[LB371 LB396 LB541 LB610 LB656]

The Committee on Health and Human Services met at 1:30 p.m. on Wednesday, February 11, 2009, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB371, LB610, LB541, LB396, and LB656. Senators present: Tim Gay, Chairperson; Dave Pankonin, Vice Chairperson; Kathy Campbell; Mike Gloor; Gwen Howard; Arnie Stuthman; and Norman Wallman. Senators absent: None. []

SENATOR GAY: All right. Well, good afternoon. Good afternoon, everyone. Thanks for coming today. Grab a seat. We'll get started. We have a busy day ahead of us. There's five bills we're going to be hearing today and they're all very important so we've got a lot of work ahead of us. I'd like to start out with some introductions real quick. I'm Senator Tim Gay from Papillion/La Vista. And I'm going to start to my right, we'll introduce ourselves. []

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

SENATOR GLOOR: I'm Mike Gloor. I'm the senator from District 35, which is Grand Island. []

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

SENATOR STUTHMAN: Senator Arnie Stuthman from District 22, which is the Columbus area. []

SENATOR HOWARD: Senator Gwen Howard from District 9 in Omaha. []

SENATOR WALLMAN: Norm Wallman, District 30. []

ERIN MACK: Erin Mack, the committee clerk. []

SENATOR CAMPBELL: Senator Campbell from Lincoln. []

SENATOR GAY: She's ready to go to work right away. []

SENATOR CAMPBELL: I am. []

SENATOR GAY: (Laughter) Okay. Before we get started I do want to cover a few things, and I know many of you have been here before but many haven't. Okay. What we do, we've instituted a timing system that we try to stick to, quite honestly. But the

reason why: five bills. If we don't kind of make our way through them throughout the day, we're here very late, and that person who's number five on this list doesn't get as much attention, you know. Just naturally they don't get as much attention. So we're trying to be fair to everybody. And what we try to do is limit it to five minutes. But, you know, discretion. We don't want to cut anybody off, but we try to not be repetitive. And if somebody has said something and you want to add to it, fine, but we try to not be repetitive on things. That certainly helps. We have testifier sheets over here in the corner. If you could print your name on that, and then when you come up hand it to the clerk because everything is being transcribed and that helps her spell it out. And also when you come up, if you could state your name and spell it out, that certainly helps, too, when we're going back and transcribing all these hearings. So with that, if you have also any cell phones, if you could silence your cell phones that's very appreciative as well. So with that, we will get started. And another thing though, too. Of course if there's any questions from committee members, you know, would take as long as you want. There will be people coming and going. I know several senators today have other bills they're testifying on throughout the day. So if you see people coming and going, they certainly care about your cause and want to listen, but they have...we're still in a lot of hearings going on and they'll be introducing bills in other committees. So don't take any offense to that. This is being on live stream on the Internet, too, just so you know, so you're aware of that, and that's new this year and it's been pretty neat, a neat program. So with that, I'll shut up and we'll get going. Senator Campbell, go ahead. []

SENATOR CAMPBELL: (Exhibit 1) Thank you, Chairman Gay and members of the committee. I'm here to introduce LB371, which is to extend the Medicaid Reform Council. And actually I am a past member of the Medicaid Reform Council as a private citizen. And while sitting on the Medicaid Reform Council, I indicated to them that should I be elected I would be glad to carry this bill and proud to do that. The Medicaid Reform Council is recommending to the Legislature this bill. The council was created with the enactment of LB1248 in 2006. The law requires ten members to be appointed by the Chairperson of Health and Human Services in consultation with the Governor and the Department of Health and Human Services. The members must include at least one person from providers, recipients of assistance, advocates for recipients, business, insurers, and elected officials. The legislation authorizing the council sunsets in June 30, 2010. Much work on Medicaid reform remains to be done, and the council members felt it was important and believe that the council should be an ongoing, permanent part of reform. And some of the primary purpose, while it is to eliminate the sunset date, other items were suggested by the council that are incorporated in the bill and I'm just going to quickly enumerate them. The change from biennial to annual, a report required of HHS. Given the magnitude of Medicaid in the state of Nebraska, we felt that was important. Number two: It adds the Chair of the HHS Committee to its membership or his or her designee. It changes a couple of deadlines to give more time for the council to respond to proposed reforms and hold public hearings on them in a meeting; authorizes the council to meet publicly at least quarterly; requires the department's final report to

address each of the council's specific recommendations; requires the council to hold public meetings at least quarterly instead of at least twice annually. It requires the department to provide to the council, no later than two weeks prior to the council's quarterly meeting, background information on proposed reforms and sets out terms for the members, obviously. We have provided for you some information, budget information on Medicaid, and that is primarily to show the significance and importance of the oversight responsibility of the Medicaid Reform Council. With that, I would like to say that I'm very, very fortunate to have today, speaking on behalf of the Medicaid Reform Council, Senator Don Pederson who was head of Appropriations when he was here. And he is the chair of that group and can answer every question from the committee. (Laughter) [LB371]

SENATOR GAY: All right, we'll take that hint. All right. Any questions for Senator Campbell right now? Senator Gloor. [LB371]

SENATOR GLOOR: Thank you, Chairman Gay. Senator Campbell, I just want to make sure I understand the wording correctly. It says: moves forward the deadline for the draft report and moves forward the council's public meeting. That means moves closer? [LB371]

SENATOR CAMPBELL: Yes. [LB371]

SENATOR GLOOR: It does move closer. [LB371]

SENATOR CAMPBELL: Yes. Gives us more time, because right now some of the deadlines were in November and like the first of December which gave the council very little time to respond to the Health and Human Services Committee, as well as to the full Legislature. So we're making them earlier in the year. [LB371]

SENATOR GLOOR: Okay. Thank you. [LB371]

SENATOR GAY: Okay. So Senator Pederson is going to come up next? [LB371]

SENATOR CAMPBELL: Yes. [LB371]

SENATOR GAY: Okay. All right. We'll hear from proponents. Thank you, Senator. [LB371]

DON PEDERSON: (Exhibit 2) Good afternoon, Chairman Gay and members of the committee. Nice to see so many new and...I used to say old friends but I don't say that anymore; I say longtime friends. (Laughter) Would you pass this around, please? Thank you. As Senator Campbell had said, I served with this body for ten years and went out with the first group that was met with term limits. But you have a very awesome task

here. This is going to be an easier task I think than some that you will face later. For one thing, the reason we have a Medicaid reform task force is because this committee and your predecessors formed that organization. And it formed the organization based upon some wording that I think is appropriate to say, and that is: Medicaid program in Nebraska as it is currently structured will not be fiscally sustainable in the future. That's why it was founded. And why they put sunset on that, I guess they thought we'd get it all done by 2010, and that didn't happen, so. But we are working on it. This is a very important thing, not only because it was created by your committee, but it's important for many of the people that are in this room because this gives them an opportunity to have a public notice and hearing as to what changes may be made in the actions of the Health and Human Services Department. So the department comes to our committee with recommendations of things they'd like to do and then we discuss that with them, and then the public has an opportunity, if they wish, to discuss that and to express their concern. Now, I've passed among you this general budget fund program. This comes from Tom Bergquist of the Legislative Fiscal Office. And I worked with this sort of thing a lot when I was on the Appropriations Committee to see where we're going with dollars. But I think you can see that Medicaid now, just looking at Medicaid alone, we spend more on that than we do on the university system and the state colleges combined. It's increasing over a 20-year growth at almost 10 percent per year. And that's when I refer to the fact, is it sustainable at that? So that's a problem when you consider how your budget grows and how we don't have much choice about this sort of thing. We have to repay...the federal government pays the money for Medicaid, and then we reimburse the federal government to the tune of about 40 cents on the dollar. So that's one thing that we're up against. And we have had the opportunity and I would say that the department has been very cooperative with us and has presented materials to us as a sounding board for things that they think about doing and get our reaction. I think it would be a mistake to not renew this particular agency, even though my duties there allow me to receive less money than I did when I was a senator, which is...it's absolutely zero to work on this, but it's something that we have to watch. We just can't let that go. And so I think the way it's structured now with the new arrangement and Pat Snyder's group--and I think a representative from that organization will be here to testify about this--help structure this. And we tried to, as Senator Campbell just said, try to get the times fixed to where we can respond, the department can respond, and then get the reports to your committee and to the Governor on timely fashion. It was just...I think it was kind of a guess and hope initially as to how that was put together, but now we have a better structure put together to see if the time lines work better for us to get this done. So with that, I would urge that you pass this particular bill from your committee, and that hopefully it will receive approval of the Legislature. It certainly...it's one of the few things that isn't going to cost us money, but it's something that we have to do. I was going to receive a letter, and I think I have by e-mail, from Linda Ollis who was the director of the Creighton University Med Center. And Linda said she was sending it to me, but my monitor broke so whatever she sent I didn't get, but she would have been present in that form. So I'd be glad to answer any questions you have. [LB371]

SENATOR GAY: Okay. When you get that letter just submit it and... [LB371]

DON PEDERSON: I'll circulate it. [LB371]

SENATOR GAY: ...we'll submit it in as a record. [LB371]

DON PEDERSON: When I get it. Thank you. [LB371]

SENATOR GAY: All right. Questions? Senator Gloor. [LB371]

SENATOR GLOOR: Thank you, Chairman Gay. Senator Pederson, thank you for your testimony. Thank you for your work on behalf of the Legislature and Nebraskans and pass that along to your committee. I'm sure all committee members are in support of our thanks to you. But I have this feeling that while the committee does its work, the department is, in fact, forging ahead with its own plan of how it sees managed care being rolled out. Is there anything in the statute as we originally drafted it and set this committee up that requires them to wait for feedback from the reports of this committee? There's the old saying that I've got to hurry to catch up with the others because I'm their leader. I'm a little concerned that we should be leading and are we having the opportunity to lead? [LB371]

DON PEDERSON: Well, I think you also have to look at this: We don't have a staff, and it's very difficult for us to generate from scratch when we do not have the staff or the research. But what has been happening...and I would say this, Senator Gloor: When we first started out we got kind of canned reports as to...we said do this, this, this, and this, and then they would come back and set up a timetable to attempt to achieve some of these goals that we set out. And some of them they didn't even pay any attention to, but be that as it may. It has worked, and we are not in a position to lead the parade but we are certainly in a position to ask them what are you doing about this. And the way that this new bill is set up, they have to respond to what we request; either say we're not going to do it or we will do it or whatever, but. And it gives these folks in this room an opportunity to have their voice heard, but I think they have to lead the show the way it is. [LB371]

SENATOR GLOOR: Okay. Thank you. [LB371]

DON PEDERSON: Thank you. Any other questions? [LB371]

SENATOR GAY: Any other questions? I've got one for you. [LB371]

DON PEDERSON: Okay. Thank you. [LB371]

SENATOR GAY: Kind of a follow-up to Senator Gloor. I mean, I've read the report. I've introduced bills that say here's what we need to do, with some success, and others...very difficult decisions have to be made. And you have a council giving recommendations of here's what should happen. In the time you've been doing this, have you seen successes from the council that's given...and I know the makeup of the council right now and I'm very impressed. But, you know, when the rubber meets the road it's ultimately tough decisions have to be made if we're going to reform something it looks like. Not in all these cases, but sometimes very tough decisions. But at what point under this new bill...you're getting teeth in it is what you just said. [LB371]

DON PEDERSON: Did what? I'm sorry. [LB371]

SENATOR GAY: You're getting teeth in this thing is what you just said because did you just say that the department has to reply to... [LB371]

DON PEDERSON: Well, the bills... [LB371]

SENATOR GAY: Where's the teeth in this thing instead just a recommendation? Now, we get recommendations all the time. [LB371]

DON PEDERSON: Well, they are required to meet with us. We are required to hear what they have to say and then express what our position is on it, and then they have to respond back on our position. That's about the only teeth we can have because as you well know this department is run by the administration. And so we can't control that, but we can ask questions and we can request that they respond. [LB371]

SENATOR GAY: And do you think by meeting more frequently...that would be...obviously I would think that it would be more helpful than what's been happening. [LB371]

DON PEDERSON: Yeah. Well, I think that it would work better in meeting more often. I know this does...I don't what the department thinks about this program, but I do know it involves a lot work on their part in order to meet this. But I think that's what they're here for and that's why we're doing it, so. [LB371]

SENATOR GAY: Yeah. And we'll probably hear from someone I'm sure. [LB371]

DON PEDERSON: Perhaps. [LB371]

SENATOR GAY: Are there any other questions? I don't see any. Thank you, Senator. [LB371]

DON PEDERSON: Thank you. Appreciate talking to you all. And we do have a very

good committee, by the way. [LB371]

SENATOR GAY: You do. [LB371]

DON PEDERSON: I mean really top people in the state. Thank you. [LB371]

SENATOR GAY: Very good. Thank you for your service. [LB371]

BRENDON POLT: (Exhibit 3) Good afternoon, Chairman Gay and members of the committee. I'm Brendon Polt. I'm the assistant executive director of the Nebraska Health Care Association. We're a trade association of proprietary and nonproprietary nursing homes and assisted-living facilities, about 400 in total. I'm here to appear on record in support of LB371. We thank Senator Campbell for introducing the legislation, and I myself worked with her in some of the drafting of the bill. Pat Snyder, the executive director of the Nebraska Health Care Association, serves on that council. This bill is very important to our members primarily because of the large number of people that rely on Medicaid to finance their long-term care. Now it's 56 percent of nursing home stays are paid by Medicaid. So we feel that the intent of the Legislature when it decided to reform Medicaid was to create a public process. We very much know by taking a look at the state budget that the need to reform isn't over. And so that public process should be continued as Medicaid continues to be reformed. We also note that if it weren't for this council and the meetings that take place, I don't want to say none of the data but just about all of the data that's been produced about what's happening with Medicaid reform, what are the changes with intent on managed care, and just data and statistics and everything come out when there's a Medicaid Reform Council meeting, and it allows the public to see what is progress, what is the intent of the department. And so that's why we support the council. And I wanted to respond to some questions that were addressed to Senator Pederson before me about the teeth. Obviously the reform council can't create law. But we feel like that provision that the department will have to respond in writing to recommendations that the council puts forth at least requires the department to say, yes we agree, or no we don't agree and here's why. And we know the political process is a public one. And that goes out publicly. People can engage their senators or the Governor and talk about these issues. If this isn't required, then it's possible that the recommendations of the council just go on a shelf somewhere and never get addressed, so. Another part of the teeth, so to speak, was to make a...initially, when the Reform Council was created, the chair of the...I'm sorry, the legal counsel to the Health and Human Services Committee and a representative from the department worked with the council to create the Medicaid reform plan. Well, under this bill you have another designee of the committee so there's a closer link to the Legislature and the committee, and we hope that gives some more strength to the recommendations. [LB371]

SENATOR GAY: All right. Thank you. Any questions? I don't see any. Thank you. Other

proponents? [LB371]

REBECCA GOULD: (Exhibit 4) Good afternoon, Mr. Chairman, members of the committee. My name is Rebecca Gould, and I'm the executive director of the Nebraska Appleseed Center for Law in the Public Interest. Nebraska Appleseed is a nonpartisan, nonprofit public interest law center that works for equal justice and full opportunity for all Nebraskans. And a lot of the work that we do is with low-income Nebraskans, in particular, and Medicaid is an issue that we've worked on for quite a number of years. And we were actually involved when this committee was working on creating this council. And just to kind of put a little bit more historical perspective on this, around the time that the Medicaid Reform Act was being discussed by this committee it was a real overhaul of all of the Medicaid statutes. And in part of that process, broad authority was given to the department to make some decisions related to the way the program was going to run. And part of the creation of this council was to ensure that that authority would be exercised in a way that was public and that allowed for input from stakeholders in the community. And so really the backbone of creating this council was about making sure that this committee would be fully informed about changes that were being made within the program and provide, you know, a well-rounded set of information coming into the committee. And so in listening to some of the questions that have been raised, I think there's a few things to keep in mind. While it's true that the council itself can't have a lot of teeth because of the structure and the nature of the process, the improvements that are included in this bill will actually make it even easier for this committee to get really good, accurate information about what's going on, and that it won't be just the information that's coming from the department but it'll also include information from the experts who are sitting on this council and also from folks in the community who have a stake in the success of the Medicaid program in the state. And so I think Appleseed is definitely supportive of the council continuing. I also think it's important to have the link, having either the Chairman or the Chair's designee sitting on that council to make sure that this committee, you know, fully participates and knows what's going on within the Medicaid program, and then can make decisions about whether it agrees with the direction that the department might be taking the Medicaid program or not. And so I think, you know, those provisions are really critical to making sure that this council can continue to work the way it was intended; that you all have the best information in front of you that you can to make decisions. And then at the end of the day we end up with a Medicaid reform process that truly reflects the best interests of our state as a whole, including the constituencies, those who are served by the Medicaid program. I guess the last thing I would say, there was a question about successes. And I would say that this council actually has had a lot of successes in the sense that they've tackled a number of tough issues. There were questions about restructuring the Kids Connection program that came before this council and they had to deal with and made some good recommendations in cooperation with the department around that issue. There was an issue that came before the council related to restructuring the Medicaid program toward a defined contribution model. There was a

lot of positive discussion and good information that came out and I think led the state into making some good decisions about whether or not a fundamental restructuring of our Medicaid program was necessary. And so I think this council and this public process has really worked the way it was intended to and has been a true success in terms of managing the Medicaid reform process. And with that, I'd answer any questions that you might have. [LB371]

SENATOR GAY: All right. Thank you. Are there any questions? I don't see any. Thank you. Other proponents who would like to speak on this issue? Any opponents? No opponents. Anyone neutral who would like to speak on this issue? All right. Senator Campbell... [LB371]

SENATOR CAMPBELL: I'll waive. [LB371]

SENATOR GAY: (Exhibit 5) ...waives closing and we will close the public hearing. We did receive--do you have a list of the letters? Nebraska Health Care, that's Brandon's. Nebraska Hospital Association has a letter of support. And that's it. And then any others that we receive we will put into the record. With that, we'll close the public hearing on LB371. And is Senator Mello here? Is someone going to get him, do you know? We'll take a short break while we're waiting for Senator Mello to get here to open on LB610. [LB371]

SENATOR CAMPBELL: Senator Gay. [LB371]

SENATOR GAY: Yes. [LB371]

SENATOR CAMPBELL: I just would like to comment and thank Jeff Santema and Erin Mack because they are the staff people to the Medicaid Reform Council. [LB371]

SENATOR GAY: Oh, very good. [LB371]

SENATOR CAMPBELL: And without their expertise and certainly without Jeff's guidance, there were many times in which the council would have gone, h'm, what shall we do here. But I was neglectful in thanking them in my testimony. [LB371]

SENATOR GAY: Very good. Thank you, Senator Campbell. That's a good point. How many people...while we're waiting, how many people are going to... [LB371]

SENATOR MELLO: I apologize for my tardiness. [LB610]

SENATOR GAY: Well, we know you're busy working with numbers, so thanks for joining us. Go ahead, Senator Mello. Open up on LB610. [LB610]

SENATOR MELLO: (Exhibit 1) Good afternoon, Chairman Gay and members of the Health and Human Services Committee. My name is Heath Mello and I represent the 5th Legislative District. I'm here to introduce LB610, a bill that would require the Department of Health and Human Services to allow for exceptions to limitations and caps on services under the Medical Assistance Program for individuals with disabilities or other chronic conditions. These exceptions would be for habilitation, rehabilitation, and other services needed to meet and maintain goals of independent living. After introducing the bill, I became aware of a couple of problems with the bill and have drafted an amendment for the committee's consideration. The first change is a grammatical correction on page 2, line 13, which should read, "conditions for whom habilitation, rehabilitation, and services are needed to meet goals of or to maintain or develop independent living." The second change would lower the percentage of the federal poverty level from 500 to 300 percent in Section 3 of the bill. This bill comes as a reaction to the limitations and caps proposed by the Department of Health and Human Services in regards to Medicaid waiver recipients. LB610 would exclude any services deemed medically necessary from such limitations and caps. In order for a service to qualify for such an exception, a request must include a demonstration of need by the physician or licensed medical professional. Once an exception has been granted, the physician or medical professional must periodically report as to the continuing need for such service. Many of the recommendations from the Department of Health and Human Services for limitations and caps on services that seem reasonable to the general population would be devastating to the disabled community. Restricting a person to one pair of eyeglasses every two years sounds reasonable for an otherwise healthy person, but could be completely unreasonable for a person dealing with MS, multiple sclerosis, whose vision may change dramatically from month to month. The limitations for outpatient mental health and substance abuse could also be devastating to our community. The treatment necessary for mental health and substance abuse patients varies dramatically from patient to patient. A patient near the end of substance abuse treatment may be able to maintain their progress and recovery with one visit a week, but a substance abuse patient new to treatment may need three or four visits a week, dependent on the substance and the individual. The disabled community and individuals suffering from chronic conditions need much more flexibility from their doctors in regards to care. The treatment one receives should be dependent on a doctor's recommendations, not dependent on HHS rules and regulations. Aside from the human costs of such limitations, these types of limitations and caps simply shift cost down the road to other areas of the state's budget. While we may see a cost savings here, there will be likely an increase in institutionalized care as individuals find the only way to receive treatment for their conditions is to be in such a setting instead of in the community. This is also the reason LB610 seeks to prevent premiums from being charged to individuals receiving care under this act. While cost savings for implementing premiums can be shown in this line of the budget, the costs are simply shifted to other areas as the burden becomes too high. Those individuals that do not move to institutionalized settings may simply forgo treatment, leading to an increase in

emergency room admittance. In the case of mental health conditions, when individuals forgo treatment we often find them in the correctional system, yet another cost to the state. Disabilities and chronic conditions are also typically considered preexisting conditions or coverage will be denied for persons seeking private healthcare. This, combined with the constant rise in healthcare, often puts families in impossible situations. Turning to state care is a last resort for individuals and families seeking medical care. Section 3 of this bill addresses a concern that families making large incomes are qualifying for Medicaid waivers. The original version of the bill states that it would disregard income up to 500 percent of the federal poverty level. The reason that 500 percent of the federal poverty level was suggested was that this was the level needed to reach a six-figure income, which I am told is a common accusation used in an attempt to discredit the need for Medicaid waivers. My amendment would lower that to 300 percent of the federal poverty level which is much more reasonable in the current economic climate. I would also like to address the Department of Health and Human Services' fiscal impact estimate. My bill makes it clear that the exemptions to the limitations and caps put in place by HHS would only be applied to those individuals for whom treatment is deemed medically necessary. I understand the impulse to estimate for the worst-case scenario but question the high number of people the department suggests would qualify for such exceptions. If indeed these services are medically necessary for as many individuals as the department's fiscal note suggests, I question the motivation behind implementing these limitations and caps. The department's fiscal note also neglects to address the tremendous cost savings to this state by keeping more persons living independently. The cost for a living in an institutionalized setting is at least twice the cost for living independently in the community. While it is difficult to get an exact amount, the fiscal note put together by our Legislative Fiscal Office does state that the costs incurred by this bill would be offset by the cost savings of preventing institutionalized care. There are many individuals that will be testifying after me to the need for these exceptions to the limitations and caps imposed for services deemed medically necessary. I urge the committee to support this bill and will be happy to work with the committee on any proposed amendments or ways to find common ground to this solution of this problem. I would be happy to take any of your questions. [LB610]

SENATOR GAY: Thank you, Senator Mello. Any questions for the senator? I don't see any right now. While you're here, I did see several people entered the room since Senator Mello testified. I'm going to, one more time, just so I get a...I got a hunch that they may want to speak on this bill. How many proponents want to speak on this bill? Okay. So we got about six or seven then. Okay. And then how many opponents? A couple opponents. And then any neutral? Okay. Because I figured there were a few more. So we'll take time to listen to everyone. Are you going to stay around do you think? [LB610]

SENATOR MELLO: For awhile, yes. [LB610]

SENATOR GAY: For awhile. I understand you're busy. Okay. All right. We'll hear from proponents. Thank you, Senator. [LB610]

SENATOR MELLO: Thank you. Thank you. [LB610]

SENATOR GAY: Hello, Kathy. How are you? [LB610]

KATHY HOELL: Hello. How are you? Hello. My name is Kathy Hoell, K-a-t-h-y H-o-e-l-l. First of all, I would like to ask for a reasonable accommodation under the American... [LB610]

SENATOR GAY: Yeah. We'll get a... [LB610]

KATHY HOELL: (Exhibit 2) No, I have a responsibility, personal responsibility under the law to ask for any accommodations that I may need, so therefore I wanted it on the record that I indeed did ask for that accommodation. Anyway, I live in Bellevue and I am here testifying as an individual with a disability, but also as a taxpayer in the state of Nebraska who's very concerned about what is going on in Nebraska with regards to people with disabilities. Therefore I am wholeheartedly supporting LB610 which would create an exception process to Medicaid caps, limits, and premium payments for people with disabilities and other chronic conditions. When the idea of Medicaid reform was first brought up, I supported it. I assumed it would be well-thought-out and done very deliberatively. However, that's not the case. A slash-and-cut mentality has taken over the process. We are hurting our most vulnerable citizens. If we continue down this road, people are going to be dropped off the rolls of Medicaid which personally I think is the goal. That's how they're creating reform. They're decreasing the long-term care budget by not allowing people to receive Medicaid. If people are not able to get treatment that they need to remain in the community, they will be forced into institutions. They'll have to go to nursing homes or intermediate care facilities for the mentally retarded, where providing all services are mandatory. Currently, the department is cutting and slashing all services to live in the community, but they are not cutting and slashing the services to be in an institution. So you're guaranteed to get those services if you go into an institution. According to numbers from the state of Nebraska, an institution is twice the cost of living in the community. The entire nation is facing an economic meltdown right now. People with disabilities are forced into poverty by the state of Nebraska because they are not allowed to work, so therefore they cannot make extra money. How are they going to be able to pay for extra services? And this does include Nebraska when we come to the economic meltdown. I want to thank Senator Mello for introducing LB610, and I appreciate your interest and attention to this very important matter and I hope you will pass it on to General File. [LB610]

SENATOR GAY: All right. Thank you, Kathy. Senator Stuthman. [LB610]

SENATOR STUTHMAN: Thank you, Senator Gay. Thank you, Kathy, for coming and testifying. I know you've been before this committee many, many times. The question that I have is, are you in agreement with the income level of changing it from 500 percent of the poverty level to 300? [LB610]

KATHY HOELL: I can understand the committee's...and the concerns about the 500, and I can live with the 300 but I would still like to see it maybe no higher or lower than 400, I mean, because when we're talking about families...I'll just give you a really quick example because I don't know if she's going to make it. Her car broke down. A friend of mine, her son is disabled. He's in a chair. He got his first wheelchair the other day. Anyway, she's a teacher, but she had to quit her job because of her son's disability and so they are surviving on one income, and with the current economic situation that's not easy. And he's got expense that average about $500 a month above what Medicaid pays. They maintain their own insurance. They have private healthcare insurance for the family. They pay the premiums. They do the copays. Medicaid is the secondary insurance. But there's still things that the insurances don't pay because he has to have special food and all these types of issues. So, you know, I think 300 is still on the low side. I would like to see it a compromise of 400, but that's my personal opinion. [LB610]

SENATOR STUTHMAN: Okay. Thank you, Kathy. [LB610]

SENATOR GAY: Thank you. Any other questions? I don't see any for you, Kathy. Thank you. [LB610]

KATHY HOELL: Okay. While I'm here though, Bill Crawford, the gentleman sitting over here, he's been feeling sick so he asked me to read his testimony (inaudible). [LB610]

SENATOR GAY: Oh, absolutely. Go ahead. [LB610]

KATHY HOELL: (Exhibit 3) Anyway. He said: Good afternoon, Senator Gay and members of the Health and Human Services Committee. For the record my name is Bill Crawford, B-i-l-l C-r-a-w-f-o-r-d. I am here today in support of LB610. LB610 allows individuals to overcome the drastic caps on Medicaid services imposed by the department last year. LB610 is necessary because the Medicaid service caps are not flexible. There is no language or intent to provide services for people who cannot sustain their health or independent living without additional health services. LB610 does not provide a blank check for services; individuals need to show a medical necessity for services above the cap. Nor does LB610 provide these additional services indefinitely; when the medical necessity for additional services is no longer present, an individual would resort back to receiving services under the caps. I am disappointed that the department gave no regard to the possibility that people, especially people with disabilities, may have unique health factors that will not work with the stringent caps on certain Medicaid services. Since everyone's medical needs are different, it does not

make good public health policy to not build in some flexibility in regulating access to certain Medicaid services. I would hope that the Legislature would pass LB610 because this would address meeting the healthcare needs of citizens, especially those with disabilities, while maintaining flexible limits on state Medicaid expenditures. It is a win-win for both the state and for Nebraska's citizens with disabilities and other significant health needs. This concludes my testimony this afternoon. Thank you for your time and consideration. [LB610]

SENATOR GAY: All right. Thank you, Kathy. We'll have a page make copies of it, as well, and distribute that. [LB610]

KATHY HOELL: Thank you very much. [LB610]

SENATOR GAY: You bet. Thank you. And we'll continue to hear from proponents and then... [LB610]

TIM KOLB: Hi there. [LB610]

SENATOR GAY: Welcome. [LB610]

TIM KOLB: Beg your pardon, my voice is a little bit froggy today. My voice is rather soft anyway, so I...can you hear me okay? [LB610]

SENATOR GAY: Yeah. [LB610]

TIM KOLB: (Exhibit 4) Okay. Please interrupt me if you don't understand what I'm saying. By the way, you have a second page, and I didn't note it but I'm telling you that the information on that second page was taken from the HHS Web site. Okay. Mr. Chair, members of the committee, my name is Tim Kolb, T-i-m K-o-l-b. I serve as CEO and the executive director of the Kolb Foundation for Disability Education, of Franklin, Nebraska. With the passage of Nebraska's Medicaid reform legislation, the Nebraska Department of Health and Human Services has entered upon not so much a series of Medicaid reforms, as an implementation of a series of Medicaid cuts with more cuts planned. For example, Medicaid recipients are limited to no more than 12 chiropractic treatments per year; no more than $1,000 of dental services per fiscal year for adults; no more than one set of eyeglasses, frames, or lenses for adults every two years; and replacement of hearing aids for adults no more than once every four years. On top of these, Medicaid coverage for outpatient occupational therapy services, speech therapy services, and physical therapy services are limited to no more than 60 visits per fiscal year. No doubt, there will be many Nebraskans for whom such cuts will not present a serious problem, but for those citizens who have more severe physical and/or mental/emotional issues such cuts will be devastating. It seems the cuts were made with little--I would add, or no--regard for the potential negative effects people with

disabilities will experience. Essentially HHS has decided to play doctor, but unlike a doctor they have taken no oath to "do no harm." HHS made no provision for people with disabilities whose conditions are such that, without a means to escape the cuts, their health would be endangered. LB610 provides the escape mechanism. Now, what about the need to save precious tax dollars and assure the future sustainability of Medicaid? It's a documented medical fact that if people with serious physical and/or mental/emotional conditions are unable to receive the ongoing medical services they require as prescribed by a doctor, such individuals will develop even more complex and dangerous conditions that require more costly interventions. Helping people get what they need in a timely manner through good medical practice saves money. Even if no one cares about the well-being of people with disabilities, it's just plain good business for Nebraska to provide an exception to Medicaid cuts as described by LB610. But I do believe we all care, and therefore I call upon this committee to move LB610 on to General File with the ultimate intention of passing it into law. And let me add that the $210 million fiscal note, in my judgment, is willingly blind to the fact that there will be a tremendous savings by maintaining people in their own homes and community. About three years ago or so, HHS's own documentation showed that the highest Medicaid expenditures came in the form of nursing home care. When we have to go back to institutions to live, it costs the state big bucks. And I think as I said earlier, if you're forced to live in a nursing home you can't get a job. Secondly, I hate to sound like an alarmist, but I'm going to do this. The cuts that Medicaid intends to make beyond those listed in my testimony may actually cause some people to die. Now, death is certainly the ultimate money saver, isn't it? Because at that point we stop costing the state. I don't think as Nebraska citizens we want the mark of being called a state that imposed its own Final Solution. I don't think we want that. And I appeal to you to prevent that from happening. Questions? [LB610]

SENATOR GAY: Any questions from the committee? Tim, I would say that your last comment is certainly not the intention of anyone that I've ever seen in this state or with the department or any state senator or anyone else that would justify that. And that obviously would never be anyone's intention, so. [LB610]

TIM KOLB: You know, I agree. [LB610]

SENATOR GAY: Okay. I think that needed to be said. [LB610]

TIM KOLB: That is...no one every says that, but if the effect of our actions creates it, who then is responsible? [LB610]

SENATOR GAY: Absolutely. I just want to be on record stating that, though, because I've been...you know, we've been doing this for some time. And, of course, I respect your opinion and you always do a good job, but I think that would never ever be the policy of anybody that I have ever worked with. Thank you. [LB610]

TIM KOLB: I pray not. Thank you. [LB610]

SENATOR GAY: (Exhibits 9, 10) Thank you. Any other proponents? For the record as well, we do have letters of support that were submitted Appleseed of Nebraska and Nebraska Hospital Association. So we have received those and those will be in the record. [LB610]

MICHELLE BARTLETT: We are actually the family that Kathy was talking about. We did make it after all. [LB610]

SENATOR GAY: Well, thank you. Thanks. [LB610]

MICHELLE BARTLETT: When I first got started with this, Kathy... [LB610]

SENATOR GAY: Can you state your name? [LB610]

MICHELLE BARTLETT: It's Michelle Bartlett and this is my husband John Bartlett and our son Jake. [LB610]

SENATOR GAY.: Okay. [LB610]

MICHELLE BARTLETT: When Kathy had mentioned what was happening with the Medicaid premiums, we got involved, because after I sat down and looked at the computer and started doing research from other states, the information that came back was that it doesn't work. My biggest concern is, if a family doesn't pay for the premium is there going to be a time frame where they're going to be kicked off the program for, like, six months? Some states do do that. If they don't pay their premiums on time, they don't get Medicaid for six months until then it gets reinstated again. That's one of my concerns. I do agree with 400 percent above poverty. That 500 would be wonderful, but 400 definitely. My husband is in the military. I used to work as a social worker. I've been working in the disability field before my son was even born. We sat down, and before we met with Senator Mello I thought, well, it would be a good idea to look at all the costs that we spend every month. And we always wondered, where did all our money go? And after we sat down and looked at it, we spend about an extra $400 a month out of pocket for extra items that TRICARE doesn't cover or Medicaid doesn't cover. We were originally on the Medicaid program when we first got here. We didn't find out for about three years. When we got it, it was a blessing because we actually got respite and we got assistance with diapers, which $200 a month doesn't seem like a lot but it's a lot to us. Not being able to have that service and not having the respite so we could take a break or...it's really hard. Every family needs to have Medicaid services to increase the quality of life for their children as well as...you know, putting a cap on something if someone needs PT or OT. If they need it to function they should get it. When she wrote

up the bill, she put in there, you know, a scrip from the doctor. She was very specific about a letter, a procedure that you have to go through. And that I completely agree with. That's reasonable. But if they need the services, they should get it. You know, we're right now looking at retiring. When we came to the state of Nebraska I really didn't know anything about Nebraska. I didn't know where Omaha was or Offutt Air Force Base. We've been very happy. The hospitals here are fantastic. The Medicaid services we've received are wonderful. My husband is getting ready to retire. We started looking at different states. Your state has waiver programs. A lot of states do not have the waiver programs. So I think this should definitely be kept intact. There are other military families that I know of that do receive the waiver, but having them pay a premium--they have so many other expenses, they have other children--paying that extra money each month might not happen. And in that case, kids will do without or hospitals will have to eat those expenses, so. I just don't really agree with it, but I understand the reasoning behind it, so. That's pretty much it. [LB610]

SENATOR GAY: Okay. Hold on. Let's see if there's questions for you. [LB610]

MICHELLE BARTLETT: Okay. [LB610]

SENATOR GAY: Senator Stuthman has a question for you. [LB610]

SENATOR STUTHMAN: Thank you, Senator Gay. Michelle, you mentioned the respite part of it that you utilize. Is that sufficient for what you would like to have? I know you and your husband need the time to be by yourself and things like that... [LB610]

MICHELLE BARTLETT: Yeah. [LB610]

SENATOR STUTHMAN: ...and do some things. Providing that service, is that sufficient? [LB610]

MICHELLE BARTLETT: It's okay. It give us enough time to get out of the house. It's 18 hours a month, so that gives us some time to have a few date nights, which is wonderful. I did talk to a mother this morning that has two daughters with leukodystrophy. And when they originally started on the program a few years back, it was 75 hours a month, and now she's cut all the way down to 18 of respite. And her daughters are much more significantly disabled than our son is. So she definitely said it's...the premiums are going to affect her, but she couldn't make it because she had to go to work, so. [LB610]

SENATOR STUTHMAN: Okay. Thank you, Michelle. [LB610]

MICHELLE BARTLETT: You're welcome. [LB610]

SENATOR GAY: Thank you. Other questions from committee members? Senator Wallman. [LB610]

SENATOR WALLMAN: Thank you, Chairman Gay. Yes, thank you for coming and testifying. [LB610]

MICHELLE BARTLETT: Oh, no problem. [LB610]

SENATOR WALLMAN: Can you bank these hours then? You know, like if you want to take them in a longer segment, to the next, month to month, or... [LB610]

MICHELLE BARTLETT: Yes. They do just keep occurring throughout the year. Every fiscal year it starts new, so... [LB610]

SENATOR WALLMAN: Okay. So you could put them all together? [LB610]

MICHELLE BARTLETT: Yeah. Yeah. If we needed to be. They like you to use something every month. [LB610]

SENATOR WALLMAN: Okay. [LB610]

MICHELLE BARTLETT: We do have to use it amongst two different respite providers, which can be tough. Our son has a seizure disorder, so we don't really have people lining up to help us for respite. So even though the state does pay them, it's still real scary for them. So we have to break it up between two providers and use something every month is what they like, but if you have extra hours it does add onto the next month. [LB610]

SENATOR WALLMAN: Okay. Thank you. [LB610]

MICHELLE BARTLETT: You're welcome. [LB610]

SENATOR GAY: Okay. Any other questions? I don't see any. Thank you for coming today. [LB610]

MICHELLE BARTLETT: Okay. Thank you. [LB610]

SENATOR GAY: You bet. Thank you. Still hearing from proponents who would like to speak on LB610. [LB610]

MARY ANGUS: (Exhibit 5) Senator Gay and members of the committee, we're having a little jockeying here who's going to get to the chair. My name is Mary Angus, A-n-g-u-s. I am the registered lobbyist representing The Arc of Nebraska. The Arc of Nebraska is an

advocacy organization working with and for people with intellectual and other developmental disabilities. This statewide organization has 18 local chapters and approximately 2,500 members across the state. We're an affiliate of The Arc of the United States. We believe strongly in the rights of people with intellectual and other developmental disabilities to a good quality of life and full participation in their communities. Unfortunately, the Nebraska Medical Assistance Program--Medicaid--has implemented restrictions on benefits that would allow people with disabilities to live in their communities and do just that. Many people with intellectual and other developmental disabilities are being left with three choices: losing needed healthcare, trying to pay for healthcare which is denied because of caps, or spending the rest of their lives in institutions. That may seem overly dramatic, but it's not. I'm going to focus on rehabilitation therapy for the purpose of this discussion. Last summer, as you've heard, Health and Human Services implemented a 60-session cap on outpatient rehabilitation therapy. That includes speech therapy, physical therapy, and occupational therapy. But it's more complicated than it sounds. Speech therapy does more than teach articulation. It can be used to teach someone to use sign language and other manual communication. It can also be used to improve swallowing disorders, which could ordinarily lead to eating problems and poor dental health. Physical therapy may be needed to increase the range of motion, to treat spasticity, or reduce stiffening of the muscles often associated with cerebral palsy. Manual dexterity is critical to the ability of people to use sign language or other manual assistive devices. Without that physical therapy you may find that that person can no longer communicate in a way that others seem to be able to understand. Occupational therapy is used to help individuals reach a maximum level of independent living. They all work together, that is until you reach your cap. I'm sure you're getting the picture. The impact of these cuts has never been truly examined. We have been given financial benefits or reductions that may be accrued by the virtue of the cuts. You've never been given the picture that would impact of the people who are receiving these services. You've not been told about the collateral damage. Don't get me wrong, we aren't trying to get people with disabilities to have the wholesale access to all of the services that are currently being reduced or cut. We're asking for consideration of extenuating circumstances. Earlier I said that the caps could mean that folks would wind up spending the rest of their lives in institutions. Medicaid is a complex system of regulations, conditions, and criteria. Some...if states want to use Medicaid there are some services that are mandatory. They have to cover institutional costs. There are also optional services, and those are the places that the state can use when they want to talk about cutting costs. You cannot cut institutional care. So they may provide optional services like eyeglasses if they so chose, but when budgets are up for cutting it's easy to say there would be financial benefits to cutting the optional services. But if your needs get capped and exceed the services available in the community, you may be forced into an institution in order to get the services that you need. Ironically, the services you need to be independent may only be available in an institution. As you know, the department has entered into a settlement agreement with the Department of Justice which includes transitioning people into the community from

Beatrice State Developmental Center. You may not know that Nebraska also has a Center for Medicare and Medicaid Services demonstration project called Money Follows the Person. That project would allow for an enhanced match of Medicaid funding that would go...ordinarily it's a 60/40, the feds put in 60 cents, we put in 40 cents. This enhanced match under this program is about 85/15. Can't do my math in front of me here. That would allow people to have that enhanced match to allow for a transition that first year out of an institution such as an ICF/MR or a nursing home. It is intended...the state's plan is to bring 200 people with developmental disabilities into the community that way. If we are able to do that, using Money Follows the Person, but the caps then preclude being able to stay in your communities. That's some of the collateral damage. Please pass this vital legislation on. We don't want any more collateral damage. Any questions? [LB610]

SENATOR GAY: Thank you, Mary. Any questions? Senator Gloor. [LB610]

MARY ANGUS: Hi, Senator. [LB610]

SENATOR GLOOR: Thank you, Chairman Gay. Ms. Angus, a question for you. When it comes to accessibility of health services for those members of the Arc that you represent, there's the issue of availability which usually has to do with, is this service even available or...well, plainly put, the available... [LB610]

MARY ANGUS: Can you get a provider. [LB610]

SENATOR GLOOR: Yeah. Can you get a provider or are there providers out there. Then the accessibility issue covers a lot of areas, whether it's with the doors, ramps, and so on and so forth. But it also has to do with payment or whether people accept payment. Do you find that accessibility, not as relates to the physical locations people go to, but do you find accessibility is a continued problem for those individuals you represent? [LB610]

MARY ANGUS: Yeah. I would definitely say yes, and I would say that all of those areas are problematic. But the problem is that even in the larger metropolitan areas, the two large metropolitan areas that we have, that there is...it's difficult to find providers who are able to work well and understand the different challenges of people with developmental disabilities. That would be even further reason to make sure that people can access those services through an extension or an exclusion from the caps. We do have providers who may stop covering people using Medicaid. Because I've had some providers say, if I can't do the amount of therapy that I need to do then I can't, in all conscience, cover that therapy. If I have to stop midway through or if my work isn't going to be able to complete what needs to be done, then I may not be able to take them. I don't know if that answers your question. [LB610]

SENATOR GLOOR: Okay. Yes. Thank you. [LB610]

MARY ANGUS: Okay. Thank you. [LB610]

SENATOR GAY: Any other questions? I don't see any. Thank you, Mary. [LB610]

MARY ANGUS: Thank you. [LB610]

PATRICIA McGILL SMITH: Good afternoon, Chairman Gay, members of the committee. My name is Patricia Smith, P-a-t-r-i-c-i-a S-m-i-t-h. I did not prepare a written testimony. I just want to add a little bit to some of my colleagues. I speak today on behalf of my daughter who is disabled. She's 38 years old, and my grandson is 19 and they both receive services in the state of Nebraska. I just want to point out that like right now my daughter Jane receives mental health services and she needs counselling and assistance. And the level of what she needs right now is down and it's down because she's doing so much better and this is what we want. But if something happened and it went back up again, then you would have to say, you know, we need enhanced...we need to have more help than what is being allowed under this...with the way they're capping the services now. And so I just want to point out to you that the health goes up and down. We want it to stay down, but if you don't have it, you know, you don't know. These are people and when do they need more? And also, Jane has one medical condition. It's under control right now, but when we were trying to figure this all out she was having all kinds of services that she needed. She doesn't need them right now. But the point is that you need to be able to say that if it were needed, and we don't want it to be needed, but if it is to be needed that it's available. And my second point is that I think that the state is really acting very penny-wise and pound-foolish because, when you have the people leaving Beatrice as they have during this last week, how could we possibly think, how could you possibly think that you would want to have people that had had services in the institutions come out into the community, which is where they were going to be, they need more help and then it wouldn't be available to them. This is beyond the pale as far as I'm concerned and I couldn't sit back there and not get up and remind you of your obligation to take care of people. And that's all I wanted to say. Okay? [LB610]

SENATOR GAY: Thank you. Let's see if there's any questions for you. Any questions from committee members? Senator Wallman. [LB610]

SENATOR WALLMAN: Yeah. Thank you, Chairman Gay. Thanks for coming. As a committee, we also feel bad of what happened. But the budget constraints and everything, we hope there are some answers out there, we'll do a better job. [LB610]

PATRICIA McGILL SMITH: Oh, I concur with that. But I think you have to be forward thinking and realize that people who have more complex needs, that it's highly likely, it's

very highly likely that they might need to have more services. And I just think you can't have it be that they're not going to be available or that they're capped. It just...it does not make sense. And I'm not saying every person is going to need it, but you have to be prepared in case they do. And the way that the caps were put on...because I remember how the members of the Arc and different ones really battled against those caps. I mean, we battled valiantly against those caps and we didn't win. And so I think that you have an opportunity now, and thank you to Senator Mello for this, we have an opportunity to change that. And I don't expect...I heard the fiscal notes were outrageously high. I personally do not have any...I was a governmental official in Washington, D.C. I understand fiscal notes. I do not think that is what it will look like, but you'll have somebody testify to that fact that they think it will. So I just don't think those fiscal notes are correct. [LB610]

SENATOR WALLMAN: Well, thank you. [LB610]

PATRICIA McGILL SMITH: You're welcome. [LB610]

SENATOR GAY: Thank you. Any other questions? I don't see anymore. Thank you. [LB610]

PATRICIA McGILL SMITH: Thank you very much. [LB610]

SENATOR GAY: Other proponents who would like to speak? [LB610]

BRAD MEURRENS: (Exhibit 6) Good afternoon, Chairman Gay and members of the Health and Human Services Committee. For the record, my name is Brad Meurrens, B-r-a-d M-e-u-r-r-e-n-s, and I am the public policy specialist and registered lobbyist for Nebraska Advocacy Services, Inc., The Center for Disability Rights, Law, and Advocacy. We are the designated protection and advocacy system for persons with disabilities in Nebraska. And I am here today in support of LB610. As you've heard, last December the Department of Health and Human Services instituted strict limits on several optional services under Nebraska's Medical Assistance Act to decrease state expenditures in the Medicaid program. However, the department neglected to include any mechanism by which the 10 percent of individuals in each service category who needed more of those services than the new caps would allow could obtain necessary additional services. Given the unique medical needs of people with disabilities or other chronic conditions and the necessity of services to maintain or develop healthy, independent living, such strict and rigid service limits will have significant impact on some individuals' ability to live quality independent lives. How independent can someone be who has a brain injury requiring daily speech and physical therapy to regain essential communication and motor skills when he or she is only allowed a combined 60 days of physical and speech therapy? What is the likelihood that this individual will be able to recover from his/her injury such that he/she can live and

participate fully and independently in his or her community? For those fortunate enough to have the financial resources to afford adequate service levels or insurance coverage for rehabilitative and habilitative these services, the strict ceilings on these services in Medicaid would not be of much effect. But for those who rely on the Medical Assistance Program, these nonflexible ceilings can be the difference between living in the community or an institution. We support LB610, as it serves as a catalyst to begin a dialogue about how can Nebraska best serve individuals with disabilities and other chronic conditions and the nature of the Medicaid program itself. Not every person requiring these services under Medicaid will be able to develop, to the fullest extent possible, necessary skills under the existing caps. Flexibility needs to be built into the programs and services directly affecting the ability of people with disabilities and other chronic conditions to maintain their health and independence. It is not programmatically or fiscally sound to only provide two months, for example, of rehabilitative or habilitative services to an individual who needs six months of services. The effectiveness of the services that are provided may be compromised by the four months of nonservice. Thus, Medicaid has unique population and program dynamics that require consideration in any effort to reform or to constrict Nebraska's Medical Assistance Program. This concludes my testimony. I'd be happy to answer any questions you may have. [LB610]

SENATOR GAY: Thank you. Are there any questions? Oh, Senator Stuthman. [LB610]

SENATOR STUTHMAN: Thank you, Senator Gay. Brad, I do respect the fact that there are people that need more services and other services. How would you say...how would you determine which one is eligible to get more services and which one is eligible to get less if there's only a pool of money that we can address the situation with? [LB610]

BRAD MEURRENS: That's a good question, Senator. I think that's built in with the bill's requirement that the exception would be based on the medical necessity of the individual. So if the individual does not need, you know, ten extra hours or ten extra units of service, then they wouldn't necessarily need to have those. But if they can show that there's a medical necessity for an additional allotment of services, then the process should work itself through and that person should be allowed to receive some additional services. [LB610]

SENATOR STUTHMAN: Okay. Thank you. [LB610]

SENATOR GAY: Any other questions? Senator Gloor. [LB610]

SENATOR GLOOR: Thank you, Chairman Gay. Mr. Meurrens, who will make that determination? Who's the person responsible for saying this is going to be needed? [LB610]

BRAD MEURRENS: Well, I think in the bill it talks about how a physician or a licensed

medical professional will come to the determination that the individual needs additional services because of a medical necessity. And then I think it's incumbent upon that physician or that individual that's making the request and the department to come to some agreement as to what would be the appropriate, you know, path from that point on. [LB610]

SENATOR GLOOR: Is that individual a licensed individual? [LB610]

BRAD MEURRENS: I think in the bill it does say licensed medical professional and/or physician. [LB610]

SENATOR GLOOR: Okay. Thank you. [LB610]

SENATOR GAY: Any other questions? Thank you. Other proponents. [LB610]

CATHY MILLER: (Exhibit 7) Good afternoon, senators. My name is Cathy Miller and I am testifying on behalf of the Nebraska Planning Council on Developmental Disabilities. Although the council is appointed by the Governor and administered by the Department of Health and Human Services, the council operates independently and our comments do not necessarily reflect the views of the Governor's administration or the department. We are a federally mandated independent council comprised of individuals and families of persons with developmental disabilities, community providers, and agency representatives that advocate for a system change and quality services. On this we did bring so that the senators might know what our council is all about. The council supports LB610, requiring the Department of Health and Human Services to establish provisions and procedures changing Medicaid limitations relating to person with disabilities. Language in the bill further specifies intent for an appeal process with outcome determinations to be completed within a time frame of ten business days. Families are aware that decisions related to healthcare and supports for persons with disabilities can be critical and must be made in a timely manner. The lack of an appeal process in the current Medicaid regulations regarding these limitations needs to be corrected. The argument that these limitations are similar to those in private insurance falls apart when considering that the majority of the people with special needs and disabilities are not currently offered options of employment and benefits. People with disabilities do not earn enough money to purchase or replace what they might require to function throughout their day. The ability to remain independent is directly related to the level of support received. Thank you. I brought my son Adam along. He's sitting back over there. He's on his third pair of glasses this year. Without his glasses he wouldn't see us, his eyes wouldn't focus. And we're already on our third set of glasses because of workmanship of the glasses or just plain, hey mom, I laid them down there and I sat on them. But without them he can't see. He was getting physical therapy, occupational therapy, speech therapy. He has hips that he literally walks out of. Speech therapy is related...he doesn't speak, but he has an eating disorder. This little nerve doesn't work.

He cannot chew and swallow food. He has sensory defensiveness to the maximum. Okay. So if there's limits on this, we are reaching the limits. This has to be ongoing for him. This can't be something that somebody says, well, you have to stop this now, you've met your limit. Well, we've heard all of this already. Okay. But it is so important for them to maintain their level. Adam lives out in the community--at home with us--but he is out in the community and he can maintain that. But if his hips start deteriorating more, he can't, and then he's wheelchair and he's in community services. Thank you. [LB610]

SENATOR GAY: Thank you. Any questions? I don't see any. Thank you for your testimony today. Any other proponent who would like to speak? If you would like to be on the record, you can also fill out a testifier sheet and turn that in and it will be published in the record if you just want to support. Proponent? Ma'am, are you a proponent? [LB610]

CAREY WINKLER: I'm Carey Winkler, C-a-r-e-y W-i-n-k-l-e-r. I have to say this is very nerve-racking. [LB610]

SENATOR GAY: Take your time. [LB610]

CAREY WINKLER: I was here last year to testify about the cuts being made to Medicaid and how they would affect my child. I spoke about how Medicaid has positively affected our lives, the respite and being able to get diapers paid for has been just phenomenal. We've been able to start paying back medical bills and credit cards that accrued with all the things that we had to pay for, for our son. I also discussed the concerns that I had of Department of HHS's going forward with charging families on the waiver premiums. I have been in contact with DHHS for the past year and a half, with another parent and I trying to engage in this conversation about the concerns we had about charging waiver family premiums. These are children who are very significantly disabled, who would require a nursing home level of care if we could not care for them ourselves. Our basic concerns were we feel that there's been no economic impact done on how premiums would affect the families that this would have an effect on. I feel the premiums are rather high going up to 5 percent of your gross annual income. I don't know how many people can afford that. It's very difficult to come by when your day-to-day living is very difficult, and the additional expenses that you incur besides what Medicaid and your health insurance pay for. We already do pay for private health insurance premiums. We are moving our way up on the caps with that. So for us as a family, Medicaid provides a safety net for us more than anything. I mean, we don't abuse the system. He sees six specialists. I can tell you, I'm really not wanting to see anymore of them than I have to. I'm good. My concerns are that, also that Mrs. Bartlett had, about what if one month you can't afford to pay the premium or two or three months you can't afford to pay the premium? What's the process in place, you know, for you to get recertified, if you will, for your child to obtain Medicaid services if you can begin to start affording them again?

These are difficult times for families and it's a very difficult thing to talk about. It's affecting my life directly and our day-to-day lives. I can say probably the first thing to go in our house is going to be...we're going to have to pull our kids out of Catholic school. We'd had them in Catholic school since before Grant was born, and it's just a luxury we're not going to be able to have anymore. It's going to pull them away from their friends and it's not something that I would feel good about doing. But it's very difficult to make decisions in your household that you already have to make day-to-day because your child requires such significant care and so many sacrifices of every family member. I mean, we all have to sit there and watch helplessly when he has a seizure, and you can do nothing about it until it's over and just hope he doesn't quit breathing again. It's a very difficult life to live. Some of the correspondence that I received back from HHS talked about how the need to balance the access to care, personal responsibility, and fiscal sustainability. I was slightly offended at "personal responsibility." I think all I've done is have personal responsibility for my child. I've lived my entire life and we've never asked for things that we didn't truly need. It's part of our Midwestern values here that you take care of your own and, if you can't, at the last resort you ask for help. And I'm so thankful that the waiver program was there for us. Respite was direly needed. I talked about, last year, how my husband said that I was actually fun again, you know, going to a football game. I went to...we actually were able to leave Grant with a provider two nights overnight, and that was the strangest thing ever. I was constantly, where's Grant, where did he go, where...oh, he's not even here. I can breathe. I just...to breathe and not have to panic and, you know, wondering where...you know, if he's wandered off or, you know, has somebody got his arm...is, you know...are any of those things going on. I also...I guess that's probably it for me. I just...I definitely support this bill. I feel it's the more comprehensive for the people that need this. I don't think that we abuse the system. I think, too, when you have the cuts and caps made, most of the people you hear from are the disabled community, because I think the rest of the population who access Medicaid understand that those are limitations that are reasonable. So does anyone have any questions for me? [LB610]

SENATOR GAY: Okay. Thank you very much. Any questions? Senator Stuthman. [LB610]

SENATOR STUTHMAN: Thank you, Senator Gay. Carey, first of all I want to thank you for coming and testifying, and in your testimony I want to thank you for it seems to me that you're trying everything possible for your child. [LB610]

CAREY WINKLER: Absolutely. [LB610]

SENATOR STUTHMAN: And I really respect you for that. And if there is any way that we can help you, you know, we surely will try, but we are in about the same situation as you are, you know. We only have so many dollars to work with so...but I really truly thank you and respect you for the fact that you're making every effort possible to give

assistance to your child. So thank you. [LB610]

CAREY WINKLER: Thank you. [LB610]

SENATOR GAY: I'm sure that would go for everybody on this committee, as well, so thank you. Any other questions? [LB610]

SENATOR CAMPBELL: You did a great job. [LB610]

SENATOR GAY: Great job. [LB610]

SENATOR STUTHMAN: Thank you. [LB610]

SENATOR GAY: All right. Thank you very much for coming today. [LB610]

CAREY WINKLER: Thank you. [LB610]

SENATOR GAY: Other proponents who would like to speak? It looks like it's it. Any opponents who would like to speak? Vivianne, I think you (inaudible) ignore the light for a minute. I don't want to rush you, but do whatever you've got to do, but. [LB610]

VIVIANNE CHAUMONT: (Exhibit 8) Okay, and I hope there's questions afterwards because there is some information that isn't quite accurate that was presented. Good afternoon, Senator Gay and members of the Health and Human Services Committee. My name is Vivianne Chaumont, V-i-v-i-a-n-n-e, last name C-h-a-u-m-o-n-t, and I'm the director in the Division of Medicaid and Long-Term Care in the Department of Health and Human Services. I'm here to testify in opposition to LB610. LB610 instructs the department to establish an exception process for Medicaid caps and service limitations for clients with disabilities or those with chronic conditions who use habilitative and rehabilitative services. The legislation outlines the exception process, includes a provision that individuals receiving an exception are not subject to pay premiums in order to participate in Medicaid. LB610 directs the department to disregard income up to 500 percent of the federal poverty level in determining the premium amount to be paid by families whose children are on the Katie Beckett program or any home and community-based service waiver that's determined without regard to any parental income. It also requires that HCBS waiver services be available at the same or greater level as institutional services. The proposed legislation includes individuals with disabilities, but the term "disabilities" is not defined. The language in this legislation is very broad. It could apply to clients with developmental disabilities who receive habilitation and rehabilitation services. It could also apply to persons with behavioral health needs who receive rehabilitation services and others with physical disabilities who receive rehabilitation services. Lastly, the bill includes anyone with a chronic condition. A chronic condition can be anything from diabetes to poor eyesight. All of

these populations appear to be included in the exception process to the cap and service limitations proposed by LB610. A second issue is that the bill speaks generally to limitations or caps on services. There is no definition. This can apply to the recent benefit limits on dental and therapies that we've heard some people talk about. It can equally apply to current units on home health, prior authorization requirements and units on home and community-based services to maintain compliance with federal law. LB610 also outlines that the exception decision process be completed within ten business days of receipt of request, and if not acted upon within this period, services are deemed approved. This requirement forces Medicaid to pay for services which may not be consistent with Medicaid requirements and puts the program at risk for loss of federal financial participation, which as you all know is 60 percent of the program. The scope and exception process, as currently provided in this bill, could cost the state up to $210 million. Along these same lines, federal Medicaid law requires the states to offer comparability of services to all recipients. Exceptions to limitations cannot generally be tied to specific population groups. LB610 requires state plan services to be provided for special groups of Medicaid recipients--persons with disabilities--above and beyond the level that other Medicaid recipients would be eligible to receive. Pursuant to direction received from federal officials, this targeted exception process is not allowable. That means any services that would be paid for under these exceptions would not be eligible for federal financial participation. Another premise of this legislation is in opposition to Medicaid reform goals of achieving cost containment and promoting personal responsibility on the part of Medicaid recipients. You have to remember that that's the language in the statute and that's the language in the Medicaid Reform Council, that's the language in all of the reports. One recommendation of the Medicaid reform plan--it came through the Medicaid Reform Council--is a premium buy-in program for children with disabilities whose family incomes exceed 185 percent of the federal poverty level or FPL. Actually, the report says 150 and we raised it to 185. This premium is scheduled to be implemented in state fiscal year 2011, and is projected to reduce general fund Medicaid expenditures by over $400,000. The bill proposes no premiums until family is at 500 of FPL. The FPL for a family of four is $110,250. When you factor in disregards, the family's gross income to be eligible for Medicaid can be substantially higher than that. The principles of Medicaid reform can be reasonably implemented at the lower FPL than that proposed in the bill, at 185 percent of the federal poverty limit. In addition. LB482, passed by the Nebraska Legislature in 2007, directs the department to establish requirements for premium payments for children receiving services under the autism waiver, which would be one of the waivers impacted by this bill's language. LB610 does not comply with federal requirements that home and community-based services waivers demonstrate cost-neutrality in comparison with institutional care. The proposed legislation states that HCBS services--that's community services--shall be available at the same or greater level as would be available in institutions. This language indicates that the cost of such waiver services may exceed that of institutional costs. This provision is not approvable by CMS in any of the home and community-based services waiver, and again would jeopardize federal funding. As written, administrative work to

establish and conduct a review process for the exception request could not be absorbed by existing department staff and would require additional resources. If exceptions are granted, Medicaid expenditures would increase to cover the additional services. Those Medicaid expenditures are probably not going to be eligible for federal financial participation. Even when exceptions are not granted, service expenditures will increase while the exception determinations are pending. Further, LB610 has an emergency clause. If it is passed into law, the requirements of the bill would need to be implemented immediately. This would simply not be logistically feasible. For the reasons outlined here, the Department of Health and Human Services opposes LB610. I would be happy to answer any questions. [LB610]

SENATOR GAY: Thank you. Senator Stuthman. [LB610]

SENATOR STUTHMAN: Thank you, Senator Gay. Thank you, Director Chaumont, for testifying. And you were here when we had the proponents testifying on the bill, and in your testimony it seems like a lot of the things are not workable and the cost is going to be excessive. Is there anything in the current program that we have now that we could address the needs of some of these individuals that testified as far as a waiver program or anything? You may have to take each individual case. [LB610]

VIVIANNE CHAUMONT: Okay. Generally, Medicaid doesn't look at individual cases. Medicaid looks at classes of people. You cover this category of people; you cover this category of people; you cover this category of people. If you're going to cover those categories, then all of those people have to get these mandatory services and then they all have to get these optional services that the state can opt, like dental would be an optional services. Drugs is an optional service. Home and community-based services are optional services. But once you say we have these people and these services, you have to give all of those people all of those services except for the waiver services. In the waiver services, the benefits that we're talking about here are state plan services and not waiver services. There would be a way that you could say that those waiver services would...those additional services would be added to a waiver and then they would...they...you know, then you can limit it to a certain group of people. But let me caution you that the waiver is the thing that has to be cost-neutral. So if you add services and then you start looking at what...that you're going to have to count against that individual in whether their services are more or less expensive in the community, adding those services to certain plans could actually push people that we are currently paying for in the community where it's cheaper for us to pay for them in the community, into an institution. So, you know, I wish there were easy answers to these things but that's not the way the program is set up. [LB610]

SENATOR STUTHMAN: Okay. Thank you. [LB610]

SENATOR GAY: Senator Pankonin. [LB610]

SENATOR PANKONIN: Thank you, Senator Gay. Director Chaumont, just to follow through on that comment you just made, but doesn't that dilemma cut both ways in that? Sometimes, if we could serve people in the community, they stay out of institutional care which saves money. So how do we work that dilemma? [LB610]

VIVIANNE CHAUMONT: And I think that's an interesting...I'm glad you asked that question because I don't agree with the statements that not having these services are going to push people into an institution where they can get these services. You can't get vision services in an institution. You can't get dental services. You can't get...you just...you...that's not the way that that works. Therapy is the only ones that you would be able to get in an institution. I also want to say that we're only talking the limit that went into effect July 1, '08, which was debated by the Legislature last year, was for outpatient therapy. So the idea that someone is involved in a car accident, sustains a brain injury, they don't just get the 60 days of therapy. They're in a rehab hospital getting...if they need to be in that rehab hospital, if it's medically necessary for them to be in that rehab hospital and they are showing improvement, they can stay there for two months, six months, however long that's necessary. Those services don't count towards this outpatient therapy. [LB610]

SENATOR PANKONIN: Thank you. [LB610]

SENATOR GAY: Any other questions? Senator Wallman. [LB610]

SENATOR WALLMAN: Thank you, Chairman Gay. Thank you, Director. How long does it take for the average person, just say to get on this? I went through this with...the brain injury thing with a child. So it was quite a deal to get on this program. He was over 21. [LB610]

VIVIANNE CHAUMONT: On home and community-based services? [LB610]

SENATOR WALLMAN: Yes. [LB610]

VIVIANNE CHAUMONT: It... [LB610]

SENATOR WALLMAN: No, I mean on rehab; you know, rehab services. [LB610]

VIVIANNE CHAUMONT: Oh, on rehab services for...under the waiver? [LB610]

SENATOR WALLMAN: Yes. [LB610]

VIVIANNE CHAUMONT: Yes, it is. That's a fairly new waiver and it's a pretty restrictive waiver. One provider. You're right. [LB610]

SENATOR WALLMAN: And how many... [LB610]

VIVIANNE CHAUMONT: And that's just for a brain injury trauma. [LB610]

SENATOR WALLMAN: How many do we have on that number, do you know, roughly? [LB610]

VIVIANNE CHAUMONT: I don't. I'd have to get that information for you. The problem with that is we only have one provider in that. [LB610]

SENATOR WALLMAN: Thank you. [LB610]

SENATOR GAY: Senator Gloor. [LB610]

SENATOR GLOOR: Thank you, Mr. Chairman. Director Chaumont, I also was a little surprised at the total dollars in the fiscal note. It struck me as high. And then I read your comment that the bill includes anyone with chronic condition. A chronic condition can be anything from diabetes to poor eyesight. Would it be your expectation that some of the reason for that is that it's been folded into the fiscal note when you were sought for your input? [LB610]

VIVIANNE CHAUMONT: Yes. Yes, that is part of it. And I'm sorry; I litigated Medicaid eligibility cases for 20 years and I know that if you have a statute that gives any room for movement, that's where people go. So that's part of it. There, as well as the fact that it just talks about limits and it doesn't...you know, it would be one thing if it was talking about the six, which in a way seems that, from listening to the testimony and from listening to Senator Mello, that he's talking about the limits that we put on the six benefits last year. But that's not what the bill says. The bill says no caps and no limitations. Limitations. A limitation on service...you can have limitations on mandatory services, by the way. Everybody thinks that you can only limit optional services. That's not true. There are states that limit a person to ten doctor visits a year. There are states that limit inpatient hospitalization days. So you can limit a mandatory service. But what people don't realize is just about every service that Medicaid offers has some kind of limitation: what the feds consider limitation, what we consider limitation, what would be there. One limitation would be that the service has to be prior-authorized. That's a limitation on the service. So that's...that, if you took away all of prior authorization, then...and expanded it to anybody with a chronic condition, any service, you could get up to $210 million easily. [LB610]

SENATOR GLOOR: Well, a follow-up question to that would be that we know when we enter into things as complicated as Medicare reform, we are not going to make a perfect bull's eye the first time. And we're hearing testimony today here of some of the ways

that what we enter into with the best of hopes misses the mark in some occasions. I know you're creative...I know your department is creative. (Laughter) [LB610]

VIVIANNE CHAUMONT: Thank you, Senator. (Laugh) [LB610]

SENATOR GLOOR: But would you say that with some of your knowledge and background there would be opportunities to sit down and work on this bill to, in fact, help us clean it up in ways that could make a difference to some of the people seeking services, and appropriately so? [LB610]

VIVIANNE CHAUMONT: Um, I think, of course I could work on the bill to make it more...but...to make it less likely to cost $210 million. But here's... [LB610]

SENATOR GLOOR: That's a start. [LB610]

VIVIANNE CHAUMONT: As a start. Yeah, that would be one place to start. But here's the philosophical thing that you all are going to have to deal with. We were told through the Medicaid reform process, through public hearings, through all of that--and Senator Campbell was there--that we needed to make this a more fiscally sustainable program. One of the goals of the Medicaid Reform Council in the initial report was to make the Medicaid benefit more like that benefit in private health, vision, and dental. Okay, so we did that. We did...and another of their recommendations was to make it more like health insurance and put in financial responsibility by adding premiums to families whose children are on Medicaid without regard to parental income. Anybody could be on this program. So you're going to have to look at that. I mean, what...you cannot...I'm sorry, there's no way to cut benefits without hurting somebody. There's just no way. Medicaid doesn't pay for any benefits that are not medically necessary. So when we put those limits, we knew we would be taking away benefits that somebody thought was medically necessary. That was the instruction that we got. That was one way to make the program more financially fiscally sustainable, and the percentage of the people that it affects is very, very small. And not all people with disabilities are affected by it. So do you open it back up and say no limits for anybody, you know? You can do that. [LB610]

SENATOR GLOOR: That... [LB610]

SENATOR GAY: Go ahead, Senator. One more. [LB610]

SENATOR GLOOR: I think, though, my question is one of recognizing--and the committee is finding out, unfortunately, that I'm a big one for metaphors and analogies--but we're talking about making cuts in a program, clearly, but trying to do so with a degree of surgical precision as opposed to concerns of coming in and doing this was a handsaw. And therein lies my question: Are there ways that we can be a little more surgically precise with some of what the program currently seems to do, which

may not be as surgically precise as we would like it to be? [LB610]

VIVIANNE CHAUMONT: I personally don't believe that there's any way to make a cut that's not going to affect somebody's healthcare. [LB610]

SENATOR GLOOR: I disagree...I mean I agree. I agree with that. But...but we can do so, I would hope, maybe with a greater degree of recognition that there are ways that those cuts can be looked at and there are ways that we can make definitions, determinations, or eligibility requirements that might take in more people who really do have legitimate needs. [LB610]

SENATOR GAY: And that will be Senator Gloor's challenge into the future. [LB610]

VIVIANNE CHAUMONT: Yeah. (Laugh) Send me an e-mail. [LB610]

SENATOR GAY: Anyway, let's...I'm going to get to Dave and then you. Senator Pankonin has been waiting. A question? [LB610]

SENATOR PANKONIN: Thank you, Senator Gay. Director Chaumont, if I recall correctly from a year ago, there was some analysis done about our program versus the neighboring states and where we stood with the proposed changes at that time with neighboring states. Do you still have that information or can you...is that very difficult to obtain for the committee? [LB610]

VIVIANNE CHAUMONT: Not at all. I'd be happy to provide that to you again. I can tell you that probably about half the states have no adult dental benefit program. Large... [LB610]

SENATOR PANKONIN: None at all? [LB610]

VIVIANNE CHAUMONT: None. Well, I'm sorry, they do pay for emergency or for if someone has an infection or something like that. But just to take care of that, and that's it. A lot of states don't have vision...I mean, I know Colorado doesn't have an adult dental, Colorado doesn't have an adult vision program. Colorado doesn't have adult hearing aids. There's...I mean, I happen to remember that one, that particular state. But there are other states. There are states that do not offer physical therapy. There are states that do not offer occupational therapy. There are states that do not offer speech therapy. There are states that do not offer chiropractic services. [LB610]

SENATOR GAY: Well, we'll look forward to the list. [LB610]

SENATOR PANKONIN: I think, especially the neighboring states, would be helpful for the committee to... [LB610]

VIVIANNE CHAUMONT: I could get that to you again. Now I have to warn you that that data is from 2006, and I know some states have added some things and I know that right now there are a lot of states subtracting things, so. [LB610]

SENATOR GAY: So, okay, we'll keep that in mind. All right. [LB610]

SENATOR PANKONIN: Thank you. [LB610]

SENATOR GAY: Senator Howard. [LB610]

SENATOR HOWARD: Thank you, Mr. Chairman. I really like the direction that Senator Gloor is going and the thinking that he's doing here on this. And I agree with him and you certainly are a creative individual; we've all found that to be true. I...my question to you would be, are you willing to sit down with Senator Mello and look at what issues would be...how do I put this? My direction is really in prevention. If we have a situation whereby doing one thing prevents something from going into a further bad situation that's going to ultimately cost us more, I would really encourage you to look at that. And I can think dental situations are a good example of that. But my question to you is would you be willing to do that? I think all of our cuts, all of our adjustments are always a work in progress. We always learn by what's done. And everything we do here, I've learned, is certainly a work in progress too. So again, would you be willing to... [LB610]

VIVIANNE CHAUMONT: I am always willing to sit down with anybody to talk about just about anything. I would be happy to do that. The one other thing that I would say is these benefit limits went into effect July 1. We've had six months. It would be nice to see some data about what things...you know, you can have conversations about, you know, we stopped paying for this so now emergency room services have doubled. In fact, they haven't. In fact, emergency room services have decreased. So, you know, there's a lot of ways where data can be helpful and where we then are making public policy based on data as opposed to anecdote. But I would be happy to sit down with Senator Mello or anybody else. [LB610]

SENATOR HOWARD: Well, I'm sure Senator Mello would appreciate that opportunity. [LB610]

SENATOR GAY: All right. Any other questions? I don't see any. Thank you, Director. [LB610]

VIVIANNE CHAUMONT: Thank you. [LB610]

SENATOR GAY: Any neutral testimony on this? I don't see any. Is there...are you neutral back there? [LB610]

TIM PICKREL: Yes. [LB610]

SENATOR GAY: Come on up. [LB610]

TIM PICKREL: My name is Tim Pickrel, P-i-c-k-r-e-l. And I don't know whether any of you remember me from the '90s. Back in '92, if you (inaudible), they had, in place, a plan to cut Medicaid completely. And I testified on behalf of myself and a lot of other people that...I am a consumer. I am on medications. I have been in all the institutions you can name, but. I came and I talked about it and I talked about the cost-effectiveness of it; what was more costly, to help pay for the medications or allow them to go back to the regional center because there's no way they can pay. There's a lot of good things in LB610 but there's a few things that concern me. Will the disabled person receive a letter on time so that they can get the waiver that you speak about? And is it a yearly thing that you have to get your psychiatrist to write that you are still disabled and you still need help once we reach that cap? And two, paying for premiums and other things to Medicaid, would that not be income considered by the federal government and a cut in funds from the federal government? I have right here that the Senate cleared the economic stimulus package plan, and NAMI is urging these parts to the House and send them to bills. I would think if you all could contact your constituents also, he's asking...they're asking for $87 billion in additional federal Medicaid matching funds over the next 27 months and a three-month extension of the current legislative moratorium on Medicaid regulations, including those for case management and rehabilitation services. I am with the Lancaster Mental Health Center. I have a counselor. I have a doctor. It makes me wonder who decides when a person has received enough services if they're mentally ill. With these new medications, I see a miracle compared to the Haldols and Thorazines of the past days, which people were just shuffling around. These new medications actually help a lot of people. But just because they look well does not mean they're well enough to go back to work. Some of them need just that point where their symptoms are manageable. And filing for exemptions, waivers. How much is this going to cost in addition to the ten people that are supposed to be on a committee? And is anybody on that committee getting paid? Or who's going to oversee them and how can they, if they're not a psychiatrist nor are they involved in any kind of a psychiatric understanding, how can they make decisions on whether I've received enough care so I no longer need Medicaid? And I really wasn't so prepared; I was just jotting down things and, forgive my embarrassment right now, but that's pretty much all I needed to say. [LB610]

SENATOR GAY: No problem. Any questions? I don't see any. Thank you. [LB610]

TIM PICKREL: Thank you. [LB610]

SENATOR GAY: All right. Anyone else neutral who would like to talk? Senator Mello,

you want to close? [LB610]

SENATOR MELLO: I'd like to thank the members of the committee for hearing the testimony of proponents, opponents, and neutral. I believe that all good policy, usually there's good compromises that come along the way. And I'd like to particularly thank Senator Gloor for expressing that viewpoint that this is not going to be easy, and to some extent I'd also like to thank Director Chaumont for extending the hand to work on this issue because, as you heard from proponents today, there are people who need services. There are people who need help and feel right now that, with the current policy in place, that they are not going to receive the services and help that they need. And with that, I look forward to working with the committee of trying to find a compromise that we can help extend services to those individuals who will so desperately need them under the current caps and limitations, as well as of Director Chaumont of trying to find ways to contain costs in a responsible way. So thank you. [LB610]

SENATOR GAY: Thank you, Senator Mello. There were a lot of good...just hold on one minute. There might be questions for you. Hold on. A lot of good. It was very good today. A lot of good input and there's a lot of...I think we all learned quite a bit of things. But if anybody can be of any assistance to you, I know Director Chaumont always will, and any of these members as well. So we appreciate you... [LB610]

SENATOR GLOOR: You volunteered me, I believe. [LB610]

SENATOR GAY: Yeah, Senator Gloor, and think Senator Campbell is probably going to be helping on this too, so. But anyway, let's see if...is there any questions for Senator Mello? [LB610]

SENATOR PANKONIN: I just have one, Senator Gay. [LB610]

SENATOR GAY: Senator Pankonin has one. You bet. [LB610]

SENATOR PANKONIN: Senator Mello, I just...we'll make sure you get that material, too, about what other states are doing. I think it is somewhat helpful to put things in perspective and where we stand. So I think they're making some copies of that but we'll make sure, if you get with Jeff here in the next couple days we'll get you that material. I think it might be helpful to you. [LB610]

SENATOR MELLO: We appreciate that, Senator. Thank you. [LB610]

SENATOR GAY: Along with that, Senator Pankonin, we'll include the department's response, too, because there's some information in here you'll probably find useful, as well, so. [LB610]

SENATOR MELLO: That would be great. Thank you. [LB610]

SENATOR GAY: Any other questions? I don't see any. Thank you. [LB610]

SENATOR MELLO: Thank you. [LB610]

SENATOR GAY: Let's take about a five minute break and then we will move on to LB541. [LB610]

BREAK []

SENATOR GAY: LB541. Thank you, Senator Campbell. Go ahead. [LB541]

SENATOR CAMPBELL: Thank you, Chairman Gay and members of the committee. LB541 is the Medicaid dental waiver. And in this situation, for the committee members, we are going to go from the broad population that we saw in Senator Mello's bill, all the way down to a specific category, and that is in dental. The dental cap was set on at $1,000, and we did review that, as we reviewed them all in the Medicaid Reform Council, so that we would have knowledge of these. But in the course of since July, the members of the Dental Association came to me and said there are some problems with that $1,000 cap. It may work, in most cases, very well, but in some cases we're having difficulty. And I felt that it was of value to bring, certainly to this committee, to look at. I did just a quick call to BryanLGH because while I understand Director Chaumont's indication that the emergency costs may not have gone up, I wanted to know how many dental cases were coming in to an emergency ward. So I called BryanLGH, and from July 1, '08, to November 30, there were 102. And if you annualize that over, there would be about 245, which very much surprised me. I mean, I knew that if you were in pain or discomfort, that most likely that's where people would go. But I was somewhat surprised at the high number because I thought it might be lower. LB541 isn't a request for an increase in dental rates; only that the cap be removed in specific situations in order to save money and provide a reasonable level of care for our adult Medicaid population. This bill is strategic in its approach. Rather than eliminate all caps, the bill removes the cap in situations where it would be more costly to have the cap in place--and we're going to try to illustrate that for you--where the benefit of treatment outweighs the increased cost of care to the patient and to the state. And I believe that's both what Senator Gloor and Senator Pankonin were trying to ask: At what point do we look at that? There are five categories, and you can see the descriptions in the bill so I'm not going to read all that: a pregnant recipient; certain dental conditions where there is an abscessed tooth, for instance, that can worsen; basic dental standards of care require that some work has to be provided in a certain order, and I think that we'll hear that; where trauma occurs to the front teeth or mouth; and finally, for a first-time eligible. And we may have to work with the director in terms of that definition, and, in fact, I'm going to waive closing right now but say that we certainly would be willing to work. But the

first-time recipient, if we could get them taken care of, that's a cost-effective measure. [LB541]

SENATOR GAY: All right. Thank you Senator Campbell. Very good opening and I like your idea. This is a very specific to dental services, so I'd remind everyone if we can keep it specific to dental services because we just spent two hours on the other bill and I think that was very well covered. And so that would help everybody. And you've got some people coming... [LB541]

SENATOR CAMPBELL: Yes. [LB541]

SENATOR GAY: We will go right to them if that's okay with you... [LB541]

SENATOR CAMPBELL: That's perfectly fine. [LB541]

SENATOR GAY: ...and we know where to locate you with other questions. [LB541]

SENATOR CAMPBELL: They are the experts. [LB541]

SENATOR GAY: Okay. Thank you, Senator Campbell. [LB541]

SENATOR CAMPBELL: Thank you, Senator Gay. [LB541]

SENATOR GAY: Proponents. [LB541]

DAVID O'DOHERTY: (Exhibit 1) Good afternoon. My name is David O'Doherty. I'm the executive director of the Nebraska Dental Association. Senator Gay, members of the committee, thank you for allowing me to speak. [LB541]

SENATOR GAY: You want to spell that out, David? [LB541]

DAVID O'DOHERTY: O'D-o-h-e-r-t-y. I would like to thank Senator Campbell for bringing LB541 and for her support in improving the Nebraska Medicaid system. As you've heard, adult Medicaid services are an optional service; however, states like Nebraska agree to provide dental coverage because it saves money. When providers give dental care, there are fewer problems presented in the form of medical needs. The recent Draft Medicaid Alternative Benefit Structure Recommendations that came out last October, otherwise known as the Mercer report, indicates that the trend in state Medicaid dental programs across the nation is to increase access to dental services. By increasing access and actually increasing reimbursement fees, these states have seen an increase in providers, ranging from 62 to 112 percent, and an increase in utilization from 38 to 76 percent on the dental side. We are only here to ask for some sanity in the system and for the ability to actually save the state money and to be fiscally

responsible. An increase in utilization for dental care is a good thing, not because of the money spent just during that visit, but because there are great cost savings by keeping individuals out of emergency rooms and operating rooms. Preventative dental care saves money, and any dentist will verify that. This bill does not attempt to repeal the entire Medicaid cap and it does not expand dental services. We understand the need for cost saving in the Medicaid program. This past week, Dr. Marse McCann in Minden, called me and asked, is the $1,000 cap still in palace? And I said, yes, it is. And she said...she described a specific patient she had to take to the hospital that would have exceeded the $1,000 cap. I asked her to document that case, and so explaining it to this committee as a specific example that will fit into one of those five categories. In one of these five categories, the cost of dental treatment would exceed the dental cap on the front end, but on the back end the entire Medicaid system will save money. Under LB541, the dental issue could be addressed in a dental office instead of ending up in an emergency room, because these folks are ending up, as you've heard or you will hear, in physicians' offices and medical emergency rooms. We believe that the fiscal note is misleading. It only indicates that there would be a cost to providing this care, and we would absolutely agree. However, there are two issues that we would take issue with on the fiscal note. The fiscal note does not provide for any cost to savings for being efficient in keeping people out of the emergency rooms, and in that sense there would be a cost savings. When they came up with the $1,000 cap, they did the study on fiscal year 2007 of adult Medicaid patients. The average annual cost for all adults, even those exceeding the $1,000 cap, equaled $384. Only 10 percent of the adult Medicaid population was exceeding the $1,000 cap, and their average annual expenditure was $1,500. As stated on page 34 of the Mercer report, "Literature review suggests evidence of increased dental compliance results in medical savings for other services as poor oral health affects general health. For instance, periodontal (gum) disease is associated with preterm delivery and/or low birth weight...vascular disease, diabetes.... Preventative measures can help minimize the impact of future morbidity." The Fiscal Office also suggests that there would be an increase of nearly $6 million of additional costs that were incurred before the cap was in place. We would dispute this number, that the entire dental Medicaid expenditure is only $11 million. That would result in a 50 percent increase in costs for removing the cap, which is unlikely. In conclusion, we understand the importance of cost savings to the state, particularly in these economic times. That is why we support LB541, as it would go a long way to bringing sanity and cost savings to the adult Medicaid system in Nebraska. I have some medical studies that support our testimony today, and if there are any concerns with the five specific areas listed in LB541 that are too broad, we would be happy to work this committee to modify the language. Thank you and I'd be happy to answer any questions. [LB541]

SENATOR GAY: Thank you. Senator Stuthman. [LB541]

SENATOR STUTHMAN: Thank you, Senator Gay. Dr. O'Doherty, are you very... [LB541]

DAVID O'DOHERTY: I wish. [LB541]

SENATOR STUTHMAN: Pardon? [LB541]

DAVID O'DOHERTY: I'm sorry. I'm not a dentist. I'm an attorney. [LB541]

SENATOR STUTHMAN: Oh, an attorney. (Laughter) Well then I will just call you David. [LB541]

DAVID O'DOHERTY: Let's be nice. [LB541]

SENATOR STUTHMAN: The situation that you're talking about, this...the one that you brought the testimony along, and you've got the individual that's 25 years old and a handicapped patient. This handicapped patient would have been on Medicaid... [LB541]

DAVID O'DOHERTY: Medicaid, um-hum. [LB541]

SENATOR STUTHMAN: ...Medicaid prior to that, that situation. [LB541]

DAVID O'DOHERTY: They are on Medicaid now. [LB541]

SENATOR STUTHMAN: They would have been on Medicaid for many years before that, right? [LB541]

DAVID O'DOHERTY: Probably. [LB541]

SENATOR STUTHMAN: Why wasn't this--and maybe you can't answer this--why wasn't this dental thing addressed five years ago instead of waiting till this time and then there was...it says there was multiple cavities and everything like that. Why wouldn't that have been addressed when the child would have been 17, 18 years old, just a regular dental deal that, you know, it would have been covered under that $1,000? [LB541]

DAVID O'DOHERTY: If Medicaid patients were seeing dentists annually or semiannually, it would have, but often they're not. I don't know the history of this particular patient. But it probably...like a lot of people, unfortunately, avoid the dentist until they really feel pain, and by the time you feel pain then there's something serious going on. And I'm guessing that's probably what happened to this individual. [LB541]

SENATOR STUTHMAN: I just...it could have been prevented, in my opinion. [LB541]

DAVID O'DOHERTY: It all can be prevented. [LB541]

SENATOR STUTHMAN: If addressed... [LB541]

DAVID O'DOHERTY: Early. [LB541]

SENATOR STUTHMAN: ...at an earlier time. [LB541]

DAVID O'DOHERTY: Right. Exactly. [LB541]

SENATOR STUTHMAN: And we're running up against their time here where, yes, it costs more than $1,000, and then we're trying to figure out ways... [LB541]

DAVID O'DOHERTY: Education is very key. [LB541]

SENATOR STUTHMAN: ...to get around that so that we can accomplish what needs to get done. [LB541]

DAVID O'DOHERTY: Correct. [LB541]

SENATOR STUTHMAN: Okay, thank you. [LB541]

SENATOR GAY: How many...any other questions? I don't see any. Thank you, David. [LB541]

DAVID O'DOHERTY: Thank you. [LB541]

SENATOR GAY: (Exhibits 7 and 8) How many proponents are going to be speaking on this? Okay, about five or six. We've also got three letters we'll read--if you're a proponent, come on up--letters of support from the National Association of Social Workers-Nebraska Chapter, the Iowa/Nebraska Primary Care Association, and Dr. Marse McCann from McCann-Carpenter Dental Clinic have all got letters in. And then is there any...how many opposition on this bill? One. So we can see amongst ourselves there's a lot of support for this bill, so if we could not be repetitive again, it's very helpful to everybody, I think, and we'll get through the day. Thank you. [LB541]

LARRY BAKER: (Exhibit 2) Hi. I'm Dr. Larry Baker. I came in from Hastings where I practice oral and facial surgery, so. I'm speaking in support of LB541. I just want to give you a little bit of my background. I grew up in Nebraska, went to college in the university system. Got a bachelor's degree from here in Lincoln, also a dental degree. Subsequently, in order to pursue an oral surgery option, I went up to Rochester, Minnesota, where I received a medical degree. I did a one-year internship in general surgery and then did my residency in oral and facial surgery. It's kind of a...spent six or seven years up there. I was glad to be back. It was awful cold. Those of you that are outside of medicine and dentistry may not really know what an oral surgeon does and

I'm going to kind of give you a brief synopsis. Basically, an oral surgeon, one of the main things that an oral surgeon does is receives referrals from both physicians and dentists for taking out teeth. They also take care of certain facial trauma; do kind of head and neck cancer reconstruction, in some cases; take care of big head and neck infections is kind of what I'll get into later; also treat some facial deformities like cleft lip and cleft palate. Kind of gives you kind of a brief synopsis of kind of some of the things that I do in my practice. When it comes to financial reimbursement for my services, it can either go the dental route or the medical route. Most of the stuff that I do actually will go medically, but things such as taking out teeth obviously will go dentally. An example of this is, to get to that, is whether it goes medically or dentally really depends not only on the diagnosis but also on the procedure that we do, and I'm going to give you an example of that. I have--and this is a very common thing that I see in my practice--either I'll see a patient that's referred in, from a physician or a dentist, that's got neck swelling. Generally, patients that have neck swelling, not all the time but most of the time that swelling is secondary to an infected tooth or infected teeth. Some people it's a lot of teeth, and some people it's a single tooth. But the route that that patient goes, basically, is that patient is taken to the operating room--they're put in the hospital--taken to the operating room, where we go in and drain the neck abscess, open it up, drain it, and then we also take out the teeth that are involved. The key point to this is that the cause of that neck abscess is the infected tooth or teeth. Now the way the reimbursement issue works, all the hospital charges and also the incision and drainage charge to go into the neck, that all goes medically, even though the primary cause is from the infected tooth; where the infected tooth, if I go in and take that out or several of them out, that's billed through the dental route. Okay? So some of it goes medical, some of it goes dental. The highest cost portion goes medical in those cases, by far, by the time you figure in the hospital cost and all the IV antibiotic therapy, nursing care, everything. So that's kind of the key point I want to make on that issue. I'm going to give you a few examples of just some people that I see, and this is very common. You know, one...again I explained the neck abscess. Another would be...and these are people that I've seen in my practice, different patient scenarios. It is somewhat of a generalization for synopsis reasons, but in general they're pretty much true stories of people that I've seen in the last couple of years, all these patients. One is an elderly gentleman. The patient came in, was admitted into the hospital by his internist. Multiple medical issues, including diabetes. The basic point of why he was admitted, because his blood sugars were just all over the place. They were trying to get that under control. During his hospital stay, the internist came in, looked at him. He just had a lot of redness and swelling in the neck; a lot of redness and swelling. The doctor ordered a bunch of tests. One was a CT scan which showed a neck abscess. The other was something called a blood culture which actually tests to see if you have bacteria in your bloodstream. He had tons of bacteria in his bloodstream. It was all over the place. So at this point it wasn't only the problem with the neck, and in his case it was caused by the teeth, it got into the bloodstream. I went in, in the middle of the night, and drained this patient; drained the neck. Took out a couple of teeth on this gentleman, again which would fall

under the dental cap even though it's the primary cause. That patient expired about two days later. We never...that patient never recovered from that. And that is probably more the extreme example but it happens, and if you're an oral surgeon it will happen to you over your lifetime, probably several times. Second patient, a very common thing that I see, long-term care patients. I see a lot of Alzheimer's patients; a lot of Alzheimer's patients. One of the reasons is, is that there really...in a dental setting, they really...you really can't send them to the dental office to have their teeth checked. It's just about impossible, especially the ones that are very far advanced. The second reason is, because you can't do any oral care on these people, so these people sit in the care facility; they don't get any oral care. They won't do it, they won't let anybody else do it, and they get in trouble. This particular patient that I'm going to explain right now, basically, typical scenario. The nursing care facility noticed she got...she ended up, over a few days, going into a few weeks, was very agitated. She wouldn't eat; maybe intermittently. And then her face swelled up. They called the doctor. The doctor looked at her; noticed she had a bunch of just really poor infected teeth and that was probably the source of the infection, and in this case it was. Standard deal, send her to me. We treat the infection. Take the patient to the operating room and take out whatever teeth need to be taken out. Sometimes it's all the teeth, sometimes it's a few of the teeth. Again, time it gets to that point you've got a lot of time and money invested on the hospital end, but the dental end isn't covered. It's capped. Last patient I want to go over... [LB541]

SENATOR GAY: I'm going to need you to...you know what? [LB541]

LARRY BAKER: Yes. [LB541]

SENATOR GAY: Can we kind of...really short if you're going to go into one more, because we need to get through some others. [LB541]

LARRY BAKER: Okay. I'll... [LB541]

SENATOR GAY: Thank you. [LB541]

LARRY BAKER: That's fine. Last scenario, just a short scenario, a patient that...one of the things that can happen if you have infected teeth, you can develop infections. Heart infections. It can infect a heart valve. You can infect joint replacement areas, and so on and so forth. So I think I've made my point there anyway. But the biggest point is, you know, when you have these dental issues, if you don't take care of the problem up front and it's allowed to progress, you're going to end up with some pretty serious medical-based issues, and that's a cost issue, as well; as well as it's also a standard of care issue. It is not good standard of care from somebody in my position to not provide...you know, it really kind of limits our ability in some respects to provide adequate services. [LB541]

SENATOR GAY: All right. Thank you. Let's see if there's any questions for you. Any questions from the committee? I don't see any. Thank you though. Those are good examples. Thanks. [LB541]

LARRY BAKER: Okay. Thanks. [LB541]

SENATOR GAY: Other proponents? [LB541]

CATHY MILLER: (Exhibit 3) Hello, Senators again. And I do have to read this disclaimer, I was told, so... [LB541]

SENATOR GAY: Oh, absolutely. Yeah, go ahead. [LB541]

CATHY MILLER: My name is Cathy Miller, C-a-t-h-y M-i-l-l-e-r, and I am testifying on behalf of the Nebraska Planning Council on Developmental Disabilities. Although the council is appointed by the Governor and administered by the Department of Health and Human Services, the council operates independently and our comments do not necessarily reflect the views of the Governor's administration or the department. We are a federally mandated independent council comprised of individuals and families of persons with developmental disabilities, community providers, and agency representatives that advocate for system change and quality services. Thank you. Okay. We are aware of the issues surrounding the lack of availability and funds to meet the oral healthcare needs. Our council is currently funding a project with the University of Nebraska Medical Center College of Dentistry. The focus of this grant is to target dental providers across the state for additional training so patients with disabilities and special healthcare needs will have increased access for receiving appropriate and comprehensive healthcare. Lack of appropriate oral health can ultimately lead to the much higher financial costs, as we've heard. It also leads to greater health risks which you have heard. But it also can be misdiagnosed behavioral healthcare needs among persons with developmental disabilities. Our council supports LB541 and the intent to exempt certain adult dental services from prescribed limitations. I just have something short to say on this. My son, it took two years to find a dentist because he has sensory defensiveness. It took two years to find a dentist for him and then it took awhile longer for him to get to the university to have a time slot so that they could put him to sleep and do oral healthcare. We're talking this kind of population. There is another member of our council. Her daughter got a toothache. It took her eight months before her daughter was cared for with that toothache because she's developmentally disabled and she had needs that, well, we'll get around to it when we get around to it. This is why we look at funding the College of Dentistry. We are very actively doing this and so this is a route to go. But our people do need the dental care, and they are very difficult, at time, to work with. We are aware of that so this is why the special training. Thank you for your consideration and I promise not to read the disclaimer again. [LB541]

SENATOR GAY: Thank you. Any questions? I don't see any. Thank you. [LB541]

CATHY MILLER: Okay. [LB541]

SENATOR GAY: Other proponents? [LB541]

BOB RAUNER: I'll be very brief. I'm Dr. Bob Rauner, a family physician. I work and teach at the Lincoln Family Medicine Program here. I'm only going to talk about 5(a) and (b). First is the pregnancy exception. I think this is important and I would want there to be an exception for this. There are very strong links now between periodontal disease and preterm labor. It's one of the few areas of success that we have to try and do something about preterm labor. It's to the point now where I really consider that to be part of a prenatal visit. If they do have dental problems, I get them into the dentist as soon as I can. I would prefer that there not be a limitation to that. It doesn't take many cases of preterm labor to save a lot of money. Second, is the (b) and the dental abscesses. Most of us who are in primary care or work in emergency rooms will tell you we frequently see people coming in with a chief complaint of dental pain. Frequently, it's a dental abscess, which we really can't do a lot about. We can throw band-aids on it with pain medications, with antibiotics, but really the definitive treatment is going to be draining by a dentist. And it does result in abscesses. There are neck abscesses. There are cases where it extends to the sinuses, it extends to meningitis, and there's even a famous case awhile back about a kid in D.C. who died from a case of meningitis, and, yes, they saved money on the dental care but it cost them a quarter-million dollars in healthcare during his case. And so those would just be the two things I would strongly advocate from the medical side because there isn't really a strong division between dental and medical sometimes, and those are two areas that I would advocate for. [LB541]

SENATOR GAY: Questions from the committee? I don't see any. Thank you. Other proponents. [LB541]

CORA MICEK: (Exhibit 4) Good afternoon, Chairman Gay and members of the Health and Human Services Committee. My name is Cora Micek, C-o-r-a M-i-c-e-k, and I am the advocacy coordinator for the Nebraska Hospital Association. On behalf of our 85 members and the nearly 41,000 people they employ, the Hospital Association supports LB541. I will keep this short. I know there are two more bills to be heard today, and so as you've heard from the previous testifiers, there is a need for this exception for adult dental services in this state. I briefly just want to say that by implementing the $1,000 cap, patient care can be jeopardized, and when the patient is admitted into an emergency room, at minimum you have about a $1,200 service charge due to the 24-hour staffing of professionals. And so the practical need for this exemption is highlighted in two letters that two of our rural health CEOs have provided, and they do a

much better job of documenting the practical need for this exemption than I could get across to all of you. So if you have any questions I'd be more than happy to answer those, but thank you for considering this issue. [LB541]

SENATOR GAY: Cora, thank you. Senator Stuthman. [LB541]

SENATOR STUTHMAN: Thank you, Senator Gay. Cora, in with the Hospital Association, you do see quite a number of Medicaid patients, correct? [LB541]

CORA MICEK: Correct. [LB541]

SENATOR STUTHMAN: Okay. Is there anything in the information that you provide these Medicaid individuals of information that could prevent some of this dental needs that...you know, be sure the Medicaid patients...if you need dental assistance or anything like that, do not allow it to get to a point where you can't get up to that or you'd be over that $1,000 cap? [LB541]

CORA MICEK: Do you mean like specific educational information like a packet or something like that? [LB541]

SENATOR STUTHMAN: Educational, like a packet or something that would say, you know, make sure that you take care of your dental needs on a regular basis instead of waiting until we've got the situation right now where, well, it's going to be over $1,000 and we've got to try to address that. [LB541]

CORA MICEK: I don't know the specific answer to that question. I can look into that and find you more information, but I would...most hospitals don't provide dental services. It is the emergency room departments that would see those patients. And so I would think that at that point there would be some at least verbal communication between the emergency provider and the patient. Most of the time a patient comes in with an acute facial abscess as was spoken to by Dr. Baker, and a lot of times these, like Senator Howard spoke to, this is a lot of prevention. And so if we can see these Medicaid patients come through dentists' offices on a more regular basis there would not be the need for the ER visits as often as may be seen now. I will find that information for you and the committee, though. [LB541]

SENATOR STUTHMAN: Well, Cora, I'm trying to find a place where the majority of the Medicaid recipients enter or where they visit or frequent the most times so that we could get that information to them so we don't get into this situation. [LB541]

CORA MICEK: Right. And I would say a hospital setting, in addition to all the clinics and community programs that they operate, would be a valuable tool to accomplish that purpose. [LB541]

SENATOR STUTHMAN: Okay. Thank you, Cora. [LB541]

SENATOR GAY: Thank you, Cora. Cora, so you testified on behalf of the Nebraska Hospital Association, and these two letters will be in the record from--of support--for Chadron Community Hospital and then also...where's the other one from? McCook, okay. From Community Hospital in McCook. So we'll put in those as separate. All right. Is that what you wanted? [LB541]

CORA MICEK: Thank you. [LB541]

SENATOR GAY: All right. Any other questions? I don't see any. Thank you. [LB541]

CORA MICEK: Thank you. [LB541]

SENATOR STUTHMAN: Thank you, Cora. [LB541]

SENATOR GAY: Any other proponents who would like to speak? [LB541]

JENNIFER CARTER: (Exhibit 5) Good afternoon. My name is Jennifer Carter, C-a-r-t-e-r. I'm the director of the Health Care Access Program and the registered lobbyist for Nebraska Appleseed, and I will also try to be really quick because I think it's clear we've or lots of people have demonstrated the problems and the more expensive acute medical problems that can develop when you don't get proper dental care. What I wanted to give is a little bit of a perspective on the low-income families and recipients and how the cap is affecting them. Eligibility for the adult parents that are eligible for Medicaid is about 45 percent of the poverty level. That means about $8,172 a year for a family of three. These families have no disposable income. There is no way they will be able to fill any gaps over the $1,000 coverage for any dental care they may need. We have actually had people calling our office. Another effect this cap has had is that some folks are not getting the first dollar of service because, I think understandably to some extent, the dental offices are concerned about beginning treatment that they can't finish, and so they want some kind of...to be able to know that they can do this treatment and they'll be able to get paid for it and ethically feel like they can start the program or the treatment. And a lot of these folks, they just...there's just no way they can commit to paying over that cap. So I just wanted to reiterate that not only...I mean, I think education and making sure people are getting their preventative care is great, but we've got people who are doing that, who are showing up at the dental offices before this becomes acute and medical, and they're still not able to get the care because of the cap. And so we just wanted to bring up that point and say that we really are supportive of this bill. And I think if we're really looking at fiscal sustainability, you have to make sure you're making sensible choices and where we're investing our money in Medicaid, and I think it makes this cap, I think can cost us more money down the line. So happy to

take any questions. [LB541]

SENATOR GAY: Thanks, Jennifer. Senator Stuthman. [LB541]

SENATOR STUTHMAN: Thank you, Senator Gay. And I don't want to dominate the questions but what is your organization doing to get information out to these Medicaid individuals as far as the information that there is a $1,000 cap and the fact that they need to do their dental work for as far as prevention? Are you doing anything there? [LB541]

JENNIFER CARTER: Well, we...since we're not a direct service organization, when people call in and we get intakes--and we do get tons of intakes--that we try to provide them with that information. We also try to work with other advocacy organizations or groups that are working more directly with Medicaid clients in Nebraska so that we can inform them of these caps that they're facing. And so...I mean, I would certainly agree. We'd be happy to tell everybody to go to the dentist twice a year, but that's...you know, to some extent it's just in terms of the resources we have, the grants, and the grant deliverables we have, kind of drive our work, and so that's not something that we...we haven't developed any resources for that at this point. I mean, we could see if we could add it to some of our brochures, but they're a little bit more on policy advocacy, being able to appeal your Medicaid rights, that type of thing, so. [LB541]

SENATOR STUTHMAN: Okay. Thank you. [LB541]

SENATOR GAY: Senator Gloor. [LB541]

SENATOR GLOOR: Thank you, Chairman Gay. Ms. Carter, does Appleseed advocate for fluoridation of water supplies? [LB541]

JENNIFER CARTER: You know, we didn't take a position on that bill I don't think. We...again it was one of those things that we thought it was a little bit...as a bunch of lawyers and social workers we weren't sure we really had the expertise to make a call on that. And sometimes...that's one of those situations with our limited resources, we just begin to...we have to prioritize what we can work on, but...so I...I mean, I could go back and we could talk about it. But we didn't take a position on that bill. [LB541]

SENATOR GLOOR: I appreciate your answer. Thank you. [LB541]

SENATOR GAY: Senator Howard. [LB541]

SENATOR HOWARD: Thank you, Mr. Chairman. I'm going to make this really brief. Senator Stuthman and I have had a couple asides about this. But for Appleseed to really fulfill its mission, to be there for people that need an advocate, I think he has

made a very good point that providing the information to the community regarding dental hygiene and the current regulations with the department would go a long way to helping people be more knowledgeable and to use these resources wisely before they reach a crisis situation. So I would certainly urge you to do that. [LB541]

JENNIFER CARTER: If we can have the resources...if we had the resources to do that I'm sure we would be happy to. But again it's not...our mission is systemic advocacy, is how are the systems working for the people in the state, low-income people, children in foster care, and others. And so we're very focused on that level and we also try to do as best we can to provide resources to the folks who are actually calling us directly. And so. [LB541]

SENATOR HOWARD: Well, I'd encourage you to stretch your creativity, as well as Vivianne's, to address what is obviously a need. [LB541]

JENNIFER CARTER: Right. No, I would just say I think we do a lot on a shoestring, so we're always helpful...you know, always wanting to be more helpful but we also have to stay within the terms of our mission and our grants, so. [LB541]

SENATOR GAY: All right. Any other questions? I don't see any. Thank you. [LB541]

JENNIFER CARTER: Thank you. [LB541]

SENATOR GAY: Any other proponents? Any opponents? [LB541]

VIVIANNE CHAUMONT: (Exhibit 6) It's still a good afternoon, Senator and members of the Health and Human Services Committee. My name is Vivianne Chaumont, V-i-v-i-a-n-n-e C-h-a-u-m-o-n-t, and I'm the director of the Division of Medicaid and Long-Term Care for the Nebraska Department of Health and Human Services. I'm here to testify in opposition to LB541. LB541 proposes to exempt five classes of adults from any limitations to dental services. Medicaid reform was mandated by the Nebraska Legislature in 2005. A recommendation by the Medicaid Reform Council, which was included in the Medicaid reform plan, was to align limitations on optional services in Medicaid with those customarily found in commercially available health, vision, and dental insurance policies. The dental limit of $1,000 per year for adults was implemented on July 1, 2008, in order to bring dental benefits in line with state employee dental coverage. Exceptions to five broad classes from the $1,000 limitation significantly reduce the savings built into the budget for the $1,000 limit. It is anticipated that the costs of implementing LB541 would not only eliminate any cost savings but could potentially result in additional expenditures by the state. Additionally, as written, the bill does not just address the current $1,000 limit in dental services for adults. The bill allows for no limits to dental services. Many dental procedures require prior authorization. About one-third of requests for prior authorizations are denied. The bill

does not allow for services to be limited in any way, so it doesn't allow for prior authorization. The bill, therefore, expands the adult dental program beyond what it was prior to July 1, 2008, when the $1,000 limit was implemented. The bill increases the department's administrative costs by establishing different tracking and reporting for different clients and services. It should be noted that treatment of certain dental conditions, that if untreated would worsen an existing diseases or medical condition, remain covered outside the adult dental limit. Federal regulations require coverage of dental procedures which could be performed by a physician even if they are performed by a dentist. The bill is a step back from the principles of Medicaid reform. Not only does it step back, it opens up the program with increased administrative costs and increased service costs. Lastly, the bill sets out a group of Medicaid eligibles that receive benefits differently than other eligibles. This is an issue that I talked about in the last bill. First-time clients are eligible for more services than second-time or third-time clients. This violates federal comparability requirements and puts federal financial participation at risk. These are categories that the feds just do not recognize. I would be happy to answer any questions. Before I do that, the only class...there are two classes of people that CMS, the federal government, federal statute and regs allow to be treated differently than other classes further than what we talked about earlier with the waivers. There's two classes. Children can be treated differently and that's why none of these services are aimed...or limits are aimed at children. And the second class is pregnant women. So that's the only category in this bill that the feds would recognize. [LB541]

SENATOR GAY: Senator Pankonin. [LB541]

SENATOR PANKONIN: Just for clarification on that, Director Chaumont, on the pregnant women and children. So they're...just help me understand it. Are they exempt from the current limits then right now? [LB541]

VIVIANNE CHAUMONT: Currently, pregnant women, if they are adults, pregnant women who are not adults are covered...did I say that right? Are...if they're children, they're covered...if they are under 21 they are covered. They don't have a limit. But currently, if you are a pregnant woman over...if you are 22-year-old pregnant woman, the limit would apply. My point is that I didn't want to mislead the committee by saying that the feds don't allow for any classes of clients to be treated differently. There are two classes of clients that the feds say you can give them services that you might not give anybody else, and that's children and pregnant women. So I wanted to make that clear. [LB541]

SENATOR PANKONIN: So... [LB541]

VIVIANNE CHAUMONT: Did I confuse you more? I'm sorry. [LB541]

SENATOR PANKONIN: Well, so children...okay, so 21 and younger on Medicaid don't

have this limit restriction right now. [LB541]

VIVIANNE CHAUMONT: It's for adults only. [LB541]

SENATOR PANKONIN: Okay. We heard from a doctor about pregnant women that have an infection that may result in early birth and that sort of thing. So could we include those people in...can we keep them out of this $1,000 exemption? Would that be something that would be...that would be able to do? [LB541]

VIVIANNE CHAUMONT: Pregnant women that have an infection can currently go to the doctor and get that infection treated. And if whatever needs to be done dentally is a service that can be done by a physician, that can already be covered under the limits outside of the $1,000 limit. [LB541]

SENATOR PANKONIN: Okay. One of the things I think that was troubling in the testimony today was about--and I can see where this could happen--dentists that ethically...from an ethical standpoint, they don't want to start that treatment because they know they won't get paid, there's more work to be done than the $1,000 limit, and so folks don't even get the initial coverage. Do you think that is happening? [LB541]

VIVIANNE CHAUMONT: We are seeing some of that happening, but here's what we're also seeing happening. Someone has a tooth abscess, they have an infection in the tooth. You can take care of the tooth abscess and the infection in the tooth by pulling out the tooth. The...so that would be covered under the $1,000. Usually that's not an issue. They don't want to just take care of the infection and they want to go ahead, rightly or wrongly--I mean, they're doing what they think they need to do--they want to go ahead and either do a root canal that costs more money and do a crown and this and that, that costs more money, or they want to do a bridge or something else. We're seeing that, that they don't want to just address the issue... [LB541]

SENATOR PANKONIN: Immediate. [LB541]

VIVIANNE CHAUMONT: ...that could be covered. They want to do what they've been doing in the past which is to put a crown or to do...you know, if there are more teeth, to do dentures, to do that kind of thing. But the pulling out the tooth would be covered. [LB541]

SENATOR PANKONIN: Okay. Thank you. [LB541]

SENATOR GAY: Senator Gloor. [LB541]

SENATOR GLOOR: Thank you, Chairman Gay. Ms. Chaumont, hypothetically, if we, the state, you and I, could figure out a way that we could provide dental care to the

Medicaid population and it didn't cost us anything--that's why this is hypothetical--didn't cost us anything, do you think Medicaid would realize a cost savings overall as a result of appropriate dental care being provided to that segment of the population such that there would be a reduction in Medicaid expenditures? And that's been the testimony that's been provided today. [LB541]

VIVIANNE CHAUMONT: I think that preventive care definitely saves money and I think that $1,000 a year in dental benefit is more than enough to take care of preventive care. Absolutely. [LB541]

SENATOR GLOOR: But above and beyond preventive care, if we were covering everything, could cover some of the extractions, some of the infections we've heard about, do you think the overall expense to Medicaid would be less at the end of a year? [LB541]

VIVIANNE CHAUMONT: I think we already can cover those infections. That's what I'm saying. You can take care of the infection under the $1,000 or under the exception with the physical. [LB541]

SENATOR GLOOR: I guess I would, by way of going back to my own previous responsibilities running a hospital, tell you that I think we are penny-wise, pound-foolish. I don't know what the dollar amount is that we should be talking about that's above $1,000, but I do think from our firsthand experience, through our emergency room, that you have a tremendous amount of expense that we incur on the medical side of Medicaid because of poor dental care and people not getting appropriate care and treatment, and the treatment of complicating issues related to dental care. [LB541]

VIVIANNE CHAUMONT: Well, I think...I don't disagree with that. I wouldn't be surprised at that, but, you know, when somebody comes in with an abscess in their mouth and then they have all of these other complications, you know, I don't know that having an unlimited...I don't know that we have more people with abscesses in their mouth coming into emergency rooms today than we did when we had an unlimited dental benefit, and that, I think, is what we have to think about. In a perfect world, would it be great to provide everybody every medical service that they need? Yes. I am surprised you haven't asked me that question, Senator. (Laugh) [LB541]

SENATOR HOWARD: You know I would. (Laughter) [LB541]

VIVIANNE CHAUMONT: But, of course, I think...you know, in prevention and all of that, of course. But I don't...I don't...I haven't seen the data yet, and maybe we'll see it. This has only been in place six months. I haven't seen the data yet that says that this $1,000 limit has caused more people with abscesses to go in and take...and have the care has caused more infections or has...you know, that's what I don't understand. Do I think that

we probably need lots more dentists in the state of Nebraska who are willing to take Medicaid clients? That I think would give you lots more costs savings than this. [LB541]

SENATOR GLOOR: Well, that may be the chicken or the egg discussion. I don't know that $1,000 is the right number. Maybe it's $2,000 or $3,000. Maybe it's $500. At some point in time I think there is a risk return number that the state would be well advised to try and find that says a better level of dental care saves us money when it comes to the medical-cost side of Medicaid. [LB541]

SENATOR GAY: I think Senator Gloor is thinking if you had a Medical Home Act it might help preventive... [LB541]

VIVIANNE CHAUMONT: I know he's priming himself for the next bill. (Laughter) [LB541]

SENATOR GAY: He's moving ahead of us, I think. [LB541]

VIVIANNE CHAUMONT: The dental home. That's what we need. (Laugh) [LB541]

SENATOR GAY: Senator Howard. [LB541]

SENATOR HOWARD: Thank you. Thank you, Mr. Chairman. Well, now I kind of feel obligated to give you the opportunity. [LB541]

VIVIANNE CHAUMONT: I know. Seriously, I'm feeling neglected that you haven't asked me anything. (Laugh) [LB541]

SENATOR HOWARD: Well, and I don't want you to leave feeling that way... [LB541]

VIVIANNE CHAUMONT: Thank you. (Laugh) [LB541]

SENATOR HOWARD: ...but I'm going to ask you this question and I think I know what you're going to say. But do you agree that having good preventative dental care is well worth the cost, especially when you consider all the ramifications and look at probably the most vulnerable populations. [LB541]

VIVIANNE CHAUMONT: There is no doubt in my mind that preventive care is the way to go. Absolutely. I mean I did not advocate for eliminating the adult dental health benefit. One thousand dollars provides you with plenty of preventive. You know, that allows you to get your teeth cleaned every...you know, all of those things every...you know, twice a year, which is what we all do, hopefully. Yeah, absolutely. That's the way to go. And education, what the two of you were talking about earlier, education to teach people about going to the dentist every six months is...should be part of their routine medical care. [LB541]

SENATOR HOWARD: Does the department have any sort of focused ongoing effort to provide information and education to people that receive these benefits? You know, I know in the past they used to slip little bulletins in with the checks, which I suppose everything is direct deposited so you don't get that anymore. [LB541]

VIVIANNE CHAUMONT: Right. [LB541]

SENATOR HOWARD: But is there any method to...? [LB541]

VIVIANNE CHAUMONT: I know that the Medicaid program doesn't do that. I know that the Division of Public Health has dental programs and grants that they do where they try to educate people. There are little brochures outside our office by the elevator on dental care and things like that. I know that there's a lot of work being done by that division on that, and by public health departments, I think as well, throughout the state. [LB541]

SENATOR HOWARD: Thank you. [LB541]

SENATOR GAY: (Inaudible). I know Senator Howard and many of us have been to the...well, the university, their Dental Days. Was that last week or is it coming up? [LB541]

SENATOR GLOOR: I think last week (inaudible). [LB541]

SENATOR GAY: Anyway, if you ever get a chance to go there--I know I didn't go this year--but if you get a chance to go there, that's a great project for youth and I know the Dental Association has its Nebraska mission of mercy thing that we've all been familiar with, so. [LB541]

VIVIANNE CHAUMONT: Which is a great program. [LB541]

SENATOR GAY: I think Creighton probably has something. [LB541]

SENATOR HOWARD: Um-hum. Creighton did it last week. [LB541]

SENATOR GAY: So there's some good things going on out there, and do what you can do. Senator Stuthman. [LB541]

SENATOR STUTHMAN: Thank you, Senator Gay. I just wanted to make a comment and I wanted to get on the record of saying the fact that I'm very sympathetic to the people that need dental care, and it does costs a lot more, and they can only do $1,000 one year and $1,000 the next year and $1,000 the next year. If they could do that all at one time it would probably only be $2,000. But being the fact that it drags out so long

and they can only do a portion of it, if they're concerned about that $1,000. But I think it comes down to there needs to be a little bit personal responsibility where the individual needs to be aware of that situation and take care of it and pay attention to their teeth. [LB541]

VIVIANNE CHAUMONT: I agree. [LB541]

SENATOR STUTHMAN: Thank you. [LB541]

SENATOR GAY: (See also Exhibit 9) All right. Any other questions? I don't see any. Thank you, Director Chaumont. Anyone neutral? Or any other opposition? Anyone neutral? Senator Campbell waived closing and we will close the hearing on LB541. And Senator Gloor is here to introduce LB396. [LB541]

SENATOR GLOOR: (Exhibit 1) Thank you, Chairman Gay, fellow committee members. My name is Mike Gloor; it's M-i-k-e G-l-o-o-r. I'm very encouraged as I sit down here. I believe I heard, for the record, from Director Chaumont that she can't speak any more. (Laughter) I am wondering if that's possible to hold her to that. And as to Senator Gay's kind of lead-in comment about medical home, I'm not sure that when we get into dental care that that is a perfect fit with medical home, but we have testimony that will come after me that may clarify that. But this has been a Medicaid discussion today and I'm happy to have an opportunity to sit down and provide this testimony and introduce this bill. One of my motivations for running for state senator, many of you have heard me say in the past, is the hope that I can bring some of my knowledge as a provider to play in helping Nebraska and Nebraskans reform healthcare or deal with the healthcare reform that comes at us or some of the healthcare reform we've already instituted upon ourselves. Nowhere do I think that need is more acute in this state than when it comes to the financially challenged Nebraskans that are out there. And so my...imagine my surprise and delight, frankly, when a group of the family practice physicians in this state began talking to me about a belief they had which is a perfect lock with a belief I have about how these services should be provided in a way that provides both quality care as well as I think will save the state money when it comes to the Medicaid program. Those beliefs are embodied in a model that we call medical home and that's the basis for this bill; specifically, we're looking for pilot projects. Medical home is a concept that is actively being used or piloted, and a large number of states, in fact most states--and there will be testimony that speaks specifically to the number of states who have already begun projects or pilot projects with medical home. We have insurance companies in Nebraska that either have implemented this or are looking at it. There will also be testimony along those lines. It's proven to be both a useful tool in reducing overall healthcare costs, as I've said, while at the same time improving health outcomes of patients. Medical home describes the relationship between a primary care provider and a patient. It's a place where patients get: guidance and education on their particular health needs in the office, by electronic communication by phone; reminders for

preventative healthcare; close follow-up of acute and chronic conditions; reminder calls for blood pressure checks, tests; even home visits on occasions; expanded hours when patients can access their medical home rather than going to emergency rooms. And so that there's no misunderstanding, they can still get referrals to specialists, get specialized tests when necessary. For physicians to give such individualized attention and the medical support to the patient, the payment structure needs to change from paying for offices visits to paying for true care and for coordinating that care. To accomplish all this, LB396 proposes two pilot programs to test this idea in Nebraska. The bill that I'm introducing provides a mechanism to create a medical home for Nebraska Medicaid recipients. It changes the payment structure from paying for office visits to paying for care. It will slow the growth of and reduce Medicaid expenditures. These pilot programs would operate for two years. There is an evaluation at the one-year mark and again at the end of the pilot. If the evaluation shows better health outcomes for patients and less expense for the state, pilots then become a guide for how we can expand this program to bring medical home to more people within the Medicaid coverage system. To help guide and create this program, LB396 proposes an advisory council and gives duties to the Nebraska Department of Health and Human Services. The council will include representatives from the fields of primary care as delineated in the bill, public medical schools in Nebraska, and a hospital. The Chairperson of the legislative Health and Human Services Committee is to serve as an ex officio member of the council. Duties of the council are to guide and assist the department in the creation of this pilot program and the evaluation of it, and that evaluation will be critically important in the expansion of medical home past the pilot program stage, if it's determined to do so, and to establish a technical assistance program for physicians with medical homes. Finally, LB396 requires the department to design and operate the pilot program in two regions in the state; change reimbursement rates to encourage medical homes; evaluate the pilot programs halfway through and at the end of two years; design and operate the expanded medical home program by March 1, 2011, if the evaluations that I've discussed agrees that it's warranted and to the extent that we as a Legislature appropriate funds; and finally, provide an annual report on the work of the Medical Home Advisory Council on related healthcare systems. The physicians testifying today and perhaps others will further explain the medical home concept and provide their insights about the practice of medicine and caring for patients. And I've distributed a letter that just came to us from the American Osteopathic Association that's a letter of support. Again, I'd be glad to answer questions but there will be testimony that follows and they are happy to answer your questions, but so am I. [LB396]

SENATOR GAY: (Exhibits 9, 10, and 11) Thank you, Senator Gloor. Any questions? I don't see any. We have about five or six letters here. We'll get them together and--Jeff just did. Anyway, we'll read these. We've got the letter, Senator Gloor, for the Nebraska Hospital Association, the Osteopathic Association that you had mentioned, the Nebraska Academy of Physicians Assistants, the Nebraska Pharmacists Association,

and from Pfizer. We received all those and those will be in the record. And I don't see any questions for you right now. [LB396]

SENATOR GLOOR: Thank you. [LB396]

SENATOR GAY: Thank you. Proponents. How many proponents do we have? One, two, there...about five. All right. Six, with this gentleman. Go ahead. [LB396]

IVAN ABDOUCH: Hi there. My name is Ivan, I-v-a-n, Abdouch, A-b-d-o-u-c-h. I'm here as the president of the Nebraska Academy of Family Physicians and I extend my greetings on behalf of the academy to all of you, Chairman Gay and committee members, and I personally offer my admiration for your attention span and bladder capacity. I've not sat through any of these hearings before and I'm impressed. I'm also an associate professor and the associate residency program director at the University of Nebraska Medical Center in the department of family medicine, and I reside in Papillion. I actually had not intended to testify today. I was going to be here today more as an observer, but as I was listening to previous testimony some thoughts occurred to me that I really wanted to share and hope that you all might take into context what you're about to hear, piggy-backed basically on what I've heard up till now. I did not prepare so I hope you don't mind that I refer to my notes here of things that I heard today. With LB371, I heard the comment that we spend more on Medicaid than on the university system. Fifty-six percent of nursing home expenses are paid by Medicaid. On LB610, I heard difficulties reconciling costs versus benefits and costs versus savings. I heard issues related to the distribution of funds and services and the limitations posed. I heard about problems with coordinating complex care and difficulties with access to even basic care in some instances. And I guess as I heard those things, I would ask that you consider that the medical home presentation really is not an isolated issue here but actually is related to all the things that we've been hearing. One of the things that I would pose for your consideration is that it's difficult for any committee or department or any institution or administrator to try and determine what a person does or doesn't need. Anything outside of a physician/patient relationship is at a very distinct disadvantage for trying to figure out who needs what. And I think that a lot of that needs to be relegated back to the physician/patient relationship, and the medical home offers that opportunity. We also even heard that Medicaid is unable to individualize things but can only take things as a group. I think that's a testimony of what I'm trying to say here, is that maybe just because our current system isn't able to individualize doesn't mean that it should not be individualized. And I hope that what you'll hear in the medical home will foster the idea that maybe it can be in some other form, because a lot of the arguments that we've heard for and against, pro and con, there's such an us/them, we/they conversation that all of this stuff, that that really has to stop. I think that collaboration is called for here, and the medical home offers an opportunity for that sort of collaboration among all the agents and parties involved. And I think to keep debating about what money we should or shouldn't spend on this or that all assumes that we're operating on the current

healthcare system, which we all know is a failing healthcare system, and to say how much shall we spend on the current healthcare system is to say how much shall we continue to spend on a failing prospect. So with that I just want you to at least consider this conversation, not as a stand-alone but in the context of the things that we've been talking about all day long, and with that I will conclude my comments. [LB396]

SENATOR GAY: Thank you, Doctor. Any questions? Senator Wallman. [LB396]

SENATOR WALLMAN: Thank you, Chairman Gay. Yes, Doctor, I talked to my doctor, one of the doctors in Beatrice about this, and it seems like a pretty good idea to me. But some doctors, will they take Medicare patients, too many? You know what I mean? They limit the scope of Medicaid patients. [LB396]

IVAN ABDOUCH: Some do. I'm sorry to say that some do... [LB396]

SENATOR WALLMAN: I know that. [LB396]

IVAN ABDOUCH: Yeah. [LB396]

SENATOR WALLMAN: So how are you going to get a home for people like that, you know what I mean? [LB396]

IVAN ABDOUCH: Yeah. Actually, some of the testimony that will follow is going to address that. I could answer it quickly, but I think for the sake of time I would defer that to one of the following. [LB396]

SENATOR WALLMAN: Okay. Okay, thank you. Thank you, Chairman. [LB396]

SENATOR GAY: Thank you. You bet. Any other questions? I don't see any. Thank you. [LB396]

IVAN ABDOUCH: Okay. Thank you. [LB396]

BOB RAUNER: (Exhibit 2) Okay, well, again, I'm Dr. Bob Rauner. I teach and work at the Lincoln Family Medicine program here in Lincoln. We're one of the largest Medicaid clinics here in Nebraska, and we're going to try and talk a little bit about some of the data that the director mentioned earlier, and that's part of what, you know, what we're here to try and cover a little bit. First, I want to start off what the medical home is not, and it is not a gatekeeper model. The gatekeeper model was tried by HMOs, and it doesn't work, mainly because whatever savings it does by throwing up roadblocks is eaten up by the bureaucracy that decides a patient does or does not need this, and so it's not a gatekeeper model and it's not intended to be that. It's also not a disease management model, because a lot of people might try and talk about this including in

the administrative area, say, well, we already do a disease management program. Well, disease management programs that work outside the doctor's office have been shown not to work over and over again. That's part of what I had in the handout here. First is a review article listing several different diseases. They've all failed to work. Second, is just from this week's Journal of the American Medical Association where Medicare used 15 randomized trials using nurses to run disease management programs. All 15 failed to show any cost savings, so it's not a disease management program. What is it? It's a component of things that evolves with the doctor and the patient. It's increased access, so that when people need to be seen they can get in today so they don't have to go to the emergency room. Also, so things can be handled early, so you prevent the hospitalizations, and that's where the big cost savings come from. It's continuity where you hook somebody up with the same person that they see over and over again, so you don't do so much repeat testing. You'll hear about the medical waste because of people getting three CT scans of their belly within six months, and we've had patients like that in our clinic. It's prevention, because the least expensive disease is one you don't have in the first place, and it's collaboration between both sides. In the past, a lot of this has been adversarial between the HMOs and the doctors. There's an article here that is the end of this. It's from North Carolina which has had a very large project, and they've been saving millions of dollars with that. And the key to that is that the people on the payer side helped out the physicians to contact the patients that needed to be seen. It wasn't throwing up roadblocks which is currently what happens for the most part, and most models may have used a collaborative relationship, and that's what works in healthcare. It's not an adversarial system, a place where that should be implemented. It works and save money. One, I think one of the guys coming after me does have some more information on the North Carolina model. I included a snippet from Medicare, one of their pilot projects. They've got a two-year summary already. It's already been shown to work such that Medicare is now launching a larger pilot...or actually, it's not a pilot. Now it's a demonstration product that's going to start next year. It involves eight states, 400 clinics, 2,000 physicians. It's been tried in numerous states throughout the country. UnitedHealthcare is working on versions. Blue Cross is working on versions. This is not an isolated thing, and the evidence so far has been all positive. In fact, you know, of all the reading I've done, there's only been two things where I've seen where it both improves care and saves money. One, is the public health things like the indoor smoking ban, seat belt laws. The second is primary care in the medical home. And so the evidence is there, and we can provide numerous examples if you want. I can talk about why this or that works. You will also, though, will hear some people coming after me if you want to ask them questions, so there. [LB396]

SENATOR GAY: Thank you. Any questions? I don't see any. Thank you. [LB396]

ROBERT WERGIN: (Exhibit 3) Senator Gay, my name is Robert Wergin, W-e-r-g-i-n. I'm a rural family physician from Milford, Nebraska, and I rise to speak in favor of LB396. Being a physician in a small, rural town in southern Seward County, I provide the first

contact care for not just my Medicaid population, but really all the patients no matter what their payment source from Milford and southern Seward County. I either provide that care directly or I help coordinate that care through this confusing maze of healthcare systems that we have out there. I think, as a committee, if you were to look at your rural costs per member in the Medicaid program as compared to your urban costs, you'll find quite a disparity there; they cost much less. And I like to tell my colleagues, some of which are sitting behind me right now, that it's obvious that us rural doctors are just a lot smarter than the urban doctors (laughter), but I don't think that's true. I think it comes down to an access and coordination issue. I'd like to say I'm smarter, but I'm not. The second point I'd like to make today, I attended a conference in Michigan just a week ago, and it was a ten-state conference of the American Academy of Family Physicians with leaders from mainly the northeast United States and what they call the Midwest, which I was surprised is Indiana, Ohio, Michigan, and Kentucky, and I don't consider that the Midwest but they do. And almost every state had some type of medical home project either just starting or ongoing or on the books. So I would say other states have taken a keen interest in this. And I want to mention two states that had actually completed their first year of the process, and I'll throw in Illinois. That's with the...I mean, correction, North Carolina savings that they realized their first two years. And I won't go in much depth with that; Dr. Rauner mentioned that. But Illinois enrolled 1.7 million Medicaid clients in their program a year ago, and they just had the preliminary data at the meeting I was at, and they also had a targeted disease registry. It was called Your First Health, and there were 220,000 people entered in there. And I should mention, it was a collaborative arrangement where the medical home administrative people assisted in the care of those patients in the medical home. Their first year, two things came about. They saved $34 million as opposed to the traditional or usual care they provided the year before, and that was below what last year's budget was, assuming there was no growth. The second thing interesting that surprised them is almost all the patients who were assigned to medical home stayed with their assignment. Their program allowed them to move around. If you had a medical home you weren't satisfied with, you could move to someone else, but they had a percentage. It was in the 1 or 2 percent range that people actually moved around in the system. The second state I wanted to mention was Connecticut. They had a pilot project, and they enrolled Medicaid population amongst 200 family physicians across their state, and they were just now crunching their numbers, and they had realized about a 12 percent savings after the first year as compared to the simultaneously operating program of their usual and customary, so there was a cost savings there. An as an aside, the speaker had said that they pulled their 30-person group--it's a multiclinic group--and their savings were actually higher than that, around 17 percent as compared to the other model, and they felt that might be more to the buy-in. I mentioned North Carolina and their savings, and they have a very specific program as well, and to get the buy-in to the program, it was payment reform. Your question was very well taken to be a great program, but if people don't participate, it won't help. So in closing, I'd just like to say, as a rural family physician, I already encompass some, but not all the attributes of the

patients that are in medical homes somewhat by geography. And I think by offering access and coordination of care, that has provided some savings to my patients, both Medicaid and otherwise, but I can do better. The disease registries and whatever I could think, we could realize even more savings. [LB396]

SENATOR GAY: Thank you. Senator Wallman. [LB396]

SENATOR WALLMAN: Thank you, Chairman Gay. What percentage of your patients are Medicaid, if I may ask? [LB396]

ROBERT WERGIN: Well, in Seward County I believe it's about 15 to 17 percent we see, and we're, of course, if...you're from Beatrice. You know, if someone knocks on my door, they pretty much get in. So we...what you were talking about is boutiquing your practice, and in rural areas it is very difficult to turn your neighbor away because they have Medicare. [LB396]

SENATOR WALLMAN: Well, thanks for being a doctor. [LB396]

ROBERT WERGIN: (Laugh) Thanks. [LB396]

SENATOR WALLMAN: Thank you, Chairman. [LB396]

SENATOR GAY: You bet. I don't see any other questions. Thank you. [LB396]

ROBERT WERGIN: Thank you. [LB396]

KEN KLAASMEYER: (Exhibit 4) Senator Gay and committee, I'm Ken Klaasmeyer, vice president of Methodist Health System in Omaha, Nebraska. It's Ken, K-e-n, Klaasmeyer, K-l-a-a-s-m-e-y-e-r. In the interest of time, I want to talk to you about the medical home model. We employ physicians in Iowa, in Council Bluffs and Red Oak and Glenwood, and they are in a medical model, medical home, with a commercial carrier in Iowa. And it's no surprise it's Wellmark, and that's been one of the companies that has been very difficult with physicians. And our docs, basically on this medical home, love it. And I want to talk just a little bit about how it's structured. I think it works very well with what we could do in Nebraska. Wellmark basically came up with their list of things that were really causing them the greatest problems. And on the back sheet that I have here for you are the various, they call them medical suites: diabetes, asthma, cancer screening, hypertension, childhood immunizations. They thought those were the ones that they wanted to start with. In fact, they started with diabetes and hypertension the first year, and this is about the third year into this project. What they do is then they take their claims data on all their diabetics, and they found the names, and said, okay, which physicians are these people going to? And so then they went out and basically got a buy-off between the carrier and the provider and the client to say, this is your

medical home; do you agree with that or not? And so, you had to buy in from all three. They basically said in future years that they would...you know, they could change things based on what the criteria was or if there was something new that popped up. Criteria for each condition is based on a national standard like HEDIS. And so the doctors, our doctors bought off on it because it wasn't just a payer criteria, you know, that they came up with. Then the payer sends all of his claims data and all the pharmacy data to a third party, and this third party then matches up the claims data with the criteria and basically puts it on the Internet. And so the docs with a password can look on the Internet and see how they are complying with national standards. And we've got docs...and I basically was telling some docs a little bit ago, we have some that don't have a lot of charisma, and by them calling their patients and getting those patients in that need to be seen for something, basically, their patient satisfaction has gone up. And so it was really a benefit we got out of this thing. We don't get any more than our fee schedule for reimbursement. We get just the fee schedule. Then at the end of the year, based on the outcome of how well we're taking care of diabetics, how well we're taking care of hypertensions, then we could get a performance or incentive dollars at that time only if they met the national criteria. So you aren't out there paying for something you may not achieve. And so we really think it's a great deal. The national criteria really makes it whether it's urban or rural, doesn't matter because it's national criteria. They should be getting the same kind of care wherever they're at. Physicians...and I think you're seeing docs like this because they're getting reimbursed or they're getting paid based on the quality of the care they're delivering rather than everybody getting the same amount. And quite honestly, Medicaid fee schedule today is the lowest fee schedule we've got. So this medical home has been really super. I've talked to both Blue Cross about it...they're looking at it very seriously in Nebraska; so is UnitedHealthcare. Everybody sees this as a cost savings rather than a cost increase. Any questions? [LB396]

SENATOR GAY: Thanks, Ken. Questions? You're off the hook. No questions (laughter). Other proponents. [LB396]

TOM WERNER: I'm Tom Werner, W-e-r-n-e-r. I'm a family doctor in Grand Island. Senators, I'd like to ask you a question. Let's say tomorrow morning, you roll out of bed, reach over to put on your shoes, and you try to sit back up, and all of a sudden you're struck with dizziness. I mean, dizziness so bad that you can hardly function. What are you going to do? You going to go to the emergency room? Are you going to call your family doctor? Are you going to call your ear, nose, and throat doctor? Maybe you're going to call your neurologist. Maybe you've had a stroke. Hard decision. Well, I can tell you, last summer I had a Medicaid patient that I see in his early sixties, and he actually did all of those things. Over the course of a two-week period of time, he saw his ear, nose, and throat physician. Then he saw his neurologist; then he went to the emergency room. Each of these physicians ordered tests. Each of these physicians ordered a scan of his head which, I'm sure this will come as a surprise, but they all looked very similar. (Laughter) And finally, two weeks later, he comes into my office, because after all of this

testing and all the specialists he had seen and after all the money spent he still did not feel like he had a good answer to his problem, didn't know what was going on, and didn't know what the plan was as far as where we go from here. So I think any of us can look at a situation and say, you know, this guy did not receive quality medical care, and I think we'd all agree he did not receive cost-efficient medical care. And that's what the medical home is really trying to address. And you may be sitting there thinking, well, as a family doctor in the medical home, how is what you're doing going to be any different than what is currently being done with an HMO and a gatekeeper model and so forth. Well, I think the fundamental difference is, with the HMO I've got somebody looking over my shoulder saying, you ought to be doing so many scans and you ought to be using so many generics, and I've got quotas to meet; whereas in the medical home it's you and me. You come in, I do an exam on you, and we decide, with your history and your exam, what tests you need and where we proceed. And I'm not sure any one of you would disagree with me that if it's you sitting in that situation when you have your vertigo tomorrow morning, do you want to be sitting there in my office, thinking, well, is Dr. Werner just trying to meet his quotas when he's ordering these tests, or has he looked at what I really need and what I need to do and ordering his tests based on that information? So that's the fundamental difference. Somebody looking over my shoulder versus me getting a chance to make my own decisions with you as a patient. Well, you think, Dr. Werner, if you're making all these decisions, how are you ever going to save any money? Well, I'll just throw an idea out to you, and that is that in the last couple of years there have been a couple of different studies done by different universities that have looked to see how many diagnoses the typical family doctor deals with in an average visit. How many would you think that is? It's seven. So if you are paying for Medicaid dollars, would you rather have a patient come in to their medical home, see the physician that they see on a regular basis, and have that physician deal with potentially seven diagnoses under one medical fee, or would you rather have that patient self-refer to seven specialists and pay seven professional fees to have all of these problems dealt with? So not only are we potentially cutting back from three scans to one, but hopefully we're getting a coordinated care and having more dealt with, with one visit. So again, bottom line, medical home is an attempt to provide better quality care for the people that are enrolled in the Medicaid program, and it's an attempt to provide a more cost-effective care for the people in the Medicaid program. If I can make one other comment, if I may (laugh). Through the course of my training...I mean, I've worked in Omaha and Lincoln and Valentine and in Grand Island. People probably look at the medical community as all one big monster that moves together (laugh). But if you think about it, physicians and the hospital administrators don't always see eye to eye. In this particular case, I do see eye to eye with Mr. Gloor, but I just have to put in a plug for him. Of all the people I've been associated with in the medical community and in Nebraska, I mean I probably trust his judgment more than anybody that I've dealt with, and so I'd really encourage you as senators to use his expertise, not only in this bill but in any bill relative to medical care, and take into account his opinions, so. [LB396]

SENATOR GAY: I think you already got his vote, doctors (laughter). No, I'm just kidding. We've been pleased and very fortunate to have him serving within. So we got a question for you. Senator Wallman. [LB396]

SENATOR WALLMAN: Thank you, Chairman Gay. I hate to monopolize this too. I think it's a good bill. But in regards to medical home, how many people have never seen a doctor, you know? Some people in their sixties and seventies or...have never seen a doctor, so how would you get a medical home for that set up with...? You know, say you're an immigrant: you know, the emergency room is your office. [LB396]

TOM WERNER: Well, if you're 60 or 70 and haven't seen a doctor, maybe you don't need to see one for awhile. You're doing something right (laughter). You must be dieting and exercising and so forth (laugh). I'm not sure I completely understand your question, because are you asking... [LB396]

SENATOR WALLMAN: I mean, if you've never been to a doctor...say you're 65, never been to a doctor. You know, how would you find...and probably your primary office this first time is going to be the emergency room, wouldn't you say, if something is going to happen? [LB396]

TOM WERNER: Well, I would hope not. [LB396]

SENATOR WALLMAN: Yeah. [LB396]

TOM WERNER: I would say, in Grand Island, if you've never seen a physician, you'd probably talk to your friends and see who they like, and you'd call somebody up and you'd get into their office. At least that's what I would hope would happen. [LB396]

SENATOR WALLMAN: Thanks. [LB396]

TOM WERNER: Does that answer your question? [LB396]

SENATOR WALLMAN: Pretty well (laughter). [LB396]

TOM WERNER: Okay (laugh). [LB396]

SENATOR GAY: Any other questions? I don't see any. Thank you. [LB396]

TOM WERNER: All right, thank you. [LB396]

DALE MICHELS: Senator Gay and members of the Health and Human Service Committee, I'm Dale Michels. I'm a family physician. I've been here in Lincoln for 34 years as a family physician and 25-plus years with a satellite clinic in Ashland. I

originally grew up in Nebraska and went to the university. I've done lots of things in terms of my medical thing outside of seeing patients most days, and I'm not going to go through those. I want to thank you for the opportunity to share. I have four items to kind of clear up or to touch base on in terms of this, as we've talked about which is a pilot project. First of all, and I think this has been mentioned, I remember once a patient who was seeing a pulmonologist at my request who wanted to help me care for that patient, so he set up four different appointments with four other people for problems that I could have easily covered in one visit. So they got four times the money for four different appointments for what we could do. I think that's one of the keys of the medical home as I see it. It's helping those patients learn that they can come to the family physician, primary care physician, internist, pediatrician if they're young, all of those sorts of things to see for most of the care that they need. From my history and experience on the Health Care Cash Fund, which I chaired for the Legislature a few years ago when we used to award competitive grants for public health and antitobacco issues, I got to see a little bit about how teams work and how the advisory council that's being proposed is well put together to make this really a team approach as we proposed in LB396. Our goal is not to have individual prima donna physicians but teams who are working together. Our office, for instance, has two PAs, five counselors, a part-time nurse educator, all doing the things to make us, as much as we can at this point, be a medical home for the patients we take care of. We bring in the specialists for the areas needed. I'm reminded of listening to some of the college basketball, and you'll find that they bring in the guy who's the 3-point specialist at this time-out and they bring in somebody else at the next time-out. They bring in the people they need to make the team work the best, and that's really what our goal is out of LB396. I know that, particularly, the department and others have talked about, well, you're not going to save any care, because we see docs just order tests to keep people quiet. Well, I think the issue for us is primarily...I thought about it. It's the analogy, if you were an implement dealer or an auto dealer, and you did warranty work but they only paid you half of what it cost you to do the warranty work, how would you be really interested in doing warranty work? But you got to do it. And we as family physicians feel we have to do it; primary care physicians feel we have to do it. We don't always get paid very well for that. So then the question comes, should you take two minutes of warranty work and write out so somebody can get what they think they need, or should you spend 20 minutes with them at no more benefit to you to explain why they really need to go a different direction? That's kind of the problems we're seeing. We see that some of the compensation mechanisms that could be built into this team would actually...the team would find interest in going forward to actually make this more cost-effective. And finally, in my quick notes is the fiscal note which you were provided for by the department. We think it's higher than it probably will be but we're confident that the return on investment will be even higher. Much of the expense in developing the pilot plan is going to be staff time and working together. We have resources from our American Academy, the national academy, to help us put together some of these things. So it's going to be some new expense but not a lot. And we think that the advisory team, as it's

constructed, will put together so that we can find effective ways for fees, formularies, management costs that we'll be able to make it actually cost less than what's proposed. And so, therefore, we're strongly in support of the help to try and help you build a better home for the Medicaid patient. I'd be happy to answer any questions that anyone has. [LB396]

SENATOR GAY: Thank you, Doctor. Any questions? Doctor, you had mentioned...I had a question, but you had said...I know you do a lot of things, but could you touch on a few other things you've done for us? [LB396]

DALE MICHELS: Well, I've been privileged to be the past president of the County Medical Society, the State Medical Association, the State Academy of Family Physicians, the EMS Inc. Council here in Lincoln. I served on the task force that put together the next proposal you're going to hear, (laughter) and so I won't go into that. But I've been privileged to try and find it...you know, we need to be involved. The goal is to try and make patients better. And as you know, I've been fortunate to be around at the right time, a couple of times, in the family Doctor of the Day program here at the Legislature, so. [LB396]

SENATOR GAY: Exactly. Good timing is everything. Senator Campbell. [LB396]

SENATOR CAMPBELL: Just a quick comment. And that is, in Lancaster County, since you used the basketball analogy,... [LB396]

DALE MICHELS: Um-hum. [LB396]

SENATOR CAMPBELL: Dr. Michels is sort of the go-to guy whenever we need some help, and he's helped the county and the city a lot, a lot of other efforts. [LB396]

SENATOR GAY: I agree. I wanted to bring that up. Thanks for all your service. I know many of your colleagues do, but you've really stepped up and we certainly appreciated that, so. [LB396]

DALE MICHELS: Sure. Well, we think this is a good program to go forward with. [LB396]

SENATOR GAY: Thank you, Doctor. [LB396]

DALE MICHELS: Okay. [LB396]

SENATOR GAY: Any other proponents? [LB396]

JENNIFER CARTER: (Exhibit 5) Hi. Good afternoon, I'm still Jennifer Carter, C-a-r-t-e-r,

director of the Health Care Access Program and registered lobbyist for Nebraska Appleseed. And I just wanted to offer some nondoctor support for this bill. We were very excited and grateful to find out that Senator Gloor was bringing this, because I think it helps to reduce costs in the Medicaid program, but it does it by actually improving and strengthening the program and the care that recipients will receive in the program. Two quick points we just wanted to make that were more of a comment clarification. Section 5(5) in this bill mentions that this will be coordinated by managed care insurers. And we would just hope that what was meant by that is that we would be using...if this happens in an urban area, that we'd be looking at the primary care case management system that's already in place rather than the managed care organizations. And I think there's been...some of the other doctors alluded to sometimes some of the difficulties in working with a managed care organization. And I think the difference is that a primary care case management system, as I understand it, the control remains with the doctor and the focus is all on the quality care. And the MCO, obviously...I mean, that's just, you know, no fault of theirs, it's what they need to do, is more...it's a lot more of an economic calculation. So we would...you know, we'd like to see this go forward and be developed in that way. And the only other thing is we'd love to see a little bit more...we like the makeup of the Medical Home Advisory Council, but I think the one consumer is really outweighed by...the council is dominated by physicians, which is great and necessary, but we'd love to see maybe additional consumers and consumer advocates included in that, and maybe consumer advocates that represent different constituencies. And we'd also love to see public input in the evaluation and the stakeholders in those pilot areas maybe having some ability to give some feedback. But generally speaking, we think this is a great step forward in Medicaid reform, and we would love to see this pilot go forward. I'm happy to answer any questions. [LB396]

SENATOR GAY: Thank you, Jennifer. Any questions? I don't see any. Thank you. [LB396]

JENNIFER CARTER: Thanks. [LB396]

SENATOR GAY: Other proponents. [LB396]

LON LOWREY: Senator Gay, members of the committee, my name is Lon Lowrey, L-o-w-r-e-y, registered lobbyist for Novartis Pharmaceuticals, a Nebraska company that's been in this great state since 1908. I hadn't really planned on testifying today, but medical home is the new wave of the future; it's a new wave of healthcare coming. And I just wanted to add that, in addition to the Illinois data and the North Carolina data which has been cited, Missouri has started a program. It's been in effect for about a year now. Roughly 147,000 Medicaid recipients have been enrolled in what they call the chronic care improvement plan. It's the same concept. And there's about another 150,000 members that are not enrolled, so they actually have two groups that they can actually do their research on. They have shown preliminary savings, and I'd be more than happy

to share that with the committee if you would like to see some additional data that's available. I'd be happy to answer any questions. [LB396]

SENATOR GAY: Thanks, Lon. Any questions? I don't see any. Thanks, Lon. Any other proponents? [LB396]

PAUL PLOFCHAN: (Exhibit 6) Senator Gay, Health and Human Services Committee, my name is Paul Plofchan, P-l-o-f-c-h-a-n, and I'm government relations director for Pfizer here in Nebraska and a registered lobbyist. And I've already submitted my testimony to you. I'm not going to go through it all in the purposes of time, but I did want to, based on the testimony that's been already offered, to just publicly state that we think LB396 is a step in the right direction. And I wanted to highlight out of my testimony, the point that...and it's sort of follows on what we just heard from Appleseed, that we believe that various stakeholders should have an opportunity to comment on the metrics and methodologies that will be used as part of the pilot, and to offer constructive comment as before the pilot is put into place. And then one final point is, if there's consideration for adding to those groups that participate in the Home Advisory Council, other healthcare-related stakeholders may have important contributions, including perhaps a pharmaceutical manufacturer. Thank you. [LB396]

SENATOR GAY: Thanks, Mr. Plofchan. I kind of figured you might bring that up when you came up. I'm surprised Lon didn't, but anyway. I do have a question, though, actually. You bring that up, and I was reading...I was just looking at the...who's on this makeup if this were to happen. And what point...we've all been on many committees that get to be very large as is (inaudible) I'm on this summer, and you get a lot of diverse...just a lot of diverse. The bigger you get, the more opinions you're going to get. But if we limit it to those practicing, they're familiar already with a lot of these other...I mean NAVA could say, I understand that, but wouldn't they already be familiar with some of the different products and services you provide anyway? [LB396]

PAUL PLOFCHAN: Sure, and I think that's why at the outset I suggested that one way to go about it might be by just offering what are the up-front, what are the methodologies and metrics we'll use to measure success, and then have a period where people could comment. I think that would be...that would meet a lot of my concerns. But then, additionally, as a pharmaceutical manufacturer, you know, a lot of it goes...we have resources that extend far beyond just discovering the medicines. We actually, because of our requirements, are tracking the success of medicines. We have a lot of reporting requirements into the federal government, and some of that information could be quite valuable. But as you point out, it may not be necessary to do it as a member of the panel, though that participation as a stakeholder we would welcome. [LB396]

SENATOR GAY: Okay. I'm sure they...yeah, they'd probably be mostly public meetings. But that question I just asked you because you're conveniently here and it popped into

my head. [LB396]

PAUL PLOFCHAN: But I certainly understand that you get too many people, and I think it's already been stressed how important it is that the physicians be making up a major component of that panel. I mean, this is a real opportunity for them. [LB396]

SENATOR GAY: Yeah, definitely. All right, we'll keep that in mind. Any other questions? I don't see any. Thank you. [LB396]

PAUL PLOFCHAN: Thank you. [LB396]

SENATOR GAY: Any other proponents who would like to speak? Any opponents? [LB396]

JOYCE SASSE: (Exhibit 7) My name is Joyce Sasse, J-o-y-c-e S-a-s-s-e. The medical home bill has many good ideas in it. One of the ideas that I think is wrong is the fact that it does not include one of the primary care providers, the nurse practitioner. Nurse practitioners, despite the fact that we do have a care agreement with physicians, do run primary care clinics, psychiatric clinics, and other types of clinics in the state of Nebraska. To leave us out of this bill, I think does a disservice to all patients in Nebraska and to physicians. We provide care that does assist our physician brothers in caring for all Nebraskans. As we know, there is a lack of primary care physicians in Nebraska. We have a losing endgame going on. We have a decrease in residents graduating from the Creighton and the University of Nebraska residency programs in family practice, internal medicine, and other programs such as general pediatrics and in ob-gyn. One-third of all the physicians who are in the primary care positions are over the age of 50 and will retire within the next 10 to 15 years. The American Medical Association, over the last ten years, has had several programs trying to increase the number of primary care physicians nationwide. The Physicians Foundation did a survey that reported over half of the nation's primary care physicians plan to stop practicing or reduce the number of patients that they see. I know that the primary care physicians in Nebraska are probably not as bent towards that as the rest of the nation's population. We have extraordinarily fine primary care physicians in Nebraska. When I see patients, I always coordinate my care with their family practitioner. It's very important that we work together. I think that this bill for the medical home needs to have the nurse practitioners work with the physicians in this. I think that our clinics need to be considered in this pilot program. That is why I think the bill, as written, is not appropriate, and that's why I'm in opposition to it as written. I think it needs to be amended. Nurse practitioners very much want to work with physicians. They're our colleagues. To be left out of this bill, I think is inappropriate, and that's all I have to say. Are there any questions? [LB396]

SENATOR GAY: Thank you. Don't see any. Thank you. [LB396]

JOYCE SASSE: Thank you. [LB396]

VIVIANNE CHAUMONT: (Exhibit 8) Oh, sorry, you ready? [LB396]

SENATOR GAY: Yep. [LB396]

VIVIANNE CHAUMONT: Good afternoon, Senator, members of the Health and Human Services Committee. My name is Vivianne Chaumont, V-i-v-i-a-n-n-e C-h-a-u-m-o-n-t. I'm the director of the Division of Medicaid and Long-Term Care at the Department of Health and Human Services, and I'm here to testify in opposition to LB396. LB396 proposes services and reimbursement of those services which would be duplicative of current Medicaid programs and initiatives. First, Medicaid reform was mandated by the Nebraska Legislature in LB709, the Medicaid Reform Act. One of the recommendations in the plan was implementation of enhanced care coordination program. In response to that recommendation, Medicaid has contracted with U.S. Care Management to provide enhanced care coordination to clients across the state on a voluntary basis. Enhanced Care Coordination Service was implemented July 1, 2008. As of January 2009, there were 331 members from 21 counties enrolled in this program. The program is voluntary, and is available statewide. It excludes folks who are in the current managed care program. Due to recent implementation of this service, data is not yet available which would provide information regarding any potential cost savings. It would be beneficial to have data on this program evaluated before considering the implementation of another pilot project, particularly a project which would replace the one we just began. Second, the Medicaid program has managed care programs in place that provide cost savings while ensuring access to clients. Currently, there is mandatory managed care in three metro counties, Douglas, Sarpy, and Lancaster. In those three counties, clients currently have a choice of enrolling in the Primary Care Case Management option or the Managed Care Organization option. Effective September 1, 2009, the mandatory managed care counties will expand to ten with the addition of the seven counties contiguous to Douglas, Sarpy, and Lancaster. The department will be releasing an RFP in the coming week or two to switch the managed care program in those ten counties then to a two Managed Care Organization model. The MCO program saves the Medicaid program substantial funds. That's documented. The bill would replace managed care models proven to work in Nebraska with a new pilot program which, at this time, has not been proven to save money in Nebraska. It is possible that this new program could save money. It is possible that it could, in fact, cost the Medicaid program money. It is certainly not proven that it will save the Nebraska Medicaid program more money than the current managed care programs that we're operating. There would be many obstacles in adding another program to the ones that already exist. This bill as proposed would create a substantial administrative burden and necessitate changes in current Department of Health and Human Services System practices. It would require systems changes to the current Medicaid Management

Information System which is the computer system that pays for Medicaid claims at a time when significant work is underway to build and implement a new MMIS. The requirements of this bill could not be met by existing staff. To administer and implement a new program, a competitive bid process to obtain the services of a program administrator would be needed. To develop reimbursement and incentive payments would require the services of an actuary which would also necessitate a competitive bid process to obtain such services. The competitive bid process is both time and resource intensive. The bill in its current form is too prescriptive. The provided time frames are not reasonable based on the work that would have to be done for assessment and implementation of these services. In order to receive any federal funding, a waiver would need to be applied for from the Centers for Medicare and Medicaid Services for the pilot project, and to implement a program statewide an amendment to the current state plan would be required. The approval process is typically long and arduous. Special funding would need to be appropriated to the department by the Legislature to implement the provisions of the bill in the stated time frames. While the bill implies that the provisions of the Medical Home Act would provide a cost savings to the state, the department's analysis is that these services are duplicative and would not offset the administrative costs to implement in the biennium. That's based on the programs that we currently have operating. All that said, we believe the medical home model is something that should be further explored and that potentially has benefits in parts of the state. We need to evaluate the data from implementation of the enhanced care coordination model. We need to finish building the MMIS system to have more flexibility as to payments and better access to data that would be necessary to run the new model effectively and efficiently. We need to ensure that any pilot of the new model has applicability in all parts of the state where it would be implemented and that the savings in implementation would be in excess of the current savings that we get from our current programs. This takes time and effort. As a result of all of the above listed concerns, we oppose this bill. I would be happy to answer any questions. [LB396]

SENATOR GAY: Thank you. Any questions? Senator Campbell. [LB396]

SENATOR CAMPBELL: Thank you, Senator Gay. Director, outside of the enlarging the ten, we really don't have a plan in place for any system like this out in the state, do we? [LB396]

VIVIANNE CHAUMONT: Outside of the ten? [LB396]

SENATOR CAMPBELL: Outside of the ten. [LB396]

VIVIANNE CHAUMONT: No, we don't have anything in the rural counties. [LB396]

SENATOR CAMPBELL: We don't have anything on the drawing board either is what you're saying. We just don't. [LB396]

VIVIANNE CHAUMONT: No. What I have said is that we are concentrating on those ten, bringing that system up, and then we would need to see what would work in the rural counties. The Enhanced Care Coordination program, which was one of the Medicaid Reform Council recommendations and in the plan, that's in the rural county. But right now, that's about it. [LB396]

SENATOR GAY: Any other questions? I don't see any. Thank you. [LB396]

VIVIANNE CHAUMONT: Thank you. [LB396]

SENATOR GAY: Any other opponents? [LB396]

SUSAN BEIDLER: (Exhibit 12) Chairman Gay, members of the Health and Human Services Committee, my name is Susan Beidler. It's B-e-i-d-l-e-r. I'm the director of the Morehead Center for Nursing Practice at the University of Nebraska Medical Center in the College of Nursing. As a family nurse practitioner, nurse researcher, and faculty member at the College of Nursing, I am pleased to be here this afternoon to discuss the reasons why we do not support LB396 as it is currently written. We have two major concerns with this bill. First, the definition of provider excludes nurse practitioners, essential healthcare providers who have been recognized as primary care providers for almost a quarter of a century. Second, the establishment of a Medical Home Advisory Council which is comprised of the 11 voting members, 9 of whom are either physicians or representatives of medical schools or a hospital, excludes all other primary care providers from the development of a medical home program that reflects the evidence-based contributions of other 21st Century healthcare professionals. One of the biggest misconceptions that is perpetuated by LB396 is that physicians only are prepared to be primary care providers and, thus, the coordinators of medical homes. Primary care is principally ambulatory, community-based care, characterized by first and continuous access, comprehensiveness, coordination, continuity, and accountability. It consists of health maintenance; self-care education; management of acute, self-limiting and chronic diseases. The scope of practice for all advanced practice nursing is distinguished by autonomy of practice, and the standards of advanced practice nursing include all of the functions that are integrated into the delivery of primary care. Nurse practitioners are prepared for primary care practice through an educational process which begins with four years of undergraduate studies in an accredited program that includes the same basic science and humanities courses taken by physicians. They then complete graduate education in an accredited program at either the master's or doctoral level. Upon graduation and prior to beginning practice, most states, Nebraska included, require that the NP take and pass a national certification exam in their specialty area prior to becoming licensed. Similar to physician practice, NP practice is regulated through state and federal laws and regulations. Certification and licensure requires ongoing continuing education and ongoing practice

to maintain essential competencies for high quality, safe patient care. In 1996, the Institute of Medicine published the report, Primary Care: America's Health in a New Era. This report was prepared by the Committee on the Future of Primary Care whose members, interestingly, were primarily physicians. This committee agreed upon the principles that underlie primary care and the need to have primary care serve as the logical foundation for the United States healthcare system of the future. They clearly defined the term "primary care clinician" as an individual who uses a recognized knowledge base and has the authority to direct the delivery of personal health services to patients. They defined clinician as the person who has direct contact with the patients and may be a physician, nurse practitioner, or physician assistant. It is well known that we have insufficient numbers of primary care providers to meet the needs of our state. The need for increased number of primary care providers has been clearly articulated to this committee in prior hearings. This is not the time to create state legislation that is designed to limit the ability of other healthcare professionals to provide the primary care services that are so desperately needed. Nurse practitioners have demonstrated repeatedly that they can provide cost-effective, high quality, primary care for many of the neediest members of society. This is the time for the effective utilization of all healthcare personnel who have been educated in programs supported by our state and federal dollars for the explicit reason to build our primary care work force. The College of Nursing at UNMC has operated a primary care nurse-managed clinic in south Omaha since 1993. On an annual basis, nurse practitioners have provided for all intents and purposes a medical home for approximately 2,500 patients who might not otherwise have received coordinated, comprehensive, primary care. In addition, the College of Nursing is currently engaged in a project funded by the Health Service Resources and Services Administration. We are receiving approximately $1.67 million over a period of five years to reduce health disparities among individuals with type 2 diabetes through our various nurse-managed health centers and practices across the state of Nebraska. These centers provide care for many individuals who are either uninsured or on medical assistance. One of the principal aims of this project is to care for patients with chronic diseases by improving their self-management skills. LB396, as currently written, would restrict patient access to nurse practitioners for primary care and chronic disease management. I see the light is on there. NPs have received direct reimbursement through medical assistance fee-for-service since 1990, so this is not something new. LB396 creates a barrier to this by excluding NPs as primary care providers in this demonstration project. In order for LB396 to be successful and its stated intent to provide high quality, accessible, and efficient healthcare, it is essential to continue to include primary care nurse practitioners of providers of medical homes. In conclusion, our current healthcare system has been criticized for providing too little care too late for too few at too high a cost. It is our hope that the Health and Human Services Committee takes the necessary action to include nurse practitioners as primary care providers in the Medical Home Act and ensure that residents of Nebraska have access to appropriate, timely, and cost-effective care. Thank you. [LB396]

SENATOR GAY: Thank you. Any questions? Don't see any. Thank you. Any other opponents? No more opponents. Anyone neutral? Senator Gloor, do you want to close on this? [LB396]

SENATOR GLOOR: I have about five pages of notes that I've winnowed down to about a half a page. But I do want to... [LB396]

SENATOR GAY: That's good. (Laugh) Good choice. (Laughter) [LB396]

SENATOR GLOOR: And right now I have a fan club of one. That would be Dr. Werner. I don't want to erode that either. Senator Wallman, I was going to answer a specific question that you asked which I think relates to how does somebody get to see a primary care physician if they're a Medicaid patient? And I think the challenge for us is that's going to get harder and harder as more physicians make the painful decision that they no longer can do that. We do need to address, in some way, ways to make taking care of Medicaid patients more attractive, and not just the dollars and cents. If you doubt the altruism of physicians, as Dr. Michels pointed out, most of these physicians back here belong to the organization that provides day-to-day oversight of us, and so there is...they would be better served to be back in their clinic if they were interested in just the dollars and cents. But I do think taking a long look at things, redoing the Medicaid system in a way that involves the primary care physicians, incentivizes not just them to take Medicaid patients, but also incentivize young physicians considering which practice to go into to consider going into primary care. As relates to the nurse practitioners, nurse practitioners are a vital, important part of addressing manpower shortage concerns in this state. And one would argue that point, and I would imagine the physicians, most of the physicians here have a nurse practitioner that they either work for or work with or works for them. But right now, as we know, before us is the issue around whether nurse practitioners can operate in an independent manner, and this isn't about that. This is about two clinics that we're trying to set up that would be tests for us. That's all this is about. Do we want to pilot the programs? And right now, if nurse practitioners aren't in a position to operate those pilot programs in an independent manner, there's no reason for them to be included in the definition. This is about two pilot projects. It's not about classifying nurse practitioners as not being primary care practitioners only as relates to this pilot project. If that should change as a result of actions of the Legislature, that certainly can be reevaluated and should be looked at, at that point in time. I was president of an HMO that we set up in central Nebraska a number of years ago, and that was, in fact, organized around the communities of Grand Island and Kearney. It became obvious to me that getting physicians involved and being the point of the spear, being the gatekeeper as the current Medicaid system is apparently moving towards under managed care, is short-term and short-lived and fraught with problems, because you can't make physicians the point of the spear day after day after day, when, in fact, they know they're working on behalf of either the payer or the person who's buying those services--in this case, the state. They're not working

on behalf of the patient, and they're not working in a way that they're comfortable or feel that they're part of the team. Medical home is successful because it involves physicians as part of the team in coordinating their care. And my last comment would be as relates to the fiscal note. The fiscal note is estimated around a cost based on current managed care numbers that the state has on a per-member payment basis. Director Chaumont, in a December 2008 letter to the Legislature, states that managed care has a lower per-member cost than nonmanaged care Medicaid patients that the state pays for; therefore, the program is going to be expanded to take care of this cost savings. And a cost savings estimate of 48 percent was, in fact, referenced in that 2008 letter. It would follow that if there are going to be cost savings that the state realizes for managed care, why would there not be cost savings in the medical home program? That's not figured into your letter, your fiscal note. There will be savings. The state knows that there will be savings. We know that there are savings from past experience with medical home across the United States. And with that, I'll end. Thank you for your patience. It's been a long hearing, but you've asked great questions and I appreciate it. [LB396]

SENATOR GAY: Thank you, Senator Gloor. Any questions? I don't see any. Thank you. That will close LB396. Senator Harms is here on LB656. This is like the Appropriations Committee tonight (laughter). [LB396]

SENATOR HARMS: Yeah, but you're not talking numbers. There's a heck of a difference in that, I'll tell you what. [LB656]

SENATOR GAY: Although, maybe it's like the Banking Committee...9 to 5 for...is what we're used to so (laugh), we are usually. Go ahead, John. [LB656]

SENATOR HARMS: (Exhibit 1) Okay, Senator Gay, my name is John, J-o-h-n, middle initial N, Harms, H-a-r-m-s, and I represent the 48th Legislative District. Senator Gay and colleagues, thank you for giving me the opportunity to come at this late hour and visit with you a little bit about it, LB656. This bill is the results of actually two years of study done by the Nebraska Medical Association concerning the state's options for providing high quality and affordable and accessible health coverage. The Nebraska residents face a crisis in the availability and affordability of healthcare in this great state. I don't care whether you're a private or a public, cost of providing healthcare in this great state is increasing annually so fast that people cannot afford to make the payments. People are having to walk away and not be able to get their drugs at the pharmacy or even make a doctor's appointment because they're afraid they can't pay for it. Many Nebraska residents do not have access to health insurance or even affordable healthcare services. The cost of providing healthcare service to the uninsured in this state fall upon those of us who have insurance or those who come from a tax-supported public program. This act is the beginning of the reform for Nebraska healthcare delivery system and healthcare financing system to start to ensure that our residents do have and will have high quality, affordability, and access to healthcare. The intent of this bill is

to develop a comprehensive plan for the state of Nebraska which ensures that healthcare insurance coverage for Nebraska residents that's not covered by Medicare and the fair sharing of healthcare costs by the Nebraska residents through a very basic health insurance benefit plan which would include preventive services, behavioral health, dental health, long-term care, and provide for a timely enactment of the necessary and the appropriate legislation to implement this plan. This bill clearly identifies a comprehensive plan that you can begin to put together. It clearly identifies the components that should go into such a plan. And the one thing I want to make sure that you understand that what we have in this bill, it doesn't limit you to this. It gives you a direction and a guidance of what should be included, but you have every right to go whatever direction you'd like to go or whatever path you would like, to find and to travel, but it does give you a direction of what we're trying to accomplish with this. This legislation calls for the creation of a Health Care Advisory Council. The council shall consist of six persons that would be appointed by the Chairperson of the Health and Human Services Committee; six persons that would be appointed by the Chairperson of the Banking, Commerce, and Insurance Committee. It would also include the Chairpersons of the Health and Human Services Committee; the Chairperson of the Banking, Commerce, and Insurance Committee; and the Chairperson of the Appropriations Committee. All three of those chairpersons are important to have if we're going to be successful with this advisory committee. The council shall include, but it's not limited to, at least one representative from each of the following classes of persons: healthcare providers, healthcare consumers, consumer advocates, business representatives, insurers, and elected officials. The council shall develop a recommendation, a plan that starts to address this issue. They'll give it to the Governor. They'll submit it to the Chair of this committee; they'll submit it to the Chair of the Banking, Commerce, and Insurance Committee; and one would also go probably to the Appropriations Committee, on or before September 1, 2010. It's a very short period of time. It's not going to be something that's going to be carried out long term. It's short impact so we can resolve the issue or at least know what the issues are in this great state. What we have found is that healthcare is out of touch in Nebraska in regard to affordability and the costs. It's clear that we're on a path of destruction in our healthcare system, not only in this state but in this great nation. And you know what? We're so fortunate that the Nebraska Medical Association came forward, and they said, look, we've been studying this issue for two years. It's out of control. We have no cost containment. There's concerns about quality; there's concerns about affordability; there's concerns about accessibility of healthcare in the state. And I can tell you, I don't think we can wait any longer for the federal government to do anything for us. It's been 13 years since we had this discussion and we still haven't accomplished this. I don't think we can count on the federal government doing anything in this area. And I tell you what. I would rather have Nebraska do it. I would rather have the people that I know and I trust get involved in this, and say, this is our plan; this is where we need to go; this is what we need to do; this is how we'll resolve it. I don't know if there's anybody in this room right now that could come up and lay down a plan that says we're going to fix this

healthcare system in this great state. But I believe we can find that when we blend these people together. I think we can find this when the time comes. I think the time has come that we can no longer tolerate this in Nebraska. It bothers me tremendously when I see, in my own community, people who cannot afford to go to the doctor. And I'm talking about the middle class or the lower middle class people who don't have insurance, and that's going to become more complicated if this economy stays in the same shape that it is today. If it gets worse, that issue is going to become more difficult for us. And so what I would just tell you, I think that Nebraska has always had the courage, the spirit, and the intelligence to take on issues such as this. And Senator Gay, I would urge you to give this great consideration. I think it's a start for us for the first time to bring everything together in this state to develop a plan. And the beautiful thing about this, that's what it is: It's a plan. I've heard people say, well, John, it's going to be too costly. I don't know if it's going to be too costly or not. But at least you know what? We're going to find out where the costs are. We're going to find out what it takes to fix it, so I would urge you to approve this. Senator Gay, I don't know how you would like to do this in regard to the amendments, my amendment. Do you want me to go through that or you could read it? [LB656]

SENATOR GAY: Nah, we got the amendment and then we'll just take a look. We get that, and then you covered it in your testimony. [LB656]

SENATOR HARMS: Okay. [LB656]

SENATOR GAY: (Exhibits 8-18) Also, do you want to...I know there's a lot of people that want to speak. I've got nine letters of support here for it that we'll put into the record. I'm not going to bother reading them, but that's very good. And then, do you want to...I'm sure other people are going to bring it. Do you want to take questions now or do you just want to wait and...? [LB656]

SENATOR HARMS: I'd be happy to take questions. I'd also like the pleasure of closing to answer any questions that you might have or anything like that so. [LB656]

SENATOR GAY: Yeah, no problem because I got a couple for you, but I was going to...but all right, any questions for Senator Harms? You know what? If you're going to stay around to close, I'll just wait and see if it's covered. Okay, thank you. [LB656]

SENATOR HARMS: Oh, I will, I will. Thank you very much. But sometimes it's nice to be the last one of the day, isn't it? (Laughter) And I know Arnie will come back, he always does (laughter). Thank you very much. [LB656]

SENATOR GAY: All right. We'll hear from proponents on LB656. [LB656]

RICHARD O'BRIEN: (Exhibit 2) Senator Gay, members of the committee, my name is

Richard O'Brien. That's R-i-c-h-a-r-d O'-B-r-i-e-n. I am a physician; a member of the Center for Health Policy and Ethics at Creighton University; and with my colleague, John Benson, who will follow me here, cochair of the Nebraska Medical Association Task Force on Health Care Reform. And I'm here to testify in support of LB656, the Health Care Accessibility and Affordability Act. I'm sorry to tell you, but healthcare as it exists in Nebraska today is not sustainable over the long haul or even over the not-so-long haul. Every year, the number of uninsured grow as shortages of health professionals create great difficulties of access for Nebraskans across the state, costs increase faster than earnings and state productivity, and hundreds of Nebraskans die each year because of flaws, one flaw or another in the system. In 2007, 232,000 Nebraskans were without health insurance for the entire year. That's 13 percent of the population, up 66 percent from 2000. During the biennium 2006-2007, 437,000 Nebraskans--that's 28 percent--were without insurance sometime, and 262,000 for more than six months. But the uninsured do ultimately get care when they are so sick, or they've been injured, that they end up in emergency rooms in hospitals, when their conditions are much worse and much more expensive to treat. Who pays for their care? You worry about costs. Who pays for their care when they get it if they're uninsured? Well, I'll tell you who pays for it. Insured Nebraskans pay for it and employers pay for it. Providers shift the costs of the care of uninsured persons to insurers and employers, who, in turn, pass the costs on in the form of higher premiums or employee contributions to their employer-provided coverage. They are literally paying a hidden tax. They're paying a tax, a hidden tax, to support care for people in our state who don't have coverage. From 2000 to 2007, healthcare costs in Nebraska rose 60 percent faster than the gross state product. I give you a little chart on the handouts that I provided. But worse, family premiums in Nebraska rose more than three times as much as median family income. It's obvious that healthcare costs spiraling upward in this manner are not sustainable for very long. In many parts of Nebraska, particularly in rural areas and underserved parts of cities--urban areas--face very critical shortages of health professionals. The federal government has designated vast areas of Nebraska health professions shortages. And, frankly, the Office of Rural Health in the state of Nebraska thinks it's even worse than the federal government has identified. Quality also leaves a good deal to be desired. It's been estimated that there are 650 to 700 preventable deaths annually in Nebraska resulting from errors or preventable infections. Nebraska hospitals report an average of nearly 600 errors annually from 2000 to 2006. The Commonwealth Fund, which has a scorecard for assessing systems, estimates that approximately 1,500 Nebraskans die premature deaths; deaths that could have been prevented by timely and appropriate care. But if you can't get the care and it's not the right care, you suffer the consequences. Senators, healthcare is not only unsustainable the way it is in Nebraska today, but it is intolerable. It needs to be changed. It's time to change. The Nebraska Medical Association has consulted with health and health stakeholders across the state: insurers, businesses, institutional providers, other professional organizations from all across the state, and these consultations have resulted in a road map, not a comprehensive plan but a road map to a comprehensive

plan, to afford high quality, affordable care for all Nebraskans. That road map is encompassed in LB656. Let's report this bill out. Let's pass this bill and get on the road to a better healthcare system and better health in Nebraska. [LB656]

SENATOR GAY: Thank you. Any questions? Senator Wallman. [LB656]

SENATOR WALLMAN: Thank you, Chairman Gay. Welcome, Doctor. I agree, healthcare things are going out of...you know, out of sight. Years ago I was on a task force about public employees. If we had a, you know, a system set up where we would pay, like Creighton, so many dollars a month; prepay as such like the ambulance service used to be here with Eastern. And that was pretty efficient. Plus, you got...what's the lag time for insurance to pay you, do you know? [LB656]

RICHARD O'BRIEN: It varies a great deal with the payer. It can be quick if you've got a good...if the insurer has a good electronic billing system, but I'd say probably it ranges from one to three months. That's an estimate. I don't know that with confidence, but it varies. [LB656]

SENATOR WALLMAN: And I know Creighton has taken a lot of the hits on, you know, getting paid. [LB656]

RICHARD O'BRIEN: Well, we take care of a whole lot of poor people, there's no doubt of that (laugh). Any other questions? [LB656]

SENATOR WALLMAN: Yes, yeah. Thank you, Doctor. [LB656]

RICHARD O'BRIEN: Any other questions? [LB656]

SENATOR GAY: Senator Stuthman. [LB656]

SENATOR STUTHMAN: Thank you, Senator Gay. You had mentioned, you know, the amount of people that are uninsured at the present time, and that is continued to grow. [LB656]

RICHARD O'BRIEN: It's probably higher today than it was in 2007. [LB656]

SENATOR STUTHMAN: And I'm very sure of that, but does that mean that every one of those that are insured are not paying their bills that are uninsured? [LB656]

RICHARD O'BRIEN: Most either don't pay their bills at all or they can only pay part of it. So somebody else has to pay the other part. There are a small number of people who are able to pay their total costs, but that's a very small fraction of the whole. [LB656]

SENATOR STUTHMAN: I mean, that was the thing that I was, you know, trying to relate to, you know... [LB656]

RICHARD O'BRIEN: Very small number. [LB656]

SENATOR STUTHMAN: ...there are people that do private pay, they self-insure themselves... [LB656]

RICHARD O'BRIEN: That's right. [LB656]

SENATOR STUTHMAN: ...and they pay on their own, and they pay their own bill. [LB656]

RICHARD O'BRIEN: But that's a small number. [LB656]

SENATOR STUTHMAN: Yeah. Why are these healthcare...why are these premiums going up at a...you know, the premiums for healthcare have escalated dramatically. Why is that? [LB656]

RICHARD O'BRIEN: There are a lot of reasons for that. One of the things and one of the good drivers of increasing premiums is improving technology, improving methodology of care from which we get better results. That's good. We won't complain about that, at least yet. On the other hand, we know that a lot of care is delivered that is unnecessary: care that is delivered because of the structure of the reimbursement system. Health professionals and hospitals get paid for what they do, not for what they accomplish. And we do things that, frankly, don't add to value, and we fail to do things, at times, that would add to value. Preventive care in this country leaves a great deal to be desired. One of the things that we call for is a very explicit and detailed approach to prevention, both primary prevention so that people avoid getting diseases, and secondary prevention so that we avoid the complications of chronic diseases. [LB656]

SENATOR STUTHMAN: The situation that I am very concerned with is the fact that the people that are insured...and because they're insured, you know, they say, well, go to the doctor, insurance will pay for it, insurance will pay for it. And it's a lot of little things that, you know, really they wouldn't have to go to the doctor for, in my opinion, just a little cough, but. [LB656]

RICHARD O'BRIEN: I know of essentially no insurance coverage that doesn't have some level of deductibility. Usually the minimum I've seen is $250. I think now most places have a deductible of somewhere between $500 and $2,500 so they're paying out-of-pocket first dollars except for preventive care in some good plans. Furthermore, there are copays. The copays vary from 10 percent to 20 percent; in some instances, 30 percent. So people are paying out-of-pocket. In fact, Americans pay 15 percent of their

healthcare costs out-of-pocket. That's more than almost any developed nation in the world, so...and other nations provide care for a lot less money and get better results. Now...well, I think I answered your question (laugh). No, there's one point I'd like to make, though. Uninsured people frequently can't...I mean, insured people frequently can't make their payments. Did you know that almost half, not quite, but almost half of personal bankruptcies in the United States result from medical debt? And 75 percent of the people who go bankrupt because of medical debt are insured. [LB656]

SENATOR STUTHMAN: They must be charging too much on the other end. [LB656]

RICHARD O'BRIEN: Well, I could refer a paper to you that was published a few years ago, the title of which, It's the Prices, Stupid: Why Health Care Costs So Much in America (sic). (Laugh) [LB656]

SENATOR STUTHMAN: Thank you. [LB656]

SENATOR GAY: All right. Any other questions? I don't see any. Thank you, Doctor. I was glancing through the letters of support, and I did mention we have nine. As I was glancing through there, there are many that said, it's a great idea; we'd like to be included. If your testimony is going to be to come up and say it's a great idea, we'd like to be included, can you please just write it down on the testimony sheet? We'll get you included in the record that you'd like to be included. Senator Harms, when he opened, said that there would be right now 18 members on this commission if it were to be established. So there's a lot of room, I think, there. But in the interest of time, if that's kind of what it is, just write that down that you'd like to be included, and we'll definitely get that in here. Another thing, though too, is healthcare reform has been talked about for a long, long time, I know. I'd like to keep a little bit because we could be here all night on that (laughter), and that's why we're looking at creating this. But if there's a certain thing, how this could benefit really, you know, how this idea would benefit and we get to that point, I think that would be very constructive for all of us so. [LB656]

JOHN BENSON: (Exhibit 3) Thank you, Senator Gay... [LB656]

SENATOR GAY: You bet, thank you. [LB656]

JOHN BENSON: ...and your colleagues on the committee. I must say, I admire you for your stamina and your patience. [LB656]

SENATOR GAY: You too. You're still here (laugh). [LB656]

JOHN BENSON: (Exhibit 3) I am John Benson, J-o-h-n B-e-n-s-o-n, M.D., a cochair of the Task Force on Health Care Reform with the Nebraska Medical Association and a professor of internal medicine at the University of Nebraska Medical Center. I wish to

testify in strong favor of LB656. Dr. O'Brien has detailed the need for comprehensive reform, because without cost control, better access, and improved quality, this situation will only worsen. Coverage is the gateway to reform, and that's covered very nicely in the booklet you've received from the NMA. I wish to emphasize the urgency of reform; therefore, legislative action. Without action this year or next, we can expect costlier reform any subsequent year. By survey, Nebraskans have overwhelmingly called for change. Pay up now or pay much more later, as you've seen from the charts of Dr. O'Brien. Some will argue that, because of the recession, the timing for reform is poor. On the contrary, this is exactly the time for reform. Healthcare is a growth industry, provides good jobs, and can stimulate an economy. Furthermore, healthy employees require less care and are more productive workers, which indirectly helps revenues and taxes in our state. And incidentally, healthy children learn better. And who is confident that federal reform can overcome lobbying by vested interests and partisan ideology this year? LB656 offers a template for consideration by various stakeholders. It calls for a public/private collaboration using multiple and existing funding sources. It is not an employer mandate, and it is sensitive to the needs of small business like ranchers and farmers in protecting their employees. Finally, it would authorize the creation of the broadly representative Health Care Plan Advisory Council, which, in turn, will develop over the next 18 months a detailed and comprehensive--I underscore that... not incremental plan, to recommend to the Legislature. This deliberate approach to reform has benefitted other states. The time has arrived when consensus can and must be reached. Each passing year without reform is a wasted opportunity to improve the health of our people, first, and to control costs in Nebraska. Thank you very much. [LB656]

SENATOR GAY: Thank you, Doctor. Any questions? I have one for you. [LB656]

JOHN BENSON: Please. [LB656]

SENATOR GAY: So this--I'm reading through here--this would be reported back to the Legislature in September...to the Governor and the different committees, September 1, 2010. [LB656]

JOHN BENSON: Correct. [LB656]

SENATOR GAY: So we'd get through this year; we'd start work in August. So any legislative changes would actually have to be introduced in 2011, so really the 18-month window you're talking about, that's...the work would be done then over that time period? [LB656]

JOHN BENSON: It's a pretty busy 12 months. I see your point. [LB656]

SENATOR GAY: Well, yeah, that's...and then another thing, you know, glancing through

here again, earlier you were here, probably heard on the medical home model. I see you have that also would be one of the things to look at in this plan. [LB656]

JOHN BENSON: Yes. We strongly urge that insurers would be rewarded for offering policies that, in fact, cover the medical home concept. And we're quite clear in our own minds that that is useful, not only for reducing costs, but for increasing quality, and quality that removes disparities, by the way, and provides access. I must say, from my own personal views--these are 20 years old now, from experience in Oregon--that I would include licensed advanced practice nurses, master's prepared nurses among providers within the scope of practice of any state's laws. [LB656]

SENATOR GAY: And then today I've seen...well, or continue to see many physicians coming up and saying, here's...we've got a mess here; let's fix it. [LB656]

JOHN BENSON: Yes. [LB656]

SENATOR GAY: It's telling right there. But anyway, on the other situation when you look at this, what goes through my head--and Senator Harms brought up this fact, and he's always very optimistic and I admire that--federal reform. Federal reform is happening or talked about, and has been forever, I know. But there's a certain point, as the largest payer, you don't think...are you that pessimistic that there won't be some federal reform, or are you looking at working along the same routes with them? Because I think there might be something done, quite honestly; I'm a little more optimistic this time. But are you going on parallel tracks here, watching what's going on all the time while this committee would be... [LB656]

JOHN BENSON: Oh, absolutely. I think... [LB656]

SENATOR GAY: ...that's what would...kind of on everyone's mind. [LB656]

JOHN BENSON: SCHIP, for example, is perhaps a low-hanging fruit which may or may not be difficult for the states, and there are other things like that, that might get done sooner. I'm discouraged that it will happen this year. And I admire Senator Harms's emphasis on the community of Nebraska being able to decide what's best for the community of Nebraska. A model, an experiment perhaps for other states, would be something we could all take pride in. [LB656]

SENATOR GAY: Yeah, and I admire that, too, but earlier we had a discussion, a long discussion on the fact is, it is what it is: Medicaid and Medicare pays certain things only. [LB656]

JOHN BENSON: Right. [LB656]

SENATOR GAY: And no matter what we do, if we want to participate in those programs it's still kind of like this is the way it is. [LB656]

JOHN BENSON: We did not feel we could mess with Medicare because it's federal, and the state does not contribute in the same way as it does to Medicaid. On the other hand, we have some optimism about useful strategies that might warrant waivers. Yes, that will take a little time. That's for the council, I think, to work out. [LB656]

SENATOR GAY: Right, and those are always useful tools, as appropriate. [LB656]

JOHN BENSON: Yes. [LB656]

SENATOR GAY: Thank you. Thank you, Senator. I don't see any other questions. Thank you. [LB656]

JOHN BENSON: Thank you. [LB656]

SENATOR GAY: How many proponents are going to be speaking? About four, five, six, seven more. [LB656]

SHAD BEAVERS: Chairman Gay, members of the committee, my name is Shad Beavers, S-h-a-d B-e-a-v-e-r-s. I'm the director of the Creighton School of Law Health Care Legislative Council, a student organization formed to push for healthcare reform in our state, and a member of the Nebraska Health Care Reform Task Force. It's been my privilege to work with both Dr. O'Brien and Dr. Benson on this project, and I'm here to voice my support for LB656. Members of the committee, state legislatures around the country are faced with challenges of expanding uninsured population. Currently, other states are taking the lead in implementing healthcare reform. Now, while these states are at the forefront of reform, their proposed programs do not rely on the state to be the single payer. They're not seeing the state as the insurer of the last resort for everyone. Instead, most policy changes are designed to increase affordability of healthcare for their populations. These other states are doing something right by taking a more proactive role in healthcare reform, and the federal government is watching closely. As you had mentioned, Senator Gay, we do wonder, is the federal system going to provide a program, or are they going to look to the state for providing programs? And being the fact that nobody quite knows at this point, we believe it's best for the state to, on its own, make its own policies. Beyond this we must, as a state, redirect our efforts from simply providing care to the sick, and increase preventive medical and educational services. This includes ensuring the patients have access to physicians, necessary medications, and therapies. I am here to encourage you to step forward, because this issue touches the lives of each and every citizen of Nebraska. And this issue demands immediate attention and I respectfully request that you give it the attention that it rightfully deserves. LB656 provides the groundwork to constructing wise healthcare reform.

Today I ask that you take the first step in advancing this bill to the floor. I will try to answer any questions that you may have. Thank you. [LB656]

SENATOR GAY: Thank you. Are there any questions? Senator Gloor. [LB656]

SENATOR GLOOR: Thank you, Chairman Gay. I appreciate the fact that there is a group of young professionals that is rolling up their sleeves trying to get involved in this. But let me ask you, during your debate has there been a discussion about whether you see--and I'm talking about the group itself as opposed to you personally although you're welcome to answer that way--has there been a discussion or debate about whether healthcare as a service or healthcare that should be provided as a service, versus healthcare being a business?--and business is what has made this country strong. There's not a right or wrong answer here, but there certainly is a difference when it comes to policymaking, on whether healthcare is a service, like law enforcement, versus a business, like many other things we do in this country. [LB656]

SHAD BEAVERS: Let me answer that from a...personally. The truth of it is, I don't think many of these young professionals quite even grasp or having come to that crossroad yet. When I was younger, when I was first out of high school I went directly into the military. For six years I was in the U.S. Army as an x-ray tech and combat medic for the 28th Combat Support Hospital at Ft. Bragg, North Carolina; and in that time, I was deployed to Haiti and witnessed some things I never even imagined. And something crossed my mind when I was there. It, to me, seemed that I don't know where the business begins and rights and the business aspect of healthcare end or begin. I do believe that America is a land that we are people that are humane and we are people that believe in taking care of each other. I do understand that. Although we are a capitalist nation, there is a humanity that America, I believe that we exhibit more than many other places. And so in my mind, in my heart I do believe that healthcare services, it is a right. I just can't see...I try to make this distinction to people many times, and I tell them, here in America if you walk across the street and you get hit by a taxi or a car or something happens to you, somebody is going to come. Police are going to come. An ambulance is going to show up to pick you up. But if you're in these other places and you get hit by a car, crawl off the road because you're going to become a speed bump. Maybe we have it too easy here. Maybe things in America we see things differently because we are privileged to live in this great land. But be it as it may, I do believe that healthcare is a right. [LB656]

SENATOR GLOOR: That is kind of an answer that I would put in the service category. I would encourage you to go back and kick that around a little bit with your group. But I would encourage Dr. Harms, as this moves forward, to me it's a fundamental discussion that has to happen. We have for-profit hospitals; we have not-for-profit hospitals. We have people who are in healthcare because it's a business, and we have people who are in healthcare for altruistic reasons. And there's a schizophrenia that develops that

puts us at odds with each other, and I think it makes it difficult to make policy and know the right decisions. I think until we solve our answer to that specific question, and not just as a state but as a country, we're going to struggle with what and how to provide healthcare to citizens and how to make difficult decisions to steer in that direction. So that's just...it's something I feel pretty passionately about. We have to answer that question. We do. [LB656]

SHAD BEAVERS: Thank you. [LB656]

SENATOR GAY: Any other questions? I don't see any. Thank you. [LB656]

SHAD BEAVERS: Thank you. [LB656]

DAVID HOLMQUIST: (Exhibit 4) I only killed about 20 trees with the handouts today, but it is our old branding so I'm using up old stuff for you. Good afternoon, Chairman Gay, members of the Health and Human Services Committee. Thank you for the opportunity to testify today. My name is David Holmquist. I am a registered lobbyist and represent the American Cancer Society as director of state legislative government relations in Nebraska. I appear today in support of LB656, the Health Care Accessability and Affordability Act. In poll after poll, people from all across the United States have indicated that one of their biggest concerns is healthcare. They are concerned about access to quality healthcare and they are concerned that should they or a loved one become ill they will not be able to afford healthcare. The ever increasing cost of health insurance and the possibility of not being able to qualify for health insurance are issues of critical importance to most Americans. Previous testifiers have mentioned...used the word uninsured. I would suggest to you that we have a large number of underinsured Americans as well, people who if a catastrophic illness happens they run out of their potential for treatment early on. That's one of the reasons for the bankruptcies across the country. In my paperwork, I include a quote: Some people think that doctors and nurses can put scrambled eggs back into the shell. And that really is the state of our healthcare system in this country. We don't do anything about it until we have to have the care. As an example, if we have certain kinds of preventive services, we may be able to avoid certain kinds of cancer. In other words, we find cancers before they become cancer, we cut out the problem, and we have avoided cancer and saved a lot of money. On the other hand, we have cancers like pancreatic cancer for which there is no prevention and for which we have little detective services. I lost a dear friend Sunday to pancreatic cancer. The good news is, she had almost seven years of fairly quality lifestyle because she lives in Nebraska and because she was able to be treated at the Med Center with state-of-the-art technology. The American Cancer Society began investigating the state of healthcare in America several years ago, and concluded that our goals to significantly reduce suffering and death from cancer by 2015 were severely compromised by lack of access to healthcare. Problems with the healthcare system have a significant impact on people with cancer. Issues for cancer patients include lack

of services for early diagnosis, transportation challenges for treatment and physician follow up, cost of drugs associated with treatment, and access to specialists, to name a few. Twenty-five percent of all cancer patients or their families reportedly used up all or most of their savings to pay for treatment. After diagnosis, 1 in 10 are denied health coverage and 10 percent are not able to pay for food, heat, or housing. We applaud the Nebraska Medical Association for its leadership in looking for ways to address this critical issue in Nebraska. Their efforts to reach out to the people of Nebraska give us a good picture of how healthcare concerns our own populace. The 14 points included in their proposal to reform healthcare in Nebraska are an excellent effort to address the problem, and they are specific to Nebraska. They are not something that's going to be sent down as a mandate from Washington that we have no control over. They are not a carbon copy of proposals put forth or implemented in other states. While some individual groups and organizations may disagree with specific items within the proposal, the overall proposal is excellent. Just as each of us must have responsibility for our own health, all sectors of the healthcare industry must share responsibility for seeking and agreeing on common ground to improve the system. The Nebraska Medical Association's recommendations seek such shared responsibility and offer access to all sectors of the population. Access to quality healthcare for all should be addressed now. And just as individuals have personal responsibilities, the state, I believe, has a responsibility to its citizens to encourage improvements in systems and should encourage a solution based on Nebraska's unique environment, not depending on the federal mandates. The American Cancer Society stands ready to assist in any way possible to improve health outcomes for those not yet touched by cancer and for those who have heard the words, you have cancer. Cancer patients and those who suffer from other chronic and/or catastrophic diseases are counting on us to make real improvements. LB656 is a unique opportunity for the Unicameral to take a giant step forward in addressing the issue of healthcare reform with meaningful outcomes. Let's not just put a bandage on the wound and hope the wound will heal itself or wait for somebody else to find a cure. On behalf of the American Cancer Society, I urge your support of LB656. [LB656]

SENATOR GAY: Thank you. Are there questions? I don't see any. Thank you. [LB656]

DAVID HOLMQUIST: Thank you. [LB656]

SENATOR GAY: How many more people would like to...are proponents? How many opponents are here? There's not one opponent here then? Okay. Any neutral? One neutral. Okay. Looks like about four...if you want to come on up a little that will help. [LB656]

KAY OESTMANN: (Exhibit 5) My name is Kay Oestmann, K-a-y O-e-s-t-m-a-n-n. I want to thank Senator Gay and the committee for letting me...I am president of the Public Health Association of Nebraska, and I'm going to make this quick because I believe in

prevention. (Laughter) Access to care is a problem that local health departments see nearly every day and that we deal with, and you know, situations where early intervention would have made a big difference. Sixty percent of the small businesses in Nebraska don't provide health insurance to their employees. Prevention and early intervention are essential components in the development of the comprehensive recommendation for reforming Nebraska's healthcare delivery system. Over the past year, the Public Health Association of Nebraska, and specifically their affiliates, the local health directors and the local boards of health, have partnered with the Nebraska Medical Association in educating citizens across the state about this very plan. We strongly support LB656. You have the rest of my testimony in front of you and I won't bore you with it. Any questions? [LB656]

SENATOR GAY: Any questions for Kay? Did we tell you you're one of our favorite testifiers? (Laughter) Thanks, Kay. [LB656]

KAY OESTMANN: Plus I show up often. [LB656]

SENATOR GAY: Thank you. It looks like no questions. Thanks. [LB656]

KAY OESTMANN: Thank you. [LB656]

JIM CUNNINGHAM: Good evening, Senator Gloor. [LB656]

SENATOR GLOOR: Hello. [LB656]

JIM CUNNINGHAM: And Senator Gay and members of the committee. This is my first opportunity to appear in front of Senator Gloor whom I have known for many years, and so I wanted to make a special greeting, Senator. [LB656]

SENATOR GLOOR: Thank you. [LB656]

JIM CUNNINGHAM: But Senator Gay and members of the committee, my name is Jim Cunningham, that's spelled C-u-n-n-i-n-g-h-a-m. I'm testifying in my capacity as executive director and registered lobbyist for the Nebraska Catholic Bishops Conference. My testimony is presented in support of LB656. Based upon our church's fundamental teaching on the inherent value and dignity of every human life, we consider healthcare as much more than a commodity or a product, but as an essential safeguard of this value and dignity, a basic human right. We believe, therefore, that securing access to adequate healthcare for all Nebraskans with a particular concern for the poor is not just another issue, another policy goal, or another political challenge, but is a moral imperative. Therefore, the Nebraska Catholic Conference supports LB656 because we view it as a significant, encouraging initiative which will take Nebraska in a necessary direction. We urge that you move it to the full Legislature. And just to be clear

for the record, our support for LB656, this road map to basic access to healthcare, does not constitute or presume our support for any specific legislation that might result. But we are confident that the goal is compelling and that worthy results will be accomplished. Thank you for your attention. [LB656]

SENATOR GAY: Thanks, Jim. Any questions? Senator Gloor. [LB656]

SENATOR GLOOR: I have to ask a question. Mr. Cunningham, have you reviewed the Catholic Health Association's healthcare reform initiative that they have out? [LB656]

JIM CUNNINGHAM: Not in great detail, Senator Gloor, but I am familiar with it. [LB656]

SENATOR GLOOR: Yeah. It would be interesting to know how closely the two mirror each other. I think in most ways they probably do, but it would be worth doing a side by side I think to find out because there may be something that can be learned. An awful lot of effort went into the work that the CHA did, and it might be helpful to us in Nebraska. [LB656]

JIM CUNNINGHAM: I have access to that and will be happy to do it. And I can say that the fundamental support, the fundamental basis for that would be consistent with the notion of healthcare being a basic human right and that there is a moral imperative to secure access for all. [LB656]

SENATOR GLOOR: Thank you. [LB656]

JIM CUNNINGHAM: Thank you. [LB656]

SENATOR GAY: Thank you. Other questions? I don't see any. Thank you. [LB656]

JIM CUNNINGHAM: Thank you, Senator. [LB656]

CORA MICEK: (Exhibit 6) I said good afternoon earlier, definitely good evening now. Senators, my name is Cora Micek, C-o-r-a M-i-c-e-k, and I'm here representing the Nebraska Hospital Association. On behalf of our 85 hospitals, we support LB656. As Senator Gay recognized earlier, health reform has been discussed at the federal level for many years. And especially in this last presidential election cycle, healthcare reform became a topic that many Americans have really thought about for the first time. And so I think we have a great incentive to act right now. And the creation of the Health Care Plan Advisory Council will ensure that a serious and comprehensive discussion of healthcare reform is done at the state level. And through the promotion of health insurance coverage for all and an emphasis on wellness and prevention, Nebraskans will be better served and the increasing costs of healthcare can be addressed correctly. And I shouldn't say this, but the Hospital Association would like to be part of the

discussion. We have members across the state and feel we have a unique perspective as providers, innovators, and leaders of healthcare across this state. So I can answer any questions you have, but I promised to keep it short so. [LB656]

SENATOR GAY: Thank you, Cora. Any questions? I don't see any. Thanks. [LB656]

CORA MICEK: Thank you. [LB656]

PAUL PLOFCHAN: (Exhibit 7) Hello again to the committee on LB656. My name is Paul Plofchan. I'm, again, the director of government relations for Pfizer and a registered lobbyist, and I'm here to testify on behalf of LB656. You have my full statement. I've also provided you healthcare principles established by our company which I believe support the content of LB656. I'm not going to read any of it except to go to my conclusion or to almost the conclusion of my statement which says that LB656 and the policy discussions surrounding it are really valuable, but there is something we would like to clarify. And while it may be implied, we believe it's important that a meaningful prescription drug benefit be included in a basic healthcare insurance plan, and would like to go a little further to say such a plan must support the physician/patient relationship by providing broad access to medicines based on value, not just costs, and to ensure that the physician can prescribe the best treatment choice for an individual patient based on their clinical judgment. So, not a program based on limited access with incentives and pressures placed on physicians and patients to use only generics, for example, just because they may be less expensive, but rather a program which respects innovation and value, and more importantly and most importantly, the full competence of Nebraska physicians in their independent assessment of a patient's needs. And finally, despite Senator Gay encouraging us not to do this, we, of course, would like to and ask that a membership of the Health Plan Advisory Council be such that it specifically includes a pharmaceutical manufacturer on this bill. The purpose for that is that pharmaceutical costs, while only accounting for approximately 10 percent of total healthcare expenditures, are an important component not only of expenditure but also of healthcare value. And it's a proven concept that pharmaceutical treatment options lower expenses in other areas, such obvious ones as hospitalization rates, reduces need for things such as surgeries, repeat visits to the doctor. And as such, representation from a pharmaceutical company and the expertise they could provide, it would be great value. Thank you very much. [LB656]

SENATOR GAY: Thanks, Paul. Any questions for Mr. Plofchan? Don't see any. Thank you. [LB656]

RON ASHER: Hello. It's good to be here. I can see that time is growing short. I did have a really long presentation. But anyway, my name is Ron Asher, that's A-s-h-e-r. I'm a private physician from North Platte, past president of the Nebraska Medical Association. And I will say the politically incorrect thing which is that healthcare in Nebraska actually

is very good. The healthcare system is not so good. The healthcare is good if you have decent health insurance, if you have some degree of health literacy, and if you have a personal physician. The nice thing about the proposal in this bill is that it supports all of those things. By decent insurance, I don't mean that anything and everything is covered because clearly that's not what we need. Coverage ought to include reasonable prevention, healthy lifestyle, cost-effective medicines, management of chronic diseases, catastrophic coverage, and ought to support a stable patient and physician relationship. Health literacy, I think you already know more about than I do so I won't talk about that. Personal physicians...I've had the privilege of fulfilling lots of hats over the years, from being an oncologist to a cardiologist to now being a nephrologist. Because I'm out there on the frontier, you sometimes have to wear different hats. And what I see is that that relationship between a patient and their personal physician is very important because of the educational process; because of the help that patients need in navigating what sometimes is a very difficult set of choices: ethical, political, moral, financial; the ability to coordinate with a variety of specialists; even the ability to talk to the state from time to time. Anyway, I am a supporter of this bill and I appreciate the fact that you folks have spent so much time dealing with healthcare issues. It's not very easy. If there are questions, please let me know. [LB656]

SENATOR GAY: Any questions? I don't see any. Thank you. [LB656]

RON ASHER: Thank you. Thank you all. [LB656]

SENATOR GAY: Any other proponents? Any opponents? We have one neutral. [LB656]

MICK MINES: Senator Gay, members of the Health and Human Services Committee, my name is Mick Mines, M-i-c-k M-i-n-e-s. I'm a registered lobbyist representing the National Association of Insurance and Financial Advisors, an association that comprises about 1,100 associates across Nebraska. I'm here today in a neutral capacity. NAIFA believes that the comprehensive healthcare reform outlined by the Health Care Accessibility and Affordability Act affects not only Nebraska residents but also our state's delivery system, healthcare finance system, and insurance providers. Our organization has reservations about some of the specific considerations described in the bill and we don't agree with all the premises suggested in the bill, but we recognize the importance and the value in discussing and developing new solutions for meeting the healthcare needs of Nebraskans, which we understand to be the overriding intent of the bill. The development of a high-quality, comprehensive healthcare reform strategy must include input from all entities, and the bill rightfully allots positions on the board for these stakeholders. NAIFA would like to offer our members and our resources to the committee and would like to solicit appointment to NAIFA to a member of the committee. I would thank you for your consideration and your long day, and would answer any questions. [LB656]

SENATOR GAY: Questions? Senator Stuthman. [LB656]

SENATOR STUTHMAN: Thank you, Senator Gay. Mr. Mines. [LB656]

MICK MINES: Senator. [LB656]

SENATOR STUTHMAN: According to my calculations right now, we've got about 25 people on that board. Is that too many? [LB656]

MICK MINES: I guess that's your consideration, Senator. The larger the board, as Senator Gay had indicated earlier, the more deliberation it takes. And you've worked on boards that have too many people. [LB656]

SENATOR STUTHMAN: Okay, thank you. [LB656]

SENATOR GAY: Any other questions? Senator Gloor. [LB656]

SENATOR GLOOR: And I'll be brief. Thank you, Chairman Gay. Mr. Mines, has NAIFA embraced a model or does it have its own model for healthcare? [LB656]

MICK MINES: NAIFA does not have a model. But in this case they took a neutral position just simply because there are some unanswered questions. It's a broad, broad ranging bill and the membership would like to be part of the discussion when that does happen. [LB656]

SENATOR GLOOR: Thank you. [LB656]

MICK MINES: Thank you. [LB656]

SENATOR GAY: Any other questions? I don't see any. Thank you. [LB656]

MICK MINES: Thanks. [LB656]

SENATOR GAY: Senator Harms is here to close. [LB656]

SENATOR HARMS: I know you're tired. I understand that. I have trouble coming this late, of switching from numbers to words, out of the Appropriations Committee. Just a couple of things I'd like to clarify for you. The number on the committee, you have the right to adjust that, as you know, to make it probably more workable. I don't think you'll find any problems with that aspect. We're fortunate we have Senator Gloor who has such a great background in this area to maybe help us think through that, and I appreciate that. The comment that you made earlier, Senator, about what we have to answer, that's correct. And I'm hoping that as we look at this, through the committee,

they'll begin to find an answer for that. The one thing that I, as I think of healthcare, I think of it as a social good. I think when we lose track of the fact that it is a social good is then when we start having our difficulties. I believe that a healthy population is more productive. When kids are healthy, they learn better. I think that healthy people require less cost. So I think the whole thing that we're after here is to find a solution to the issue of our health plan. And I know that people would like to wait for the federal government, but let me tell you what. I feel more comfortable with people like yourselves or people like you and I, that our hearts are in Nebraska and care about our citizens, starting to carve out what we think. And what I would be in hopes that you will keep in mind is this is just a plan that gives us the chance to identify what the issue is. Because the hard work then really comes, then what are we going to do with this; did we answer the question, Senator Gloor? What is the solution to this? And I don't have any of those answers. I don't know if any of us do. So that's what this is about, and I hope that you'll be gracious enough to bring it out. I thank you for your time and your effort. And I know you're probably getting hungry, so I'm...Senator. [LB656]

SENATOR GAY: Any last questions of Senator Harms? Thank you for your patience too. And by the way, thank all of you for sticking around. As we said earlier at 1:30, it's hard for those that are last on this list and appreciate your patience and appreciate the committee members' patience. Thank you all. [LB656]

Disposition of Bills:

LB371 - Placed on General File with amendments.
LB396 - Placed on General File with amendments.
LB541 - Held in committee.
LB610 - Held in committee.
LB656 - Held in committee.

Chairperson

Committee Clerk