital and for myself as well to support this bill in its entirety. But I especially want to support the provisions that do allow for automation in long-term care facilities. And I'm just going to talk a little bit more about what the previous speaker was saying. If you're not familiar with Madonna, we are a hospital, so we're licensed as a hospital. However, we do have beds that are also licensed as long-term care. So as the director of pharmacy, it's my challenge to make sure that we're providing quality pharmaceutical care for both our hospital patients and our nursing home patients and complying with all the state and federal laws on both sides. I see things I can do on the hospital side that do provide a higher level of patient safety, but until this bill is passed, one particular item I can't do for my nursing home patients, and that is the automated dispensing machine. We're currently using them on our long-term acute care hospital side. And we've been using these machines for about two and a half years. And we've really had some wonderful benefits from that experience. Improved patient safety. As a nurse and as a pharmacist both, that's our number one goal always is to have improved patient safety. One thing I'll add to what the previous speaker had mentioned was, when the orders are entered, and the pharmacist actually enters the orders into the computer system that goes to the automatic dispensing machine. So when the nurse pulls it up, she actually pulls it up by patient, and all those patients orders are listed on the machine, and they come up. If they're routine orders, come up just as they're due. So if it's not due, it won't be there. Things that are just as needed will come up anytime, they can pull those up anytime. Nurses can override the orders. However, when they do override, it does require two individuals, so one nurse can't pull a wrong medication by herself. And usually when you have that second set of eyes, you can usually save that. And anytime that's done, a report is generated and reviewed by a pharmacists, so we can catch it right away. In the past two and a half years, the number occasions where we've had an override that was not a correct order has just been extremely rare. I can't say it's never happened, but it's extremely rare. Increase security. As a pharmacist, my concern is security. If things are leaving the hospital or the nursing the home inappropriately, it is my problem. With automatic dispensing machines, we have a very high level of security with all medications that are contained in the machines. It's easy to walk away from a med cart and accidently forget to lock it. You know, we have a very good staff, so I don't think it happens often. But, you know, we're all human, it can happen. With these machines, if you leave a door open, it just starts making a horrible racket after, you know, a matter of

seconds. So you can't do that, you have to close it. And then if a user is logged on, we also set a number of seconds to log that person automatically off. So if they walk away it's not going to be open to just anyone that comes by for more than just a few seconds. In fact, we've had nurses complain that sometimes they think it logs them off a little too fast, but we're leaving it that way just to keep our security high. Controlled substances, that's really what we're...we're concerned about everything, but we're really concerned about controlled substance security. The machines are set so all the controlled substances are not only in the locked machine, but they're in a locked drawer inside the locked machine. Anytime one of those drawers is opened, the nurses ask to count the number of doses in there. And if it doesn't match, the machine will say, are you sure, which clues them that something is wrong. They'll count again, and then if it's still not right, a discrepancy report will be generated. And it will give them the last few transactions. And sometimes they can figure it out and sometimes not. So if they...they can correct it and then go on. But in any case a report is still going to be generated to an automatic dispensing manager, which in my case is me. So I'll see that and I have to look at everyone even that they correct to make sure that it's been done correctly and they haven't just said the count was wrong, it has to be a reason. And I'm running out of time, so I will hurry here. It does improve increase efficiency for pharmacy. Medications are stocked daily based on an automatically generated report. When we stock controlled substances on the nursing home units now, my staff has to find a nurse to stop what she's doing and come and count with her and sign them in together. With this, we have automatic tracking. So the technicians can go ahead and stock controlled substances without finding a nurse, and it's all automatically tracked if there's a problem later. And I do audits to make sure that they are putting in what they say they're putting in. Paper problems. I have one large, very large file cabinet, actually, that holds about three months worth of controlled substance paper records. And with the ADM I can just actually run a report and pull up anything anytime. I don't have to keep files and files full of paper. And then lastly, consistency. It would be just a wonderful service for our facility to be able to be a little more consistent across the hospital and nursing home units. And we're not the only facility, I'm sure, in the state of Nebraska that provides multiple level of care. Questions? [LB220]

SENATOR GAY: Thank you. Are there any questions? I don't see any. Thank you. [LB220]

MARSHA WAGNER: Okay. Thank you. [LB220]

SENATOR GAY: Other proponents? [LB220]

BRENDON POLT: (Exhibit 8) Good afternoon. Again, I'm Brendon Polt, that's P-o-l-t. I'm with the Nebraska Health Care Association. Again, we have a membership of about 200 nursing homes and 200 assisted living facilities. Many of the points that I have in my written testimony, which I did bring along with me, I won't repeat the ones that were

already covered before. But I do want to point out a couple of things that we appreciated in the process. One of the things that the long-term care members of the workgroup that came together to create this legislation with the other groups and the state, we determined that some of the fixes for us particularly pertaining to the chart orders and whether or not those are used for dispensing, those can be fixed in regulation. So that didn't actually need to be in the bill. But at least we were able to come together through that process in agreement with the state and all the other providers up front. So we very much appreciate the participation in that group. Another significant area that we appreciate and an efficiency created by this bill pertains to those drug boxes. And one thing I didn't hear point out is it's a real efficiency. In the past, you had a one-size-fits-all approach to those drug boxes. Every facility in the state was bound by the same drug list, but that necessarily didn't apply to each facility. So it's a real nice update here to have that analysis done by a facility by a facility basis. And now the drug boxes are way more effective and useful by our facilities. Probably one of the biggest reasons our association initially came on board this project has to do with those automated medication distribution machines. And as was indicated by a previous testifier, the savings associated with med errors...there's the economic savings associated with not wasting drugs, which I think a previous witness testified to, but there's also the issue of patient safety. And there's numerous reports that demonstrate how many people are admitted to hospitals from all sorts of care settings or get treatments that would have otherwise not have been needed because of a med error. So the cost to Medicare, to Medicaid, and just the private system is immense. And I think I can leave it with that. Everything else is in my testimony here, but as I said, I want to make it brief, end of the day, end of the week, and I do have my testimony. [LB220]

SENATOR GAY: Thanks, Brendon. Do you want to hand it out, though, we can get copies? [LB220]

BRENDON POLT: I have ten copies here, so if you... [LB220]

SENATOR GAY: Oh, why don't we distribute those. Are there any questions? Senator Wallman. [LB220]

SENATOR WALLMAN: Thank you, Chairman Gay. Yes, Brendon, thanks for coming. Is this a huge cost going this route or not? [LB220]

BRENDON POLT: To buy one? [LB220]

SENATOR WALLMAN: Yeah. [LB220]

BRENDON POLT: The machine itself? You know, it's funny, yesterday, as some of you know, we had a large meeting of our membership and this issue came up and we talked about it. I heard ranges from facilities that have attached hospitals paying anything from

$150,000 to $50,000. But nevertheless, depending on the size of the organization and how that gets spread, the cost gets spread across a number of facilities, there certainly were a lot of facilities interested now in purchasing them. Then there was another group that already has them that would then be able to also use them in a nursing facility side or wing of a larger complex, so to speak. But then there's also a recognition by our membership that, you know, costs come down. You know, it's $150,000 now, and in two years they'll be $9.99 at Wal-Mart. (Laughter) That's an exaggeration, but obviously as technology moves forward, costs come down. So it was something that our membership took a huge interest in. And that was one of the bills, as we discussed a whole number of bills, that was a lot of enthusiasm. Actually, it was more than I thought there would be, to be honest with you. [LB220]

SENATOR WALLMAN: Thank you. [LB220]

SENATOR GAY: Any other questions? Don't see any. Thank you. Any other proponents? Any opponents? And neutral we read...we received the letter. Senator Gloor (inaudible). I do have a question for you. [LB220]

SENATOR GLOOR: I'll be very brief. Thank you, Senator Gay. By way of reassurance to the committee, again, it's worth pointing out the number of entities and organizations, associations that came together on this recognizing the fact that we needed to move from what's called a retail environment, which you would recognize as taking your prescription, going to the pharmacist, having them fill it, filling out a bunch of well-intentioned paperwork that shows that you were educated on it. And you walk away with your prescription, as opposed to a hospital where the physician charts what prescription you need, the pharmacist fills it, the nurse dispenses it. We're moving our long-term care facilities from something that looks more like the retail setting to more like the hospital setting. And as a result of these changes, providing for a degree of electronic dispensing that will certainly provide an increase in both availability, accessibility, quality, as well as some efficiencies in spite of the cost of the units. People wouldn't buy them if they didn't think there was eventually some sort of payback on them. Thank you very much. And I'd be glad to answer any questions. [LB220]

SENATOR GAY: Thank you. Senator Gloor, I have question for you. You said this kind of been worked on for some time, and it looks like a lot of collaboration has been done on it. Do you know when the last time was that somebody looked at these issues? And I know some, you're looking at the future on e-prescriptions. Do you know at all? [LB220]

SENATOR GLOOR: I cannot tell you... [LB220]

SENATOR GAY: Probably been awhile, though, huh? [LB220]

SENATOR GLOOR: ...again, because the origins of this started with Senator Aguilar

and some people who approached him. So I don't have the full history on it. I'm sorry, Senator Gay. [LB220]

SENATOR GAY: Any other questions? Nope. We'll close the public hearing on LB220. And then we're going to go ahead with LB301. [LB220 LB301]

SENATOR GLOOR: Again, good afternoon, Chairman Gay, members of the committee. I am Mike Gloor, G-l-o-o-r, senator from District 35 in Grand Island. I'm here to introduce LB301 regarding medical records. Current state law allows medical providers to charge for copies of medical records. It sets a cap of $20 handling fee, plus up to 50 cents per page for medical records with two exemptions for which there can be no charge: records for workers compensation claims and records for social security, disability, application, and certain Medicaid applications. LB301 proposes the elimination of exemption to records for social security, disability application, certain Medicaid applications. You may ask, these are unfortunate people. Some obviously don't have great financial means, surely they deserve to not have the added cost of getting their records charged for for disability determination. The issue is not as simple as that. For example, the Social Security Administration, in making their disability determination, make their own requests for medical records. So the question must be asked for whom are the medical providers providing the record? The patient because of the patient's interests? Their legal representative since most get legal representation for this? Furthermore, the continued assumption that the medical system should just absorb this expense rather than the requesting individual would be reasonable taken on its own merit were it not for the human cry about high medical costs, and the fact that a lot of that human cry is built around, speaking from personal experience, thousands and thousands of hidden costs of this sort, sometimes regulated, sometimes expected, but usually unfunded. We talked earlier today about EMTALA where the federal government expects all patients to be assessed when they present to an emergency room. We've had discussions about safe harbor where adolescents, children will be dropped off at emergency rooms. They will be the safe harbor. We talked earlier today about the need for interpreters for the deaf. That being an expense, and the list goes on and on. Those costs, including the copying that we've talked about, are then shifting it to the entire patient population, adding to their medical expense. And many of these individuals being the same type of individuals, and many cases in worst financial cases, that we're trying to assist in this case. The bill is but one small way we need to move an expense that is not directly related to the provision of healthcare away from a healthcare system that is no longer involved and to the legal system where it belongs. Most healthcare providers will be reasonable in their charge. This is not a profit-making opportunity for anyone. My personal experience at St. Francis Medical Center, routinely we receive requests from the Departments of Education disability determination division on behalf of the Social Security Administration. Rarely do they receive this request from a patient. The agency is then billed 50 cents per page and a $20 handling fee. When a patient makes a request for their own needs, they are charged 50 cents per page, no handling

fee, unless they are taking records for continuity of care at a specialist, and then there is no charge. The University of Nebraska Med Center charges similarly. This charge may be no higher than the cost just quoted. On the other hand, attorneys may recover this fee as an appropriate access to justice. The issue will soon be moot when the country moves to an electronic medical record. The new administration has set a national goal of five years for that to occur. The department shared with us that this bill will not effect applications for Medicaid or assistance to children because in the cases where they might need medical records, they acquire them through a medical information release. Therefore, the department did not take a position on this bill. Thank you. [LB301]

SENATOR GAY: Thank you, Senator Gloor. Any questions from the committee? Senator Pankonin. [LB301]

SENATOR PANKONIN: Senator Gloor, I've got a couple of questions. One of them being, you know, as we all know, folks come to us about these bills sometimes, sometimes it comes out of our own experience. Was this a bill that came out of your own experience from being a hospital administrator or did a group approach you about this bill? [LB301]

SENATOR GLOOR: I was approached by a group, and sat down and visited. But it didn't take long for it to ring a very strong bell with me knowing that...and small world that it is I had a visit with somebody this morning at a reception that got to talking about the fact that they'd hired a full-time person who's responsibility is to make copies of various medical records that are requested. And they were very sympathetic with what we're talking about in this bill because it, again, is an issue that strikes home with them. So whether I would have introduced it this year or not on my own or not, it was only a matter of time before I would have, I think, sought some redress on this issue. [LB301]

SENATOR PANKONIN: The follow-up question is, as a small business employer I have also had to copy records and more employment-related for social security disability claims. And in most instances, and it hasn't been that many, but in those instances those folks were...one in particular was a young man who was 34 years old and Stage IV colon cancer who ended up dying the day I before I was elected in 2006. It was really a traumatic experience. But I guess what I look at here is sometimes these folks are in pretty dire straights and we're asking them to pay when...in his particular case everything was coming to an end from, not only his health, but finances and it was a very tough situation. And so I have some hesitation about the fact that this is still a cost that people many times are not in a good position to pay. And do some hospitals and doctors actually farm this work out to have others do it then as a third party? [LB301]

SENATOR GLOOR: I can't speak for medical practices, but as relates to hospitals I don't think there are many hospitals that would feel it would be cost-efficient to pay somebody to do this as opposed to keeping it under their own roof. I would say that

many of the same patients that are making this request are going to have been patients of the facilities in question. And as a reminder with very, very few exceptions in this state, all of our hospitals are not-for-profit organizations. And because of that, they operate as charitable enterprises. The type of patient that you're talking about, if they had a financial need, will probably already have been provided a considerable amount of care for which there will be no compensation. Someone might say, well, then just add the records to that. And my answer would be, yes, but now we're moving from direct healthcare provision to somebody's disability determination, which is not a healthcare issue, but rather has moved into the realm of what are the legal determinations. [LB301]

SENATOR PANKONIN: Thank you. I'll listen to the rest of the testifiers. [LB301]

SENATOR GAY: Thank you, Senator Pankonin. Senator Howard. [LB301]

SENATOR HOWARD: Thank you, Chairman Gay. And my concern is just would echo Senator Pankonin's. I'm wondering, you're charging people 50 cents a page and I imagine if they're applying for social security, their records must be fairly extensive. There must have been some severe problem that would make them potentially eligible. We're not talking ten pages here... [LB301]

SENATOR GLOOR: Sure. [LB301]

SENATOR HOWARD: ...which that alone would be $5. Is this an equitable charge? Do you charge insurance...or the hospitals, not you personally, the hospitals charge insurance companies? [LB301]

SENATOR GLOOR: Certainly. [LB301]

SENATOR HOWARD: I'm sure they request documentation. [LB301]

SENATOR GLOOR: Yes. [LB301]

SENATOR HOWARD: What do they pay? What's their charge? [LB301]

SENATOR GLOOR: Actually there is a...the charge that you're quoting is the ceiling of what can be charged, but there's also written into the original statute that it has to represent a cost. And you can be audited for that to make sure that that is your true cost. It does sound expensive, but when you take a technician off the job and have them spend hours copying that on a copy machine, people will say, I'm sure in follow-up testimony, they can run down to Kinkos and make those copies for 7 or 8 cents a copy. That may be the case, but you're taking a hospital employee who may have to run off-site to gather up these records because sometimes they're so voluminous that hospitals don't have the space within their facilities to store some of these records, and

assigning them a responsibility to go through and in some cases sort out the information. There may be information in there that doesn't relate to this specific case, and so they have to sort out. We have HIPAA interests that are out, things that may not relate to this disability case, so that doesn't get sent along with everything else. So it isn't just a case of sitting down and slapping pages on a copy machine. [LB301]

SENATOR HOWARD: But you know as well as I do that insurance companies will never pay the full bill. I mean, if I would go in and have...I was my own payee, it would cost me more at a hospital than...the insurance company is able to make a better deal than I am. So I just would really wonder if they're paying a flat out 50 cent a page as well as the person would have to pay per page, but you may not know the answer to that. [LB301]

SENATOR GLOOR: Well, what I'd tell you is that when I had the responsibility to make sure those bills were sent and collected, I expected it to be paid in full and it wasn't negotiable because it did represent a cost by the insurance company, because it represented a cost. It wasn't a business. [LB301]

SENATOR HOWARD: I just would have to echo Senator Pankonin. I just think this is going be another horrific hardship in some cases on people who have already suffered a lot, so. [LB301]

SENATOR GAY: Any other questions? I have one question for...did you say during your testimony that when we went to e-records or electronic records that there wouldn't be charged for that. Why not? I mean, because you could charge for download a song. E-commerce can be charged. Why would it just go away? [LB301]

SENATOR GLOOR: And perhaps I'm being overoptimistic in what electronic medical records will do for us, but in reality if all of that information is kept in a very simplified way where you can, with a keystoke, perhaps send that information and sort through that information electronically rather than manually having to go through it all, it's reasonable to think that we'll be back talking about changing the statute in other ways that I would expect would be significantly less costwise. The reason for going to an electronic medical record, among other things, it the ease of medical record information sharing from provider to provider and various other organizations across the country, and would not see that as involving much expense, if any. [LB301]

SENATOR GAY: Well, but earlier you said if an employee is doing that and you got to pay something for their charge, you still got to look it up on the computer, do that, and I've seen people charge...I thought it was a lot to do something I thought was very simple. There's still a charge. So you send it, a 50- or 100-page document to somebody and they do charge you, I wonder if there might be something to just...I don't know how you...you know what I'm saying? [LB301]

SENATOR GLOOR: Yup. [LB301]

SENATOR GAY: There's a certain point. You still have that technician who needs to know what we're looking for to send it. So down the road, I think, maybe that's something if the concerns are that it could be abused, well, it could still be abused even with e-records because you see big companies do that all the time. Oh, it's a $25 fee and they just put it on your bill, and it was nothing but punching something to me. But it's just something I wanted to maybe that we need to think about if we pursue this. [LB301]

SENATOR GLOOR: Yeah. I would say that probably until we really know what health information system we end up with in this country, it's hard to know what the exact expense would be associated with something of that sort. But certainly what everybody is striving towards is something that would make all kinds of communication far less costly and simpler. [LB301]

SENATOR GAY: Yeah. Not to belabor the point, I guess, but there's...did you say you can be audited for the cost of it? So maybe the auditor would catch that, an excessive charge, so. I don't know. To move on. [LB301]

SENATOR GLOOR: Yup. [LB301]

SENATOR GAY: Anyway, thank you, Senator Gloor. Any other questions? I don't see any. Thank you. [LB301]

SENATOR GLOOR: Thank you. [LB301]

SENATOR GAY: Other proponents? [LB301]

DAVID BUNTAIN: Senator Gay, members of the committee, my name is David Buntain, B-u-n-t-a-i-n. I'm the registered lobbyist for the Nebraska Medical Association, and we are the group that approached Senator Gloor about introducing LB301. We have been involved with the medical records law since it was originally enacted, and Senator Gloor has covered a lot of the substantive part of this already. Under the current law, a patient has the right to request the records, and the provider has the right to charge for those records. There is a maximum that's set. It's not what the charge will necessarily be. The maximum is $20 handling fee and 50 cents per page. What has happened since the medical records law was passed is that HIPAA...the HIPAA regulation was adopted and that also provides for patient access to their records. And it says that a provider can't charge more than the actual cost. And so there is that limitation on it. And the $20, 50 cents per page is the figure you always hear, but there are a lot of providers who don't charge that full amount. It really varies from provider to provider. That fee applies whether it's the patient who requests it, an insurance company, an agency, anyone. But

under HIPAA whoever it is, if it's not the patient, has to have signed consent from the patient for the release of those records. When the medical records law was passed, there was an exemption put in, and that's what's an issue here. And the problem has been we've been getting more and more complaints from provider offices about the cost that's entailed with having to provide free medical records. And if the lawyer asked for the record, under the law you can charge a fee. If the patient comes in and wants the record, under the law you have to provide it to them in this limited set of circumstances without charging them. If the agency asks for the record, you can charge for it. So it's basically those situations where the individual comes in and requests the record. And really what it is is a cost shift because some of these records are voluminous, the time that it takes to prepare them, to photocopy them, to produce them, that is a cost of your physician's office. If you're physician is making that cost, that's going to be a part of the overhead that indirectly is paid by everybody else. So we hear about cost shifts all the time in healthcare, and this is not...I mean, there are a lot more significant ones than this one, but it is a cost shift. And our position is that it should be...those costs should be borne by the system. When we have cases involving torts, automobile accidents, those kinds of cases which also can be very serious heartrending types of cases, you know, providers are allowed to charge for those. Generally those are eventually paid, if it's a meritorious case, through the settlement of that case. This in some ways is similar to that. So that's what the motivation is behind this. We appreciate Senator Gloor carrying it forward. And I'd be happy to answer any questions that you have. [LB301]

SENATOR GAY: Thank you. Any questions? Senator Wallman. [LB301]

SENATOR WALLMAN: Thank you, Chairman Gay. Thank you for coming. And I find it ironic you mentioned cost shift. You know, if I was a patient and I have MRIs or whatever I have done at the hospital, you know, that's a significant bill. And then you're going to charge me for getting that out of there sometimes, you know. Is that what you're going to do? [LB301]

DAVID BUNTAIN: I'm not going to do it, but I mean, yeah. There are costs associated with that. It may...in part it's going to depend what you want to do with that. I think as Senator Gloor indicated in situations, for example, where you want to take that to another provider for a second opinion or to a specialist, typically it's my understanding that there is not a charge imposed in that situation. Now, it may vary from office to office, I will grant you that. But, you know, a lot of this depends upon the circumstances, I think. [LB301]

SENATOR WALLMAN: Thank you. [LB301]

SENATOR GAY: Thank you, Senator Wallman. Senator Pankonin. [LB301]

SENATOR PANKONIN: Thank you, Senator Gay. Mr. Buntain, why do you think...I

mean, you've explained that maybe these costs have increased over time, but as Senator Howard has said, I mean, it looks like if you're a lawyer you can get it back and get it back on many of these things. So it seems to me it's...we're thinking backwards. The patient who's asking is the one, you know, getting these records right now at no cost. But on the other hand, if this goes, I just sometimes think that these folks are in the dire straights of maybe having a serious disability. And in my employee's situation, it was a very desperate situation and we're going to charge him. I've got customers that ask for copies all the time. I don't think in 33 years I've ever charged for a copy in insurance-related things to accidents on farm equipment, whatever. I mean I think, to a certain extent it's a cost of doing business. And, I mean, is this so significant that it's driving up medical costs? [LB301]

DAVID BUNTAIN: I wouldn't say it's so significant. It is one of the costs. I mean, it is significant and obviously it's going to vary like orthopedic surgery offices have...it's a bigger part of their...I mean, they have a bigger patient load than some others. It would vary, you know, dermatologists it's probably not a big issue. So it is of sufficient concern that we've heard a lot of complaints about why are we carving out this one area from, you know, from the medical records law. [LB301]

SENATOR PANKONIN: When was this law first past? [LB301]

DAVID BUNTAIN: I believe it was about 10 or 12 years ago. I don't have the history in front of me. [LB301]

SENATOR PANKONIN: So why do you think they were exempt of them patients? [LB301]

DAVID BUNTAIN: Probably the same kind of argument that you're making here. I mean, it's...there was a concern expressed about that. I don't think...at that time, I don't think the providers really knew exactly what the impact of it was going to be. But, yeah. I mean, this was debated at that time. [LB301]

SENATOR PANKONIN: Thank you. [LB301]

SENATOR GAY: Other questions? I've got a question. So follow up with Senator Pankonin's question then. I mean, can you give some examples of what the cost might be to a...I mean, I know, maybe did you ever do a study to say this is costing my members X amount a year? [LB301]

DAVID BUNTAIN: We do...no, we haven't done a formal survey. It's been more different offices coming forward and saying, you know, why is there this exception? This is when we...out of all the records we do, why is this part exempted from the other records? We do have someone here from an office who may be able to explain a little bit more about

the practicalities of it. [LB301]

SENATOR GAY: Okay. I'll wait for that then. Okay. [LB301]

DAVID BUNTAIN: Okay. And just one other thing. On the e-records, right now this has to do with copying. I mean, obviously if we get to electronic health records, we'll be back here talking about, you know, a whole different law having to do with access to patient records. I mean, there are a whole host of issues that people are working on on that. [LB301]

SENATOR PANKONIN: We can hardly wait. (Laughter) [LB301]

DAVID BUNTAIN: I know. [LB301]

SENATOR HOWARD: We may stay just for that. [LB301]

DAVID BUNTAIN: We'll try to work it out in advance. How's that? [LB301]

SENATOR GAY: There you go. Thank you. How many...I don't see any other questions. Thank you. [LB301]

DAVID BUNTAIN: Thank you. [LB301]

SENATOR GAY: How many other proponents do we have that are going to talk on this issue? Come on up. Just one. Okay. We've got one more proponent. How many opponents will be talking? One, two, about six (laugh). Okay. And probably no one...anyone neutral on this one? And no neutrals. Okay. [LB301]

NANCY HANSHAW: Good afternoon. My name is Nancy Hanshaw, N-a-n-c-y H-a-n-s-h-a-w. I'm the clinic manager at Southeast Nebraska Cancer Center, and I was asked to come and speak to you by the Lancaster County Medical Society. In my clinic, we have five physicians and four mid-levels, so we have a very busy clinic. We customarily receive 20 to 25 requests per week for medical records. These requests are from insurance companies, from disability determinations, and attorneys. The average request means 20 to 25 pages. This takes a medical records clerk approximately one-half hour to review the chart and print the documents. And we do have an electronic medical records, so it still takes time. At this rate, we are paying her for 12 and a half hours per week to provide records to other entities which are not reimbursed. As an example, and I brought this along as a visual aid, if you can all see it. We had a request for a patient's entire chart. She came to me, the clerk came to me and said, this is going to be a very big chart. The lab itself is over 100 pages. So I said do not send the lab, they probably don't need that, call and ask if they need it. She did. They wanted the entire chart. Four-hundred and seven pages. This took her three and a half hours.

And, again, we have electronic medical record, but we do not send every single piece of paper, so she has to go through and print it out. This would be if we charged for it, it would be over $200. Now, we would not charge a patient. We do not charge patients for anything. If they want a copy of their path report, if they want a copy of their follow-up note, they get that for free. This is only if it's requested by an outside entity. It also had to be FedExed. And we had to pay the FedEx bill. And I'm sorry, I don't have that cost for you. I just want you to know that, you know, I'm paying a clerk, as I said, you know, 12 and a half hours a week to do something that we do not get reimbursed for. And that's all the information I'd like to share with you. If you have any questions I'd be happy... [LB301]

SENATOR GAY: Senator Campbell, go ahead. [LB301]

SENATOR CAMPBELL: Thank you, Chairman Gay. You said you only charge outside entities, not the individual patient. [LB301]

NANCY HANSHAW: No, we do not. [LB301]

SENATOR CAMPBELL: So an outside...give us an example of the outside. An insurance company? [LB301]

NANCY HANSHAW: Insurance companies, attorneys, that would probably be it. If we refer a patient to another physician, of course, that's continuity of care and they get no charge either. [LB301]

SENATOR CAMPBELL: And so do you charge that, do you say to the attorney this is $200? [LB301]

NANCY HANSHAW: Um-hum. [LB301]

SENATOR CAMPBELL: And do they all... [LB301]

NANCY HANSHAW: Yes they do. [LB301]

SENATOR CAMPBELL: They pay. [LB301]

NANCY HANSHAW: Yes. [LB301]

SENATOR CAMPBELL: Okay. Okay, go ahead. [LB301]

SENATOR PANKONIN: So, well, Senator Gay. So I guess to make sure I'm clear then. You right now, you don't...if it was $200 you don't charge a patient if they ask. [LB301]

NANCY HANSHAW: No. [LB301]

SENATOR PANKONIN: So do you think that's fair to charge the patient then under these circumstances? [LB301]

NANCY HANSHAW: This bill wouldn't charge a patient. It would charge...or at least the way I read it, it would be a charge to the requesting entity. So if a insurance company was requesting it to determine whether they were eligible for a disability, then they would be charged. There wouldn't be no charge patient. [LB301]

SENATOR PANKONIN: I don't think that's the way we interpret it. I think we interpret it as the patient pays. [LB301]

SENATOR GAY: They're the entity requesting. [LB301]

NANCY HANSHAW: And I would have to, you know, send it over to Senator Gloor, but no. [LB301]

SENATOR GAY: We'll check. We'll make sure. [LB301]

SENATOR PANKONIN: Okay. [LB301]

NANCY HANSHAW: We would never charge a patient. [LB301]

SENATOR GAY: Senator Howard. [LB301]

SENATOR HOWARD: Thank you, Mr. Chairman. I'm going to make this brief because we're getting real late. Are there things that doctors do as a professional courtesy to their patients to... [LB301]

NANCY HANSHAW: Certainly. [LB301]

SENATOR HOWARD: I mean, I've always appreciated when the doctor will call me in the evening when one of my children were sick to call in a prescription for them. But it seems to me like there's a practice issue here regarding doctors building in certain costs as a part of the cost of doing business, for lack of another term. And I would see this as a piece of it personally. And I don't bring up the issue of calling after hours and not billing as a suggestion in any fashion, so please don't take that away. But I just think there are certain things that make you have confidence in the relationship you have with your physician, and that's pretty invaluable. [LB301]

NANCY HANSHAW: Well, as I said, we do not charge patients for anything. And we actually provide many, many patients with care for free. If we have patients that don't

have insurance or are underinsured and our doctors say they need chemotherapy, they get it. We would never turn a patient away for that. And if a patient came to us and said, I need my whole record for disability, I'm going to have to pay for it, we wouldn't charge them either. But if it's an insurance company requesting for it, then we would charge the insurance company. [LB301]

SENATOR GAY: Any other questions? I don't see any. Thank you. All right. Any other proponents would like to speak? Okay. I don't see any. All right. Opponents come on forward. And then if we could take time, but if we're not repetitive that would help everyone. So if you've got something to add to discussion or you want to testify, come on forward. [LB301]

MICHAEL MEISTER: Mr. Chairman, members of the committee, I'm Michael Meister, M-i-c-h-a-e-l M-e-i-s-t-e-r. I practice law in Scottsbluff, Nebraska, and I am here on behalf of my 46 social security clients. Although about 40 minutes ago I found out I am also testifying on behalf of NATA. So I'm going to speak on behalf of NATA first, and with the caveat that if I say anything that is adverse to NATA's interest, listen to me, don't worry about them. When this bill was first passed approximately ten years ago, it was in response to a fight over a myriad of charges being made and certain cottage industries coming in and trying to set up a system to sell medical records. That's what this bill started as. Some places were charging as much as $1 a page, some people were charging 50 cents a page, some were charging $2.50 a page. So an agreement was reached between NATA, the Medical Association, the Hospital Association, and any other player in this game. And the agreement that was reached was they would be able to charge an exorbitant amount for medical records, i.e., $20 a handling fee and 50 cents a page for tort claims. And contrary to what Senator Gloor has said, workers' compensation claims are not exempted by this statute, you pay for those too. The only exemption is disability claims. That's the only exemption, and that was the trade-off. They were allowed to charge this much money in return for not charging on disability claims. That was the trade-off. Taking advantage of term limits is a shameful thing, and institutional memory, that's a shameful thing, but that's apparently what we're doing today. So that's NATA's position. Now, let me tell you mine. If each of you were limited to living on your legislative salary, you would not be eligible for social security disability benefits because you make too much money. You make $20 more a month on your $12,000-a-year salary than you would make to qualify for social security disability benefits. That's this panacea of money that people are getting. If you qualified, if somehow I was able to get you benefits, because you make on average $1,000 a month I will only be able to get you $800 a month to live on because you get 80 percent of your last ten years of salary. In order to qualify for social security disability you have to have been our to work for a year. By the time people see me, they have sold all their worldly positions, they are...many of them moved back in with mom and dad or worse, moved in with their kids. They move in with their cousins. They are trying to figure out do we spend money on electricity this month or on gas this month. They don't have a pot,

folks. They just don't. And now we got the Medical Association here, again, usurping the institutional memory because it's not here anymore saying, oh, gosh, let's charge these folks. Well, let me tell you the unintended consequences of that. In the last year, I represented three clients: One had a $65,000 bill with Region West Medical Center; one had $45,000 bill with Region West Medical Center; and one had a $35,000 medical bill with Region West Medical Center. Had we not gotten their records, those people could not prove their claim. If they could not prove their claim, they cannot qualify for Medicaid or Medicare. I think many of you have served on county boards. You understand Medicaid and Medicare. If in those three instances we got the records, we submitted the records, we were able to get benefits for all three of those folks. And because the hospital social worker had done her job and made sure all the paperwork was filled out, the hospitals got paid. What we're talking about is being pennywise and pound foolish. Because now that those people are on the system, they are eligible for medical care, they can pay their doctor's bill. Lord! That's an amazing thing! We have done what we need to do. We have done it in a right, fair, and impartial manner. And going back, Senator Wallman, your question earlier, yes, they're asking you to pay for your own records. That's what this thing does. Somebody asked earlier about money. It depends on the case. Cardiac case, that bill might be $50 to $100, $150. I had a mental health case, accidently the hospital sent me the bill for it, it was $1,083. Now, I'm not paying that. I pay it in tort cases, but grudgingly because that was the agreement that we entered into years ago. And I recoup that money from my client because I'm required to by my state bar ethics. This is not shifting the costs to the lawyer. This is shifting the cost to the patient. Any questions? [LB301]

SENATOR GAY: Any questions from the committee? Nope. Thank you for your testimony. [LB301]

MICHAEL MEISTER: Thank you. [LB301]

PATRICK CAVANAUGH: (Exhibit 1) My name is Patrick Cavanaugh. Thank you for having us here today. Senators, I am a attorney in Omaha and do primarily private practice in regards to social security disability. That's the main focus of my practice. And as such I am a sustaining member of the National Organization of Social Security Claimants Representatives whose sole group is advocacy for social security claimants. As has been spoken there today, we're talking about a lot of attorneys are here advocating for their clients. We're the people that do the advocating. There is no lobby for social security claimants. There's no PAC for social security claimants. These are people that don't know until they're in the situation that they are going to need someone to advocate for us, and that's what we are here today. These costs are significant for our clients. And not only for our clients, but for people that apply for benefits and don't receive representation of which there are number of claimants that do file these claims and are not represented and they are out to get their...they are charged with getting their own medical records. At the initial stages there is the state agency, disability

determinations that Senator Gloor spoke about, the group that collect the records and do compensate the hospitals and providers at that stage, at the retail level of $20 and 50 cents per page. But after that it's the claimant. It is the patient that the person is being cared for by their doctor or their medical provider that are responsible for paying for these medical charges. And that can be significant, that can run from $25 to $50 for even the most routine of records, as has been discussed here up to the hundreds of dollars. And on a case where a client has multiple medical providers, that can be several hundred dollars for them to get their medical records. Most of these people have been hardworking people working on lines at factories, housekeepers, things that don't have a lot of saving, don't have a lot of savings or a lot to live off of, they become disabled, they file these applications. And they're losing everything. They're losing their home, they're losing their car, they're losing their savings, if they have any. The bill to pay for a medical record is simply untenable for them. Any extra money they have is going to be used for medical coverage. The hope is this electronic filing will be a panacea, save us all. But that's not the current situation. The Social Security Administration is attempting to convert their files to electronic files, and the hospitals and medical providers obviously, as has been discussed, are trying to convert that to electronic folder into electronic files as well making for easy transfer of documentation. But that is still a couple of years off. And even at that time, there will still be some cost I would assume. However, that cost cannot be borne by the individuals that have applied for these benefits when they are simply incapable or unable to afford even the simplest of daily living and sustenance. This is public policy that was implemented in 1999 so that the poorest of the poor could have one roadblock removed from their ability to get social security disability benefits. Please don't remove this exemption that is very important and very integral to a large group of underrepresented individuals simply as a pass-through or a redistribution back to the hospitals and medical providers. The hope is, the long-term goal is get this people on disability, get these people on benefits so that they can get back into the system, so that they can get the medical coverage, so they can go back to their doctors, so that they can pay their medical bills, so that they can continue on their life and return to some semblance of normalcy. [LB301]

SENATOR GAY: Thank you, Mr. Cavanaugh. [LB301]

PATRICK CAVANAUGH: Thank you. [LB301]

SENATOR GAY: Senator Howard. [LB301]

SENATOR HOWARD: Thank you, Chairman Gay. I'm going to, again, make this quick. I see in here that you got a notation that the average wait for a determination from the administrative law judge can take over two years, which I've heard, too. But I've also heard that oftentimes people are initially refused social security disability and have to apply again, which I would assume would mean that there would be more cost if they ask for additional documentation. [LB301]

PATRICK CAVANAUGH: Correct. As I stated, the initial application process is done through disability determination, the state board of education is the one who handles that. They make the initial decision. You're denied twice. You file an appeal to an administrative law judge level. At that point, the administration no longer obtains records for you. The claimant is on their own to get those records, to obtain those records. And, yes, the wait is currently over 20 months for a hearing once requested. [LB301]

SENATOR HOWARD: Okay. Thank you. [LB301]

SENATOR GAY: Senator Wallman. [LB301]

SENATOR WALLMAN: Thank you, Chairman Gay. Thank you, Mr. Cavanaugh, for coming down. In regards to these disability claims, do you have to go sometimes for one or two or three doctors that will actually take this under advisement, you know, for giving you advise? [LB301]

PATRICK CAVANAUGH: For getting advice? [LB301]

SENATOR WALLMAN: For disability. [LB301]

PATRICK CAVANAUGH: Well, in many cases they have multiply doctors because they'll have multiple medical problems, and they'll have multiple providers. And, yes, then that will cause...then records from each provider would be a significant expense. Is that your question? [LB301]

SENATOR WALLMAN: Yes. [LB301]

PATRICK CAVANAUGH: Okay. [LB301]

SENATOR WALLMAN: Thank you. [LB301]

SENATOR GAY: Senator Campbell. [LB301]

SENATOR CAMPBELL: Just real quickly. Mr. Cavanaugh, why these people are waiting to be determined, in many cases they would probably be on county general assistance, would they not? [LB301]

PATRICK CAVANAUGH: And that is another advantage to helping to assist them to get on benefits. Once they are placed on benefits, yes, then they can pay back whatever. If they have a general assistance reimbursement agreement, then that will pay that money back to the counties, pay that money so that they can get back on...then they'll continue to receive their benefit, and the county will be reimbursed from the SSI benefit

that they should have been receiving all along. [LB301]

SENATOR GAY: Any other questions? Don't see any. Thank you, Mr. Cavanaugh. [LB301]

PATRICK CAVANAUGH: Thank you, Senator. [LB301]

SENATOR GAY: Other opponents? [LB301]

WARREN REIMER: (Exhibit 2) Chairman Gay, members of the committee, thank you for giving me this opportunity to speak. My name is Warren Reimer, W-a-r-r-e-n R-e-i-m-e-r. I'm an attorney from Norfolk, Nebraska. My office is primarily involved in representing people in claims for social security disability. I'm not going to take the time to detail all of what's in my handout. Quite frankly it echoes much of what Mr. Meister and Pat have had to say, and I'm sure what the others will have to say. What I think I bring to the table with my presentation is the chart that's on the last page. I was working in Lincoln the other day meeting some clients or perspective clients and I met with six of them, and I just sampled those six individuals for you. Real names not included, but the facts are all absolutely accurate. Two of them had no high school education. One is a non-English speaking refugee. One has a special education high school degree, and two high school diplomas. They earned small amounts of money during their working lifetime, they can't work now. The real sad fact is that they're going wait from three to five years before they actually get a chance to get the benefits that they're entitled to. Through this period of time we have to get the records that social security hasn't gotten. We have to get the records as they are regularly updated to see if we can get benefits for them earlier. If we can do that, we can get them something more quickly. The fact of the matter is even a nominal charge or what is believed to be a nominal charge, but more accurately was represented by Mr. Meister to be an exorbitant charge on a repeated basis would run these people right out of the world. They have no money. They are ultimately responsible for the charges. This isn't the time for a cost-shift to people as I represented to you. And, again, I don't want to take anymore of your time. I do make all my arguments in writing. [LB301]

SENATOR GAY: Thank you. Are there any questions? I don't see any. Thank you. [LB301]

WARREN REIMER: Thank you. [LB301]

TIMOTHY CUDDIGAN: (Exhibit 3) Chairman Gay, my name is Timothy Cuddigan, C-u-d-d-i-g-a-n. I've put my arguments in writing. I'm not going to take your time at this late hour of the day. Only want to emphasize two points. Number one, what Mike Meister said earlier about the compromise that was made, Senator Steve Lathrop and I and Mike Haller were involved in that action about ten years ago, nine years ago, and

that's when it was worked out. At that point in time it was recognized that the people we represent are the poorest of the poor, and that this was their opportunity to get benefits and to make their life better. The second point I want to make is that the proposal is quite shortsighted because 25 percent of the people that are at the hearing office in Omaha are unrepresented. So that means that they don't have the tools if they would not have the finances to go out and get the records to help get their disability and to help pay these doctors and hospitals back the medical bills through Medicaid and getting on Medicare. And so it's very shortsighted to take this road. I'm not going to say much more. Everything has been said already and the hour is late. Thank you very much, Mr. Chairman. [LB301]

SENATOR GAY: Thank you. Any questions? I don't see any. Thank you. [LB301]

MICHAEL HALLER, JR.: Good afternoon, Senator Gay, members of the committee. In 1995, I approached the senator in this Legislature about this bill. This bill that was finally passed in 1999. It took three years to get it through, and every year this came to this same committee. January... [LB301]

SENATOR GAY: Can you state your name real quick? [LB301]

MICHAEL HALLER, JR.: I'm sorry. Michael Haller, Jr., H-a-l-l-e-r. [LB301]

SENATOR GAY: Thank you. Sorry to interrupt you. [LB301]

MICHAEL HALLER, JR.: No, I'm sorry to have forgotten that. That law was not drawn up out of a vacuum. Texas has an almost identical law, and we are not some renegade state that has this free piece of pie for individuals situated in the social security system. So you have Nebraska, Texas, Georgia, Connecticut, Minnesota, Ohio, Rhode Island, Vermont, Massachusetts, Nevada, all of them have free medical records if you're in the social security disability system. When I have someone sitting across from me as you are, Senator Gay, I show them this chart. And you can see it's a triangle and there's gray coloring, and it's for the several levels of appeal in a social security case. And I say as long as we're in this gray area, as long as we're in the social security system, your records are free. And I can't tell you how consistent their response is. Their shoulders drop. They just relax because they suddenly realize that at least something is going to go their way because, as the first person that testified said, they've already sold their house, they've already gone through their savings, they're already living in a van down by the river. It's not very pretty sight. I thought it was interesting Mr. Buntain used the word "overhead." Is it the province of the Legislature to increase the overhead of an industry? This is a very, very narrow piece of the pie, and there are tremendous benefits to the state of Nebraska, as already mentioned--Medicaid, Medicare. Past present and future bills will be paid to the medical providers, as well as the possibility, who knows, the possibility that a cure or resolution of that medical condition will occur and those

people will return to the working class. That's what we always hope as practitioners, each one of us that has testified today. I also thought it was interesting that some of Mr. Buntain's constituents complain that this exists. And he wasn't very specific. I can be very specific with you that everybody that I've represented has had a very tremendous benefit. I can't tell you how many people I've already told they're going to have free medical records. If you undo what was done ten years ago, it's really going to be a bad thing. This is a good law, please don't change it. Happy to answer any questions. [LB301]

SENATOR GAY: Thank you. Are there any questions? I don't see any. Thank you. Any other opponents who would like to speak? [LB301]

JOHN LINGO: Good afternoon. I'm John Lingo, it's L-i-n-g-o. I'm a lawyer from Omaha as well. Thanks for having us today, and late in the day. This sounds a little bit mundane. Gosh, medical records, how much more boring can this get, and we're not talking about a lot of money. But I rise with my other colleagues from representing these folks. They are less than hanging on by a thread, and the medical records are the linchpin of their case. We cannot prove without these medical records any claim for disability, and frankly the narrowness is the term that's been used. This was very, very specifically crafted by Mr. Haller and Mr. Cuddigan and others. And we're able to take advantage of this now with very good reason. This is the one single area that there's no charge for medical records. Everything else that has been mentioned from personal injury to medical malpractice to workers' compensation and even the DDS folks pay for the records. This is the one place that the records are not paid for. I take great issue with the proponents of the bill that this is a substantial cost to their clients because it is not. It clearly is not. We do not duplicate the records that DDS has already gotten. We're looking for new and different records that they have not gotten from the government standpoint. I submit to you that this is far less than 5 percent of the cost of all the record requests that are made. They're getting paid on 95 to 99 percent of the records requested. We're that tiny little 1 percent. And don't back up on the deal that was cut from before where this legislation was crafted in the past. [LB301]

SENATOR GAY: Thank you. Any questions? Don't see any. Thank you. Other opponents who would like to speak? All right. Doesn't look like any. Any neutral? Senator Gloor, would you like to close? [LB301]

SENATOR GLOOR: Absolutely. I am going to be brief, but I am going to hope for if not pray for an "aha" moment here. We have gotten way off the point that was trying to be made. The Social Security Administration agrees with all of you and me and the attorneys who testified that the poorest of the poor should not have to pay for the medical records, which is why the Social Security Administration goes to the providers and requests those records themselves. The Social Security Administration and the determining agencies make their request to the hospitals and the physicians for this

information, and the hospitals and the physicians send them. It's not that they don't trust the legal representation, but they want it directly from the entity that holds those medical records so that they can't be tampered with. What I don't think the Social Security Administration envisioned was that somewhere along the line that the relationship between the citizen making the request for disability and the Social Security Administration would be...and find institutionalize the fact that most of us, and I probably also, would seek legal advice. Imagine my consternation running the hospital when someone requests, a patient requests their record for disability determination and I find out we've already sent those records to the social security disability administration because that's what we are supposed to do. What this law would allow us to do is to charge them for this second request that doesn't go to the Social Security Administration for disability. Your employee will have had those records sent directly to their insurer or the disability at Social Security Administration. Those records are going someplace else. Maybe the patient is keeping them for their own reassurance or maybe they're going to legal counsel. All I am saying in this bill is let's not duplicate that expense to the healthcare providers. Records are being provided to make that determination. Whether we have gravitated to an institutionalization where multiple copies are required and multiple copies ought to be made I can't speak to. I do know that it makes sense to me that one copy go to where that determination is made, paid for by the healthcare providers. And if additional copies are requested, they should be paid for by the individuals making that request. Who those individuals may be probably is answered if you look at the number of individuals who came today and provided testimony against us. But I can assure you those records find their way to a determining agency, and it's not a cost that has to be borne by the patient. Thank you very much. [LB301]

SENATOR GAY: Thanks, Senator Gloor. Any questions from the committee? Don't see any. Thank you. That will conclude today's. Thank you all for your patience. [LB301]

Disposition of Bills:

LB220 - Placed on General File with amendments.
LB301 - Indefinitely postponed.
LB310 - Held in committee.
LB341 - Placed on General File with amendments.

Chairperson

Committee Clerk