[LR83 LR85 LR219]

The Committee on Banking, Commerce and Insurance and the Committee on Health and Human Services met at 9:00 a.m. on Wednesday, November 30, 2011, in Room 1401 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LR85. Banking, Commerce and Insurance Committee Senators present: Rich Pahls, Chairperson; Dennis Utter; Chris Langemeier; Paul Schumacher; Mike Gloor. Health and Human Services Committee Senators present: Kathy Campbell, Chairperson; Gwen Howard; Mike Gloor. [LR85]

SENATOR PAHLS: Good morning. Thank you. One response is not all bad this time of the day. I want to welcome you to the Banking, Commerce and Insurance Committee hearing today. My name is Rich Pahls. I'm from Omaha, and I represent District 31. The committee, or the committees, will take up LR219 (sic) as posted. That's our interim study that we will be discussing, uh...well, I know why you're here. You know what we're discussing. This is the time for you to come forth and give us your opinions, your ideas on the directions, some of the directions we should take. Now, to better facilitate the meeting, I would like you to follow, look at some of our rules in here that are similar to many of the committees. If you take a look at those, I will not repeat those. The one or two things a little different here, you see we have reserved seats up here. What I ask you to do is come forth and sit in those seats so it gives me an idea of how the testimony will proceed. One difference on the rules over there, it says we have the proponents, opponents. Today, we do not. You come up when you feel like coming up and testifying, and when you do, you do need this sheet, and they are at the doors, and you will give those to Jan or to one of the pages. Today, on the resolution, Bill Marienau will be introducing that for us. If you have copies of information that you would like to have, we need at least 10 copies of that if you want to share that with the committee, or committees. And right now, if you do not have 10 copies and you want to share it, wave your hand, because then we will have one of the pages run some off for you. I see no hands waving. Thank you. The person sitting here, Bill Marienau, like I say, he will be

giving the, introducing the resolution today. Jan Foster is the Committee Clerk who will make sure that we follow the rules, and she is very vicious, just to let you know. (Laughter) So to get this thing moving, because that's my intent, because I know a number of you have been here for the last month or so, at least the senators. I know some of the rest of you have been here. I will start over here, and I will have the senators introduce themselves starting with... [LR85]

SENATOR UTTER: I'm Dennis Utter. I live in Hastings and represent the 33rd District. [LR85]

SENATOR SCHUMACHER: I'm Paul Schumacher. I live in Columbus and Stanton, part of Colfax and Platte Counties. [LR85]

SENATOR LANGEMEIER: My name is Chris Langemeier. I live at Schuyler. [LR85]

SENATOR GLOOR: Mike Gloor, District 35, Grand Island. [LR85]

SENATOR CAMPBELL: Kathy Campbell, District 25, east Lincoln and Lancaster County. [LR85]

MICHELLE CHAFFEE: I'm Michelle Chaffee, legal council to the Health and Human Services Committee. [LR85]

SENATOR PAHLS: I think Senator Howard will be with us in a little bit, and we have a couple of our pages over here. Emily Gilmore, would you wave your hand, Emily? And Ben Blowers, and they are from Lincoln. Mr. Marienau, I think we are ready. [LR85]

WILLIAM MARIENAU: (Exhibit 1) Good morning, Senator Pahls and members of the Banking, Commerce and Insurance Committee, and Senator Campbell and members of the Health and Human Services Committee. For the record, I am Bill Marienau, legal

counsel to the Banking, Commerce and Insurance Committee, and I appear before the joint committee to make a few opening remarks about interim study resolution LR85. LR85 was introduced by the members of the Banking, Commerce and Insurance Committee and calls upon the committee to review how Nebraska's insurance laws should be amended to respond to the federal healthcare reform legislation of 2010 as it regards establishment of health insurance exchanges by the states. The resolution asks the Banking Committee to review the development of the health insurance exchange planning overview and recommendations, which has been managed by the Department of Insurance pursuant to a federal grant, and which was released in October. This subject has been a matter of continuing interest on the part of the Banking Committee and also the Health Committee in these joint committee settings. LR85 was introduced on February 24 and was the very first study resolution introduced during the 2011 regular session. The Banking Committee held a briefing session by the Department of Insurance on the Affordable Care Act on March 14, then the Banking Committee joined by the Health Committee held two more briefing sessions by the Department on August 15 and October 28. At the most recent briefing, the Department made a PowerPoint presentation that concluded with its recommendations. At this time, I will have passed around the department's recommendations in order to refresh everyone's recollections about them. Finally, LR85 calls upon the committee to consider the input of interested persons. Senator Pahls has indicated that today's proceedings would be in the nature of a more traditional interim study hearing where there would be an opportunity for the members to hear testimony from interested persons. Now also, there may be some interest as we go on in terms of what will be the time line for the challenges to the Affordable Care Act before the U.S. Supreme Court. I know this is going to be a matter of interest for everybody for about the next seven months. A couple of weeks ago, the U.S. Supreme Court indicated there will be five-and-a-half hours of oral argument, and there will be two hours on whether the individual mandate is a constitutional exercise of federal power, one hour on whether challenges to the individual mandate are barred by the Anti-Injunction Act, one-and-a-half hours on whether the individual mandate is severable from other parts of the act, and one hour on whether the Medicaid expansion

is constitutional. The commentators that I've been following have been busy trying to divine the time line for the consolidated cases. I found one who makes the following prognostications, and hopefully, you might find this interesting. They speculate that the due date for the briefs will start December 29 and conclude March 7, including the briefs by the petitioners, respondents, amicus curiae and then reply briefs by the petitioners. Then, the speculation is that oral argument would be over two of the following three days: March 26, March 27 and 28. Then, the opinion from the U.S. Supreme Court would be likely issued during the last two weeks of June. Now, the exact scheduling of the oral arguments could come from the court at any time beginning in December. Anyway, that will conclude my remarks, so the members can get to the input from the interested persons. [LR85]

SENATOR PAHLS: Thank you. Thank you, Bill. Before we begin any testimony, I hope the majority of you have had an opportunity to read today's World-Herald section in the midlands. It's a very good article about the insurance and how Nebraska has just received an additional $5 million, I think $5.5 million to proceed with the exchange idea. And I would like...make sure that you do read it, because I think the director has pointed out some very interesting facts for all of us. Well, we are ready anytime. By show of hands, how many testifiers are we going to have today? Looks like one, two, three, four, five, six, seven, eight, nine. Okay, that's good. So, whoever wants to lead the charge, please do so. And if I could get a couple more just to get in the habit of moving to the reserve so we could. [LR85]

DAVID HOLMQUIST: (Exhibit 2) Good morning. I guess I was the only one who wasn't shy this morning, I don't know. (Laugh) [LR85]

SENATOR PAHLS: I appreciate that. [LR85]

DAVID HOLMQUIST: Thank you, Chairman Pahls and Chairman Campbell, and members of the two committees who are here today to listen to testimony from a variety

of interests. My name is David Holmquist. D-a-v-i-d H-o-l-m-q-u-i-s-t. I am a registered lobbyist. I represent the American Cancer Society and the American Cancer Society's Cancer Action Network. It is my pleasure to appear before you today to support the vision of creating a health insurance exchange for the people of Nebraska. The American Cancer Society has long been committed to assuring access to care for all, particularly to those suffering from cancer and for whom resources are limited or not available at all. This is particularly true when your neighbors in Nebraska either lack health insurance completely or are underinsured. It is the fundamental principle of the American Cancer Society that everyone should have meaningful public or private health insurance. Public meaning Medicaid or some sort of health insurance exchange, or private health insurance, the traditional employer provided, or open market. Meaningful health insurance can best be understood in terms of our four A's. These are our guiding principles. Health insurance should be adequate providing timely access and coverage of the complete continuum of quality evidence-based healthcare services including prevention, early detection, diagnosis and treatment. Health insurance must be available regardless of health status or claims history, and policies must be renewable or not allow for recision. The coverage must be affordable, including provisions that premium pricing is not based on health status or claims history, and the insurance must be administratively simple with clear, up-front explanations of covered benefits, financial liability, billing and claims filing processes. With particular reference to the creation of a Nebraska health insurance exchange, the American Cancer Society encourages the following guidelines: The exchange governing board should be properly structured to ensure that its decisions serve the best interests of all with special emphasis on consumers, patients, workers, and small employers. The rules for the insurance market outside the exchange should complement those inside the exchange to mitigate adverse selection. In other words, creating a level playing field should be important, and should exist, thus avoiding those outside the exchange the...giving them the ability to sell products under more favorable terms such as cherry-picking the healthiest consumers. The Medicaid program should be well integrated with the exchange to ensure seamless enrollment and movement between the exchange and Medicaid as

circumstances like employee status... I'm sorry, employment status, seasonal work, and so forth happen during the year. The exchange should be structured to emphasize administrative simplicity for consumers, thus making insurance more accessible. Plan premium information, enrollment forms, plan benefits, provider networks, appeals processes, and consumer satisfaction measures must all be readily accessible. The exchange should have a continuous and stable source of funding. Funding should not be subject to the vagaries of the legislative process. Funding should be generated from plans both inside and outside the exchange so plans outside the exchange are not afforded an unfair financial advantage that could lead to adverse selection. As you know, the Affordable Care Act requires that all states intending to operate a state-based insurance exchange pass legislation to create an exchange and inform the United States Department of Health and Human Services of that decision no later than January 1, 2013. In the event a state-based exchange is not created, Nebraska control will default to the federal government. The American Cancer Society and its sister advocacy organization, the American Cancer Society Cancer Action Network, encourage the Nebraska Legislature to create a Nebraska insurance exchange. The information that I have passed out to you is a little bit more detailed information about the things that the American Cancer Society believes are important for the Nebraska Health Insurance Exchange in terms of benchmarks. And with that, I conclude my testimony, and I would be happy to answer any questions. [LR85]

SENATOR PAHLS: I have one. You say the American Cancer Society. Is this going...are you promoting the same thing throughout all the states? [LR85]

DAVID HOLMQUIST: We are. We are promoting a similar thing. I wouldn't... [LR85]

SENATOR PAHLS: Or similar. [LR85]

DAVID HOLMQUIST: I mean the information I gave you is specific to Nebraska because of its unique status. We are a Unicameral state, we have insurance laws that

differ from other states, so it is, it is, has been...the benchmarks that we've suggested are designed to be consistent with Nebraska law. [LR85]

SENATOR PAHLS: Okay. Senator Gloor. [LR85]

SENATOR GLOOR: Thank you, Chairman Pahls. Mr. Holmquist, a question for you about the boards, the governance of this. Everyone that I've talked to seems to think it's a good idea to have input from a broad base of consumers, John and Jane Q Public as an example. But realistically, and I have some experience in not-for-profit boards, trying to get John and Jane Q. Public to attend meetings and participate regularly is always problematic, because quite frequently, they're hourly-paid workers, and being able to leave work to participate actively is problematic. Would the Cancer Society be supportive of the various associations that represent components of that group? In other words, AARP or some of the advocacy groups that advocate for people who might more likely use an exchange? [LR85]

DAVID HOLMQUIST: Yes, we would. [LR85]

SENATOR GLOOR: Okay. [LR85]

DAVID HOLMQUIST: We've also suggested in some cases that if there is a need for additional expertise, that there could be...that could come from the educational community, for instance, professors at the University who have expertise in insurance law and other issues, business issues. [LR85]

SENATOR GLOOR: Okay. Thank you. [LR85]

SENATOR PAHLS: Senator. [LR85]

SENATOR SCHUMACHER: Why would a countrywide organization like the Cancer

Society not be seeking a default to a uniform federal standards rather than 50 different state-managed exchanges? [LR85]

DAVID HOLMQUIST: We feel that, that generally speaking that the states should be engaging in their own health, if you will. No, we are active in all 50 states, and we have a large government relations office in Washington, D.C. We've been active in this issue from the very beginning, because we see a real crisis in healthcare access for cancer patients. And Nebraska has unique geographical issues that other states may not have. We have unique demographic issues that others may not have. We are not California. California is not New York. So that is why we have encouraged the states to do state-based health insurance exchange law. In fact, I will be attending...a meeting next week with some of our national people to look at some more drill down to Nebraska. I will be attending it with my counterparts in Texas, Oklahoma, Kansas, Missouri, Hawaii, New York, New Jersey, and some of the mid-Atlantic states, so. [LR85]

SENATOR SCHUMACHER: Thank you. [LR85]

SENATOR PAHLS: Seeing no more questions, thank you, Mr. Holmquist. [LR85]

DAVID HOLMQUIST: Thank you. [LR85]

SENATOR PAHLS: Good morning. [LR85]

ANDREA SKOLKIN: (Exhibit 3) Good morning, Senator Pahls and Senator Campbell, members of the committees. My name is Andrea Skolkin. A-n-d-r-e-a, Skolin, S-k-o-l-k-i-n, and I am the chair of the Health Center Association of Nebraska which represents the interests of the six federally qualified health centers in Nebraska. I am also the chief executive officer of one of the health centers located in south Omaha, OneWorld Community Health Centers. As you are all aware, Nebraska's racial and ethnic minority population has been growing over the last decade, and Nebraska has

been very fortunate to increase the number of health centers in the state based on the increasing demand for services for low-income and underserved populations. Federally qualified health centers are community-based organizations that provide comprehensive primary care and preventive services to persons of all ages, all backgrounds, according to their ability to pay. Services include medical, dental, behavioral health, pharmacy, and numerous support services. In 2010, the six health centers were the healthcare home for 63,330, that is unique individuals, providing care through 238,433 visits. Ninety-three percent of those patients had incomes under 200 percent of poverty, which is about $44,700 for a family of four, and 57 percent of those patients were uninsured. The majority of our patients are the working poor, women, and children. We are your experts in providing primary care for underserved patients with complex issues and needs. The Health Center Association of Nebraska strongly supports the creation of a state-based exchange in Nebraska and applauds you as committee members for taking the necessary steps to plan for implementation of this important program. The creation of an exchange will be a significant step forward to provide additional access to affordable healthcare for thousands of Nebraskans. There are four key points I would like to touch on in regards to the implementation of an exchange in Nebraska from the perspective of the six federally qualified health centers. First, since the exchange is required to serve as an entry point for public and private insurance, the Health Center Association of Nebraska believes that establishing a state-based exchange versus a federal or regional exchange will make it easier to coordinate state health insurance options as well as to coordinate with private insurance. This will allow for better collaboration between the public and private sector and insurers and help create a more efficient system for consumers. Second, health centers across Nebraska provide care to an underserved population such as refugees, migrants, and low-income workers, people with low literacy. For this reason, it is critical that a state-based exchange be easily accessible in easily understood language and formats. It will be critical that a culturally appropriate navigator program is established to support individuals applying for health coverage on the exchange. Health centers and its Health Center Association of Nebraska are well positioned to provide this service based on our experience in

outreach to the medically underserved communities as well as rural communities. A good example of this is our health center's recent experience enrolling over the last two years almost 9,000 children in Kids Connection, children that would otherwise not have been enrolled or maintained their coverage. Health centers are in a unique position of trust that should be utilized by the state to ensure the success of the exchange among vulnerable populations. Third, the governing board for the exchange will have the opportunity to certify insurance plans that are sold on the exchange. It is critical that federally qualified health centers are covered entities in these plans since they are a key avenue for assuring compliance with Section 1311 of the Patient Protection and Affordable Care Act that says exchanges should certify only plans that include safety net providers that serve predominantly low-income, medically underserved individuals. Federally qualified health centers serve Nebraska's most vulnerable populations, as I've said, children living in poverty, pregnant women, the uninsured, and in areas of the state where there is lack of primary care providers. It is imperative that insurance plans offered on the exchange include health centers as covered providers. Fourth, in addition to requiring that federally qualified health centers are included as providers in all insurance offerings on an exchange, it is critical to the financial future of these safety net providers that payments for federally qualified health centers on these health plans through the exchange be paid at no less at what the health centers are being paid today, which is the Medicaid PPS rate. Further, exchange policy insurers should be able to negotiate mutually agreed upon rates with federally qualified health centers as long as they are at least equal to the insurers' generally acceptable...applicable, sorry, payment rate from the state. In closing, I would like to thank members of the Banking, Commerce and Insurance Committee and the Health and Human Services Committee for your commitment to ensuring the healthcare of all Nebraskans. Thank you for your time. I would be happy to answer any questions. [LR85]

SENATOR PAHLS: Senator Campbell. [LR85]

SENATOR CAMPBELL: Ms. Skolkin, one of the questions that has been discussed, at

least in the Department of Health and Human Services, is the problem of using an income tax form as a way for people to show proof of what they might be eligible for. And many of the people that you would serve, I shouldn't say many, but a considerable number, would not have filed an income tax form. Have you and your association given any thought to what might be used as another document or way? I know the department is worried about this, because they've had some discussions with those of us on the Health Committee. [LR85]

ANDREA SKOLKIN: Thank you, Senator. That's a great question and both a comment, I think. From the health center's perspective, we do use tax forms when available or when a patient family is willing to bring that forward, but we use proof of one month of income, as we use our sliding fee scale, and we determine what patients are able to pay. So, documentation of one month of income, or whether it's one month or two months, is another way in addition to tax forms that could be used. [LR85]

SENATOR CAMPBELL: Thank you. [LR85]

SENATOR PAHLS: Senator Utter. [LR85]

SENATOR UTTER: Thank you, Chairman Pahls. Ms. Skolkin, the health centers are private nonprofits? What's their organization? [LR85]

ANDREA SKOLKIN: Senator, each health center is slightly different. Most across, there are many across the country, but in Nebraska, four are nonprofit 501(c)(3)s, one is housed in a community action agency, and one is operated by the health department. Columbus is the example of that. [LR85]

SENATOR UTTER: I'm a little, you mentioned statewide coverage. Is that coverage consistent throughout the state, Mullen, Nebraska; Broken Bow; those communities same as would be in Hastings, or Lincoln, or Omaha? [LR85]

ANDREA SKOLKIN: Senators, no. The coverage across the state is not completely there. Patients come from 43 out of the 93 counties to health centers, so that says that not all counties or people living in all counties have access. That is one of the reasons that we've been working hard to establish additional health centers or satellites throughout the state, but I think the answer to that is there is not coverage for the whole state, but we would like to have coverage. [LR85]

SENATOR UTTER: The...one more question for you. Can you address just a little bit for me the transparency of the organizations of the health centers in terms of transparency with regard to finances and also with regard to the services they provide, the efficiency of the services that they provide. How does that work? [LR85]

ANDREA SKOLKIN: Senator, I'm not sure I understand the question wholly, but health centers are a recipient of a base of federal funding... [LR85]

SENATOR UTTER: Let me tell you, the nexus of my question is that I'm concerned that as much of the funding that flows to any private nonprofit's direction is used to benefit the citizens of the state, and is not used to promote bloated excessive salaries for the management of the organization. And I just want to know what transparency is there there that I as a private citizen or as a state senator can take a look at and assure myself of those questions. [LR85]

ANDREA SKOLKIN: Thank you for the clarification. For all 501(c)(3)s, a 990 tax return is filed every year, and so that is a public record and accessible either by calling the health center, or there is a site where you can get access to them on-line without calling the health center. Most of the health centers, I can't speak for the community action agency if that's the tax return they file, or the county health department, but the ones that are 501(c)(3)s do that. Additionally, because of the Freedom of Information Act, inquiries can be made, and health centers can respond to that. Plus, we file reports

annually with the federal government, which are called our UDS reports, and that reports all of our expenses and revenue, and there is only a couple items on there that are protected information. The rest is, should be available for public view. [LR85]

SENATOR UTTER: Thank you. Thank you. [LR85]

SENATOR PAHLS: And I have one question. I see that you're in charge of the...you're the chief executive officer of the OneWorld Community Center in south Omaha. I'm curious. Let's say, I'm fortunate, that I do not, in this position, but let's say I happen to be one of the 57 percent who are uninsured. If I come to your organization, do you turn me away? [LR85]

ANDREA SKOLKIN: Our answer needs to be no. However, our demand, our specific health center, and in health centers across the state, is so great right now that we cannot accommodate all the appointments that are being requested. So we cannot turn someone away for inability to pay, if that is your question. However, volume makes it very difficult right now, specifically for adult patients, to get appointments at our health center. That, there's an element of that, I think, across the state, because our volume, if you were to look at our numbers, have almost tripled in the last couple of years of patients that are coming from everywhere, not just our immediate surroundings. And we're not geared up enough to be able to handle all the appointments, so two answers to that. [LR85]

SENATOR PAHLS: Okay. So if this exchange, everything would dissolve, you would still be there to, you're telling me you'd still be there to give aid, but it would be limited because you just can't handle the capacity. I mean, there is just too many people. Is that what I am hearing? [LR85]

ANDREA SKOLKIN: We as, if I'm understanding your question correctly, Senator Pahls, the health centers are going to be in existence with or without the exchange providing

care to a target audience of underserved and low-income folks. So, I'm not sure if that answers your question. We're...our health center, and I know the health center in Columbus and here in Lincoln are in the midst of looking at expansion plans. Ours are hopefully to start soon so that we can accommodate more folks. We believe that as the exchanges come on board and the Affordable Care Act moves forward that there will be, of course, the expansion of Medicaid, and likely fewer providers taking Medicaid, so that we need more availability of appointments, and so we're trying to gear up for that. But right now, we are stretched to provide care to everyone in this, across the state let alone in our immediate surroundings. [LR85]

SENATOR PAHLS: Okay, so you're telling me if the Affordable Care Act proceeds and goes in the direction that some people indicate that there is a strong possibility, that would be a plus for you is what you're telling me, for your organization. [LR85]

ANDREA SKOLKIN: I'm not sure, Senator, if plus is the right answer, but there will be increased demand for services through the community health centers. [LR85]

SENATOR PAHLS: And you will be there to provide it. [LR85]

ANDREA SKOLKIN: We will be there as best we can to provide, on the resources that we have available, the care that's needed. [LR85]

SENATOR PAHLS: And the reason why I'm just throwing these numbers out again, because there are people watching us via the air. I mean, you have 63,000 patients that you do see, and 57 percent are uninsured. [LR85]

ANDREA SKOLKIN: Uh-hum. Correct. [LR85]

SENATOR PAHLS: Okay. Senator Langemeier. [LR85]

SENATOR LANGEMEIER: Thank you, Chairman Pahls. Miss Skolkin, thank you. In your testimony, you put on here, you say it's imperative that healthcare exchanges include health centers like yours, so we should mandate that. Then in your next statement, it says that you should, it's crucial that you allow health centers like yours to be able to negotiate mutually agreed upon rates. [LR85]

ANDREA SKOLKIN: Right. Uh... [LR85]

SENATOR LANGEMEIER: So you want us to mandate that you're in. You want us to mandate that you can set, negotiate rates, but then in the next line, you want a mandate that those rates then cannot be below the Medicaid PPS rate. [LR85]

ANDREA SKOLKIN: What health centers are concerned about, Senator, is being left out of the whole mix. When the insurance exchanges are established and new products are on the market, mandate might be a strong word, but we want not to be excluded and to be considered a provider as the plans roll out and to be...have the opportunity to negotiate, just as any other provider would be, for our rates. [LR85]

SENATOR LANGEMEIER: What other provider has a floor in the negotiation to set rates that you're asking for? You're asking for, to negotiate but not be able to negotiate less than Medicare PPS rates. What other provider out there gets to negotiate that has a floor that says we're only going to try and get more. [LR85]

ANDREA SKOLKIN: Our rural, all of Nebraska's rural health clinics are paid similarly to the federally qualified health centers, so, though I'm not sure if they're here today, I assume they would be looking for that as well. [LR85]

SENATOR LANGEMEIER: Thank you. [LR85]

SENATOR PAHLS: Senator Howard. [LR85]

SENATOR HOWARD: Thank you. Thank you, Mr. Chairperson. I think it's important to remember that even though this is...your agency is a community healthcare provider, you provide quality care, and you've never settled for sort of a secondary consideration for this, and I think that's important that people realize that you really strive for the best possible for everyone that comes to you, whether they can provide insurance or whether they can pay themselves. But no one is treated as any less, or the quality of the care you provide. I know your physicians are topnotch. And so I don't want anyone to have the impression that the cost would be less, because you're doing more, and I think it's important that you be recognized for the quality of service as well as the community of outreach. [LR85]

ANDREA SKOLKIN: Thank you, Senator. I couldn't have said it better. [LR85]

SENATOR HOWARD: Thank you. [LR85]

SENATOR PAHLS: Senator. [LR85]

SENATOR SCHUMACHER: If we run the scenario that the Supreme Court throws out the Health Care Act, what planning do you see that we should be doing, what contingencies we should be prepared for, in order to meet the healthcare needs of the population that you serve? [LR85]

ANDREA SKOLKIN: Senator, that's as great segue for an advertisement, I guess, for community health centers. We believe across the state there are not enough community health centers to pick up the pieces where others are not able to, or insurance products are not affordable, so we would want to see the state continue to plan for additional community health centers across the state. In fact, there are some planning efforts afoot, but it takes an influx of cash, of course, to get those health centers off the ground. North Platte is an example that is doing some planning for a community health center.

Grand Island has been planning for a long time and attempting to attain that status, and there are other, you know, parts of the state that could use community health centers, so I would say planning for general expansion. Both in a Democratic administration and a Republican administration has been an initiative for community health centers to grow across the nation because of these low-income, underserved populations, and we have them in Nebraska. [LR85]

SENATOR SCHUMACHER: Where then do you see this influx of cash coming from? I mean, the state finances are between a rock and a hard place, and the federal government, the presses may run out of ink one of these days, so (laugh) where do we get the money? [LR85]

ANDREA SKOLKIN: Senator, I don't have the answer for that. At this point in time, I think that that is a dilemma we would love the opportunity to look jointly at with you. [LR85]

SENATOR SCHUMACHER: Thank you. [LR85]

SENATOR PAHLS: I see no more questions. Thank you for your testimony. Thank you. The floor is yours. [LR85]

ALVIN GUENTHER: (Exhibit 4) Good morning. My name is Alvin Guenther, G-u-e-n-t-h-e-r, and I come to you this morning as a longtime, lifetime Nebraska resident and a consumer. I want to recognize Senator Pahls, Chairman Pahls, Chairman Campbell and the rest of the members of the committee. I am a retired Nebraska educator. My 35-year educational career was at both the secondary and community college level teaching economics, finance, and accounting. I currently live on the family ranch raising Hereford-Angus cross cattle. Additionally, I remain very active utilizing my knowledge and expertise as a student of economics organizing and presenting economic panel discussions and economic forums. I come before you today

to strongly support the creation of a health insurance exchange or marketplace. We are surely aware that the current recession in the United States has been the result of increased costs of healthcare, food, and energy to our households across our nation. Healthcare costs have been eroding the household's disposable income and discretionary spending for a minimum of four decades. Nebraska has continually bragged about its low unemployment rate, its Angel Tax Credit program, the Nebraska Advantage, and its internship program. Now it is time for Nebraska to be a leader in healthcare reform too. The unintended consequences of inaction will surely be a continuing demise of rural entrepreneurship activity and rural economies. The lack of competition in the healthcare marketplace is one of the major causes of healthcare unaffordable costs. Policymakers must do what is within their powers to help make healthcare cost affordable and more competitive. A way to accomplish this is to spread the cost of healthcare over the breadth of the marketplace. The creation of the health insurance marketplace will accomplish this very objective. The distribution of costs across the marketplace is no different than a farmer that purchases a $300,000 combine and harvests 300 acres of crop. The cost per acre is forbidding. However, if the farmer increases his acreage, the cost per acre becomes more affordable. For example, harvesting 300 acres with a $300,000 combine creates a cost of $1000 per acre. Harvesting 3000 acres creates a cost of $100 per acre. Obviously, this represents a significant difference. Similarly, the proposed exchange must provide services to as many individuals as possible to ensure a lower cost per person. Objective achieved. Pooling health insurance consumers to accomplish quantity purchases is another positive aspect of establishing a healthcare marketplace. This ability to negotiate prices for a large volume of people would put farmers, entrepreneurs, and other small businesses back on an even playing field with the deals big businesses receive. This concept is the driving force behind the success of Walmart. Walmart is able to make quantity purchases and create significant impacts upon the costs of goods sold. Failure as a policymaking body to act today will deny households, once again, the ability to exercise privileges afforded big business. I am keenly aware of the political rhetoric associated with the Affordable Health Care Act. I am keenly aware that Nebraska is a

participant in a lawsuit to overturn the Affordable Health Care Act based upon the mandate enclosed within the act. However, establishing the health insurance marketplace is something I believe Nebraska should pursue regardless of the Supreme Court ruling. Having a health insurance marketplace is a good idea, and Nebraska could choose to make use of the marketplace, even if the Affordable Care Act is struck down. It doesn't cost Nebraska taxpayers either, because federal grants can cover the cost of implementation. If the United States Supreme Court rules in favor the Affordable Health Care Act, passing legislation now will ensure that a health insurance marketplace is created by Nebraskans for Nebraskans. Finally, I believe the healthcare marketplace or exchange should be transparent and represent the interest of consumers. The people most likely to buy from the marketplace, self-employed farmers and ranchers, and small business owners, should be represented on the governance board. The board should be diverse in geography, expertise, and age. Individuals with a direct conflict of interest due to a financial stake in the healthcare industry should not be allowed on the board. I would be glad to entertain any questions, or, anyone might have. [LR85]

SENATOR PAHLS: As I see, apparently your last paragraph is probably one of the most significant things that you are pointing out. [LR85]

ALVIN GUENTHER: Uh-hum. [LR85]

SENATOR PAHLS: That's, okay. Seeing no questions. Thank you. [LR85]

ALVIN GUENTHER: Okay, thank you. [LR85]

SENATOR PAHLS: The reserved seats are getting...be brave. Thank you. [LR85]

MARK LISKO: (Exhibit 5) Senator Pahls, Senator Campbell, the rest of the committee, thank you for holding this hearing. My name is Mark Lisko, M-a-r-k L-i-s-k-o. I am the owner of a small insurance agency in Omaha. I'm an independent insurance agent. I am

here on behalf of the Independent Insurance Agents of Nebraska. The Independent Insurance Agents of Nebraska are in favor of the formation of a Nebraska-based exchange. We have a long history working with this body as well as with the Department of Insurance. We feel that a Nebraska-run exchange is critical in the distribution of health insurance products. We also believe that we as agents are a critical part of serving the consumers in the state of Nebraska in the distribution of health insurance products. On a personal note, just within the last couple of weeks, I myself have assisted people from a multimillionaire down to a young man just out of college in securing different kinds of health insurance products based on me knowing what they need and finding the best product for the best price to fit their situation. We also feel that any insurance agents involved in the exchange need to be licensed, certified, and fairly compensated for their services. We have always been a critical piece in delivering insurance products to consumers of Nebraska, and we feel we should be a main part of this exchange. As far as other parts of the exchange, the navigator issue, if that navigator is involved in the sale of insurance, we believe that that person should also be licensed to sell insurance. There is a considerable debate regarding the formation of this exchange, but we are strongly in favor of the formation of a Nebraska exchange as opposed to a federal exchange. Thank you for your time. I will entertain any questions. [LR85]

SENATOR PAHLS: I have one question. [LR85]

MARK LISKO: Sure. [LR85]

SENATOR PAHLS: And this is not a test. (Laugh) Have you had any chance to read what the State Department, their report? [LR85]

MARK LISKO: I've read the summary. [LR85]

SENATOR PAHLS: Okay. Okay, because I was just wondering if there is anything

contradicting in here contradicting your views? If not, I mean, again I'm not... [LR85]

MARK LISKO: Not directly, no. [LR85]

SENATOR PAHLS: Okay, I just, and it's not a test at all. [LR85]

MARK LISKO: Sure (laugh). I've read a lot of summaries, so I (laugh). [LR85]

SENATOR PAHLS: Okay. Okay. Okay. Seeing no more questions...oh, I'm sorry. Senator Gloor. [LR85]

SENATOR GLOOR: Actually, at previous meetings, Mr. Lisko, I remembered the discussion about navigators need to be agents. But let me ask that question...well go ahead. [LR85]

MARK LISKO: Well, licensed in some format. I, you know, I don't know whether it needs to be the exact same license as an agent's license. That part is, we'd be willing to work with people on. [LR85]

SENATOR GLOOR: Would that have to be changed? Would that require a regulatory change? Do we have... [LR85]

MARK LISKO: The Department of Insurance could probably answer that question better. [LR85]

SENATOR GLOOR: My guess is it probably would, but let me ask if the opposite is true. Should anybody who sells health insurance be a navigator? [LR85]

MARK LISKO: You know, to be honest with you, I don't know the answer to that question. There has been some contradictions in the interpretations of the statutes. I'm

not sure that they've actually been formalized yet, so I don't know the answer to that question. [LR85]

SENATOR GLOOR: Okay. Thank you. [LR85]

SENATOR PAHLS: Seeing no...oh, Senator Utter. [LR85]

SENATOR UTTER: Not really a question, but I just want to point out on the second page, your second point from the bottom, there is no need for a massive new government bureaucracy. I certainly agree with that part of it. [LR85]

MARK LISKO: Thank you. [LR85]

SENATOR PAHLS: Thank you. Come on down. [LR85]

BRUCE RIEKER: (Exhibit 6) Good morning, Chairman Pahls, Chairman Campbell, members of the joint committee. My name is...Oh, here you go. I had to read it so I know who I was. (Laughter). My name is Bruce Rieker. It's R-i-e-k-e-r. I'm vice president of advocacy for the Nebraska Hospital Association here to testify in general support of forming a state-based exchange. On behalf of the 88 hospitals and nearly 43,000 people that we employ, we do support and encourage the state to take all the steps necessary to meet the federal deadlines and ensure that the option of creating a state-based exchange remain available to the state of Nebraska. And as I just as...I talk about those numbers. When we employ 43,000 people, we consider ourselves to be one of the largest purchasers of healthcare coverage as well as largest providers, so we're on both ends of the spectrum, and I hope that you'll take that important point into note as you hear our testimony. As you know, an important or critical component of the Patient Protection and Affordable Care Act is forming these exchanges with some of the goals to reduce the number of people without health insurance and to improve access for individuals and small groups. The task of putting this together is no small

undertaking, to say the least, and that we need to have this established by January 1, 2014, if that is what we're going...you know, if that is what we choose to do. We included some deadlines, starting at the bottom of page one of this testimony. And just recently, within the last week or so, CMS has changed the deadline for the Level One grants, which Senator Pahls already drew the audience's attention to with the article that was in the World-Herald, but, so Nebraska is ahead of the curve there, but other states are behind, but the deadline for the Level One exchange grant has been moved back six months. Some other deadlines that have not changed, and I don't know whether they will be changed or not. Some speculate that they could be with all the political action that is involved in this. But until that happens, we are working on the premise that June 29, 2012, will be the application deadline for the Level Two exchange grant, which I don't know the exact amount, but I have heard estimates of well over $60 million, maybe even up to $80 million. So I don't know what those numbers are, but we sure think that that's an important element for you to consider. January 1, 2013, hopefully, the United States Department of Health and Human Services will certify a state plan. The health insurance exchange must be fully operational by January 1, 2014, and financially sustainable by the following January 1, 2015. To date, some federal regulations have been released, but in many areas regulatory guidance is still lacking. However, the NHA feels that it is critical that we continue to conduct the necessary research and preparation that meets the...so that we meet the established deadlines to maintain all available options, and we definitely appreciate all of the work that the Nebraska Department of Insurance has already invested with meetings with stakeholders, applying for the $1 million grant. That report that Senator Pahls already referenced to was very in-depth, and I think that it was a very informative report, making...and they made recommendations for the establishment of the exchange. The NHA encourages the Department of Insurance to continue to actively work on that. In addition, we have our interests from the Hospital Association, and we formed what we call an issue strategy group, which is 12, we have 12 members or representatives from our member hospitals that have come together. We've had one meeting. We continue to have meetings via electronic means as well as we'll bring them back together. But this is

a very important issue to us, and we are working on developing key principles for the Nebraska's hospitals of what we would like to see in the exchange. The detailed principles are attached to the back of our testimony, but some of the highlights are to increase affordable insurance coverage, improve or promote quality improvement, that we need to increase competition, as well as governance. And it's already been mentioned, but governance is an important factor for us. With our experience in the Medicaid realm where we have a Medicaid advisory board or council, it's well intentioned, but those folks do not have a lot of clout to help change the direction of where HHS and the operation of the Medicaid program goes. But in agreement with some of the previous testifiers, we think that there needs to be a healthcare interest represented as well as business interests represented not to run the exchange on a day-to-day basis, but there has to be a board or an oversight board that brings more of the, all of the stakeholders' interests together to govern this. Some of the things, in closing, that I would say that...the NHA feels the urgency for the Legislature to tackle this situation sooner than later and to, and it may not result in a bill being passed in this upcoming legislative session, but to have a discussion, to have maybe a bill introduced or two where we can have public debate, because there are so many issues that we already have identified, and I'm sure there are more in this complicated matter, but governance is truly something that is very important to us, how we're going to fund this program. And I think that, you know, in some way, introducing legislation or having this debate and continued discussion will help us build a foundation for the house that we're going to build, if we decide to build a state-based exchange, or whatever it may be. Adverse selection is a key issue. Medicaid eligibility enrollment is a very large one for us, and I know that there has been previous conversation about interoperability. In 2014, Medicaid will be expanded. The eligibility will be expanded to 133 percent of the federal poverty level, and it will be income based. There won't be criteria about status in life, single, married with children, or whatever it may be. When that happens, Nebraska will go from approximately 225,000 people that are eligible for Medicaid, or 1 in 8 now to nearly 400,000. Some estimates, depending on whether it's Milliman or the Kaiser Commission, estimate that our increased eligibility for Medicaid will go up to nearly

390,000 by 2014, which is 1 in 5 Nebraskans. And as we understand, one of the rules of the exchange plays a role in determining eligibility and enrolling people in Medicaid. And for those that were at the hearing yesterday about ACCESSNebraska and all of the frustration that consumers have already experienced, the ease of operability and access to this program to the exchange is critically important, and interoperability between HHS, the Department of Insurance, the federal IRS, these are all things that I think are going to take a great deal of thought. And we want to submit to you those considerations that may prompt earlier conversation rather than waiting for what the Supreme Court does and then we'll decide to move forward. So, we could talk about other key actions, but I think that generally sums up our perspective, and I would welcome any questions. [LR85]

SENATOR PAHLS: Senator Campbell. [LR85]

SENATOR CAMPBELL: Mr. Rieker, I want to go back to your point about (inaudible) and somewhat adamantly in your testimony, with regard to meeting the deadlines and being prepared to meet them on the grants. On the June 29, 2012, deadline, that's the Level Two, do you happen to know off the top of your head, some of the components that Nebraska would have to have in place on that application? Don't we have to have a governance structure? [LR85]

BRUCE RIEKER: We have to have...as I understand it, we have to have a governance structure. We have to have a budget associated with it both from a, well, primarily how we would fund it and utilize that grant money. Those are the two key components, but then stepping down into more of the details, I don't know those as well as I probably should, but I know that we see those as two large items that we have to have in place, uh, and thought out by June 29. It's not something that we can just put together shortly after the Supreme Court decides what they may or may not do. [LR85]

SENATOR CAMPBELL: It might serve both of the committees' benefits to request of the

Department exactly what the components of that Level Two grant entail, what we might need to be prepared, what we have to have prepared, primarily because the Level Two funding is considerably more, and I don't remember in our previous discussions between the two committees exactly what that amount is, but it's very large, and it also has to do with us being prepared from a data implementation. And I concur with you, the hearing yesterday afternoon on ACCESSNebraska drove home the point of we can try to put in place what we think is a very simple system for people, and yet yesterday, we heard how difficult it was for Nebraska consumers, the everyday working person in this state, to access that. It was really heart wrenching at some time, particularly for our elderly citizens. So for us to be prepared from a data perspective is no small point, and I realize that's a statement, but yesterday was really quite an eyeopener, I thought. [LR85]

BRUCE RIEKER: Senator, I agree with your statement. [LR85]

SENATOR PAHLS: Senator Gloor. [LR85]

SENATOR GLOOR: Thank you Chairman Pahls. Bruce, this is probably more a commentary than a question, but I inevitably make it when we end up talking about the Affordable Care Act and insurance exchanges, and you're as easy a target for me to make this statement now as before, since you represent an organization I used to be a member in. So we're going to go from 1 in 8 Nebraskans eligible for Medicaid to 1 in 5. [LR85]

BRUCE RIEKER: Correct. [LR85]

SENATOR GLOOR: And I've seen those numbers, and that doesn't include the number of people currently who don't have insurance because they can't afford it whose employers now will offer insurance, or they themselves will take insurance, because it becomes more affordable. Here's my concern about the Affordable Care Act and the

way insurance exchanges fit into it. We know that that segment of the population now that has insurance coverage is currently charity care, uncompensated care, or in accounting terms, bad debt. I mean it's unpaid-for care that finds its way back into everybody's bill. And so there is a reason to feel comfortable that this might be a more logical way to do it than the hidden cost for people who show up at emergency rooms or the hidden costs that has to do with government subsidization of federally qualified clinics and whatnot. However, my concern, as a former provider, is that additional money that is now going to flow appropriately into the healthcare system, where is it going to go? What is it going to pay for? Is it going to pay for addressing the nursing shortage that we had a hearing on yesterday by way of figuring out scholarships or ways to pay for more nurses to be trained? Is it going to go into improving quality of care, or are we going to see a mushrooming of for-profit imaging centers, ambulatory surgical centers, doc-in-the-boxes, that, I mean, is that...? We have an insatiable appetite for healthcare in this country, and I think without a change in the delivery system, without incentives that make people wiser consumers or that have providers having some skin in the game, rather than continuing to submit bills getting reimbursed based upon outcomes or based upon managing those dollars a little better, we're talking about the potential for a huge uncontrolled inflationary increase that undermines all the good things that could happen as a result of insurance exchanges. And I don't know what the real answer to that is except I think it's something that has to be talked about. As we get excited on, with the opportunity for people to have coverage, where are those additional dollars going to go, and are we going to drive ourselves into an even higher realm of inflation than we already have in healthcare? It's a complicated issue. It's not one that gets talked about hardly at all, but it's one that really, really bothers me and one of the reasons I remain very skeptical about whether we can pull this off without it being inflationary to the state and to the employers, and ultimately, to consumers, the patient. [LR85]

BRUCE RIEKER: May I respond to that, Senator? [LR85]

SENATOR GLOOR: Sure. Like I said, it's more commentary than question, but I'm happy to have anybody answer it or address it for me. [LR85]

BRUCE RIEKER: If I may share with the committee some of the dynamics that are coming with healthcare reform. As I mentioned, we represent 88 hospitals, which is almost all the hospitals in Nebraska, and the net patient revenues are about $5 billion per year, so to give you an idea where we are. But in 2010, our hospitals provided, in the way of community benefits, collectively a little over $1 billion. Two-hundred million of that was in bad debt; $130 million of it was uncompensated care for Medicaid patients. For Medicaid patients, we lose 27 cents on every dollar of care that we provide. Not the charge, but the cost for providing that care. For Medicare, we lose 16 percent, and our Medicare undercompensated care was $359 million. We subsidize areas that do not make money, such as neonatal care, burn units, to the extent of somewhere in the neighborhood of $60 million. A lot of those things in our hospitals are going to be squeezed as to what we can, especially those areas that we subsidize. I mean, they may be, you know, there may be some tightening there. We also provide millions of dollars in educational assistance to help people that work for us get better educations. With healthcare reform, and Milliman produced this report at the request of Governor Heineman, and if 100 percent of the newly eligibles, newly Medicaid eligibles participate, it's going to cost the state $760 million between 2014 and 2020. Okay, so this is one thing that we hope, you know, probably should be talking to the Appropriations Committee, but there is this big financial requirement that is coming down the pike with Medicaid reform and Medicaid expansion, so it's somewhere in the neighborhood of three-quarters of a billion dollars that the state is going to have to come up with. Well, with provider cuts that we received last year in Medicaid plus the $855 million of Medicare cuts that our hospitals are going to incur because of healthcare reform, we estimate that between Medicare and Medicaid, our additional uncompensated care between now and 2020 is between $1.2 billion and $1.8 billion, so our hospitals are going to be absorbing even more uncompensated care. At the low end, if only 50 percent of the newly eligibles participate in Medicaid, our uncompensated

care will go up from $130 million a year to $195 million a year. If 100 percent of them participate, it's almost $800 million over six years, or it would double our uncompensated care. All of these pressures, coupled with many other issues...I mean, even as you were speaking or making your comments about this, Senator Gloor, I think it emphasizes the importance of your bill on the 407 process, because we have to redesign the delivery system, and we have to have mid-level practitioners who are capable of providing that care to help us deliver the care in a much more cost-effective way, and so, that's probably a little bit of just my statement about what is coming. But going back to the issue at hand with the health insurance exchanges, and I'm not saying that everybody is going to rush away from being employed and having employer-provided insurance, but the eligibility for getting insurance in the exchange, aside from the Medicaid, is for those that earn between 133 percent and 400 percent of the federal poverty level. Based upon our calculations, looking at some census data that, from the most recent census for Nebraska, just slightly over 70 percent of all Nebraskans earn less than 400 percent of the federal poverty level. It's right in the neighborhood of $80,000 for a family of four. So forming this exchange is very important, because there is the potential that 70 percent of Nebraskans could be eligible. I'm not going to say they're all going to buy the insurance through it, but 70 percent of Nebraskans could be eligible to participate in it, 50 percent buying commercial insurance, and 20 percent getting their Medicaid coverage and their eligibility determined through this exchange. So, it's almost like we're creating a parallel universe of insurance, but it's a monumental, monstrous task in our eyes, so. [LR85]

SENATOR GLOOR: Well, and just to make sure that you're clear in my concern, those dollars going to appropriately paid providers working their way into the system to address issues that are appropriate reimbursement and can affect the quality of care and access, good thing. But there is, without some degree of control, those dollars also can be seen as capital... [LR85]

BRUCE RIEKER: Sure. [LR85]

SENATOR GLOOR: ...that could result in three investor-owned hospitals in the state, new investor-owned hospitals in the state, two dozen more investor-owned imaging centers, ambulatory surgical centers, that don't, aren't located where they can help, don't address the needs that may be out there for underserved populations, and it's that component that concerns me, because those dollars are also, can be seen as an investor opportunity. And it isn't going to be just an issue for this state. It's going to be an issue for every state in the union where this plays out unless we figure out ways to be a little wiser in how the delivery system operates and how these insurance plans are set up. [LR85]

BRUCE RIEKER: As long as there is the opportunity for providers to do fee-for-service and volume-based operations...I don't mean that as in surgical operations, but procedures, I mean that they run volume-based businesses, there will be the opportunity for them to take the well-paying cases and have volumes and capital leaving, in our case, the community hospitals and other public providers, public health departments, to try to make ends meet to care for those that, well, quite frankly, their health benefits or lack thereof do not come anywhere close to helping keep us in a financial position to continue doing what we're doing. Is that close? [LR85]

SENATOR GLOOR: Helpful responses. Thank you. [LR85]

SENATOR PAHLS: Okay. Senator Schumacher. [LR85]

SENATOR SCHUMACHER: The cost of healthcare and insurance was rising dramatically long before ObamaCare showed up and continues to rise even though ObamaCare isn't in full gear. Let's suppose that the dog catches a car and Nebraska is successful in its suit against the Health Care Act. Should we be doing any planning? Should, where do we go to get a grip on the problem here in the state, and how do we integrate that with something in nearby states, maybe nationally, that makes sense?

This can't go on. Is there any suggestions as to what we should be planning for as a contingency in the event that the Health Care Act is stricken? [LR85]

BRUCE RIEKER: Well, if the Health Care Act is stricken in its entirety, which I don't think is going to happen, but if it were stricken in its entirety, there would be immense planning that we would need to do, because the cuts from the federal government are already in place, and those providers, including the ones I represent, will already be incurring the reimbursement reductions without Plan B anywhere behind. If the Supreme Court rules that the insurance mandate is unconstitutional, and that is the only part that they rule is unconstitutional, we will still have healthcare insurance exchanges. And some, by some accounts, and I know we're in a nonpartisan environment, but there are many Republicans nationally saying that insurance exchanges were a Republican idea in the '80s and the '90s. And there are governors as we speak that are out there saying health insurance exchanges are a good thing, such as Haley Barbour from Mississippi, and he's one of many. It is absolutely imperative in our minds that the Legislature needs to keep moving forward devising solutions to our healthcare situation. Part of it may be Medicare...or excuse me, healthcare reform. Part of it may just be our own initiatives that we should be looking at and dealing with. There are some good things in healthcare reform that push providers towards focusing more on pay for performance and quality rather than just fee-for-service of how many, you know, procedures can you perform. Those are good things, and the transparency components, those are all good things, and I think that, you know, we need to continue to go that way. And in our testimony we talked about how we think it's important that the exchange also promote improved quality and that we look at ways to improve pay for performance. Even if the federal government has their perspective on it, the states, and maybe it's just by provider by provider, but we should be looking at those sorts of solutions in Medicaid, outside of Medicaid, in the exchange and outside the exchange. So the challenges are daunting, but I also think that the opportunities for us to make some improvements in the way we deliver care could come about through the formation of the exchange if we do prudent governing and build accordingly. And, you know,

I...two separate issues, most definitely, but I would rather see the Legislature tackle this in a more deliberate method than for us to get to a special session and that we try and wrestle through all of these ideas in a short amount of time and that we put something together that just isn't as well thought out as we would like it to be. I know that that is an option to some. Some think that we can wait for the Supreme Court, and then we have all these what if's, but we from the Hospital Association strongly contend that prudent governance requires that we examine these issues now. [LR85]

SENATOR SCHUMACHER: Thank you. [LR85]

SENATOR PAHLS: Senator Campbell. [LR85]

SENATOR CAMPBELL: Thank you, Senator Pahls. Mr. Rieker, I would like to look at the last page of the written testimony where you talk about the governance, and the last two points of your...the last two bullet points there are preference toward a quasi-governmental entity, and then the fourth one, exchange to serve a more passive role toward market reform and oversight. Can you explain those last two bullet points? [LR85]

BRUCE RIEKER: I'd love to turn around and look at a couple of people that were instrumental in writing that, but I'll do my best. (Laughter) Preference toward a quasi-government entity, and I think that that definition varies from person to person. But through our issue strategy group and what we've discussed is we do not think that a new agency needs to be created. And we are, based upon the expertise that we have seen in the Department of Insurance and all the work that they have done, we see them, if we form a state-based exchange, as being the government entity that carries it out and executes upon what the exchange needs to do and oversees that, probably working with the Department of Health and Human Services when it comes to the interoperability, and then I go even a little bit further. It may involve the Nebraska Department of Revenue and, but, I mean, we have to have a focus on...there are

government entities capable of doing this, and we would have to figure that out. However, we are not comfortable with it being simply a government entity that runs it without either legislative oversight, and I mean strong legislative oversight, or some sort of independent board that that agency must, or those agencies must be accountable to. There has to be a level of accountability to bring the business sense, the provider sense to the table so that this is much more of a public/private partnership that hopefully operates more efficiently and is more responsive to consumer needs and serves the state's interest. [LR85]

SENATOR CAMPBELL: Is that like the Virginia? I mean, one of the places we've looked at is the state of Virginia, I think, has what might be defined as a quasi... [LR85]

BRUCE RIEKER: Yes. [LR85]

SENATOR CAMPBELL: Do you know, is that a model that might come into question here? [LR85]

BRUCE RIEKER: Um-hum. [LR83]

SENATOR CAMPBELL: It's the last bullet point, did you want to add anything to that? [LR85]

BRUCE RIEKER: Yeah. The exchange to serve a more passive role toward market reform and oversight. In those areas, we don't see that it should exercise more authority over the insurance providers than need be. That that would be better left to the private sector to, to be able to, I mean, the parameters, what is a qualified plan, what do they need to do to be either in the exchange or offer insurance outside the exchange? We see the exchange doing that much more than the exchange being a provider of insurance, so that's how we look at that. We don't see the exchange becoming an insurance company. [LR85]

SENATOR CAMPBELL: Got it. [LR85]

BRUCE RIEKER: Okay. We see the exchange regulating what happens within the insurance industry, and for those eligible to participate, but not to be a buyer and seller of insurance. [LR85]

SENATOR CAMPBELL: Got it. [LR85]

SENATOR PAHLS: Senator. [LR85]

SENATOR SCHUMACHER: There has been some discussion that there perhaps is some additional cost caused by a paid-by-procedure instead of paid-by-outcome focus. To what extent do you see that the threat of lawsuits encourage, promote, unnecessary procedures or procedures that may be remotely necessary but probably not necessary? [LR85]

BRUCE RIEKER: So you're asking me what is the cost of defensive medicine? [LR85]

SENATOR SCHUMACHER: Yeah, basically. [LR85]

BRUCE RIEKER: Okay. Well, from a national perspective, and when you think about this, this is a pretty big range. But for those educational institutions and others that have researched this, the estimates range that the cost of defensive medicine is somewhere in the neighborhood of $50 billion to $100 billion per year nationally. I don't know what it would be here in Nebraska, because Nebraska with its malpractice statutes and the Excess Liability Fund, we probably have one of the better systems in the country. And, if we could get the people in Washington to subscribe to that as well, that would be nice, but healthcare reform went the other way for malpractice and defensive medicine. It went against providers. So I say that, it's, you know, somewhere in the $50 billion to

$100 billion. In comparison, to put that into perspective, our nation spends about $2.7 trillion to $2.8 trillion per year on healthcare, so that will give you an idea of what fraction of that healthcare spending is spent or were procedures performed in defensive practices. [LR85]

SENATOR SCHUMACHER: Let me just follow up then, one little bit then. We spend those trillions of dollars on healthcare. How does that compare to what other countries spend, and how does our healthcare rank according to world standards with the care provided in other industrialized countries? [LR85]

BRUCE RIEKER: The nation spends the most on healthcare of any industrialized nation on the planet. And as far as quality of care, it doesn't rank so well. I mean, I've seen based upon whatever criteria they, the various research institutions look at, you know, we're somewhere in the eighth or ninth or tenth best depending on which country we're compared to, or, you know, various factors that they take into consideration. [LR85]

SENATOR SCHUMACHER: I mean, that is pretty dramatic. What are we doing wrong? [LR85]

BRUCE RIEKER: (Laugh) Now we've entered healthcare reform debate. [LR85]

SENATOR SCHUMACHER: Well, I mean, isn't this all part of what we've got to deal with? [LR85]

BRUCE RIEKER: Well, there are several things that we can improve, and, you know, we talk a lot about personal responsibility, and I think that that is a component. But I'll share with you firsthand that when I was a congressional staff person, and for two, the two congressmen I worked for, I would be the first one to tell you that I advised those members that high deductible plans were a good thing. It will lower the cost of insurance. It increases personal responsibility. However, that may be a good thing in

good economic times, but in bad economic times, and I know Nebraska is faring better than many other states around the country. But those community benefits that I referred to earlier where we provided $200 million in bad-debt care in 2010, the year before that was $175 million, so it went up 16 percent. That increase was primarily from people that were insured under high deductible plans. The insurance company paid their obligation, and the people walked on their personal obligation of paying our hospitals. So, and how you legislate personal responsibility is beyond me. I've been in this for two decades, and I don't know how you do that. But we need to do a better job of deciding whether or not the actual procedure is necessary. We have a country with consumer expectations that we want it, and we want it now. I want that, (inaudible). You know, one of the phrases that frustrates me the most is, "I've hit my deductible," so then for the rest of the year I'm going to have whatever I need. Those things run up the cost. We also have what many experts say is overutilization, and that goes to fee-for-service and doing assembly-line procedures rather than doing the necessary procedures. And most of the data that, you know, national experts present and write about in this area says that because we have a fee-for-service system rather than a system that pays based upon performance, quality, and outcome, that roughly 30 percent of all healthcare expenditures would be alleviated if we got rid of the fee for service and it all went towards pay for performance. Some of the things will come about through bundled payments, accountable care organizations. You probably won't see a formal accountable care organization in this state, but you will see hybrids of them. But we will have bundled payment issues or organizations and things like that, and because you won't see an ACO is because the Congressional Budget Office has estimated that it costs somewhere between $17 million and $25 million to form. Okay, if you're going to spend that kind of money to form an accountable care organization, I don't know where you're going to get the savings or the increased Medicare reimbursements to pay for something like that. So, those are just some of the things. And, we have one of the, we have a country that has some of the poorest health in the world. And, with that, comes lots of illnesses. [LR85]

SENATOR SCHUMACHER: Thank you. [LR85]

SENATOR PAHLS: Senator Utter. [LR85]

SENATOR UTTER: Bruce, the figures that you alluded to in terms of losses, accounts, and those type of things are truly astounding. No question about that. Ultimately, hospitals cannot continue to keep the doors open unless those dollars are, those true losses, are recovered somewhere. It seems to me like it's only two sources of covering those true losses. One of them is for government assistance, or the other one is to increase the costs on those who are insured or have the cash to pay and do pay to make up for that. Either way, it seems to me like whether it's through government assistance or whether it's through increasing costs, and they have increased, as we look at insurance premiums through the years, increasing those costs. It seems to me like that's a tax for medical care. The taxpayers have to furnish the government the money. Those who are insured are more than likely taxpayers that may be paying twice through an increase in their insurance premiums and over here through an increase in taxes to make up these losses. That may be a rather simplistic view, but to me, it points out the importance that we attach equal importance to providing care in a more efficient, in a more cost-effective manner. And so I don't see the formation of an insurance exchange or the Affordable Health Care Act as necessarily encouraging as strongly as it could the study and development and actually putting into practice a more efficient, more effective healthcare delivery system of some kind. It seems to me like that is on your table, and I applaud what you're doing. I'm just wondering how much further can you go? [LR85]

BRUCE RIEKER: Oh, we have a lot further to go if we're going to continue to exist. Almost all of the hospitals we represent are full-service community hospitals. There are some with very specific markets that they serve, such as the Heart Hospital, the Spine Hospital, things like that, but overall, they're full-service community hospitals, nonprofit. And, Senator, yes, we are nonprofit, but we're not in the business of going out of business. We feel that it is a responsibility, especially in a state that is as rural as this, to

make sure that we have access to care, and appropriate and high-quality care. And Nebraska is known for being a high-quality and low-cost state as far as providing care. Healthcare reform, healthcare reform was payment reform, and the government said we're going to cut you. We'll give you a few, you know, we'll throw a few nuggets out there that say you can form a bundled payment group or an accountable care organization or whatever it may be, and we're going to have you report on quality. But we're going to cut where we can cut, and then you as providers figure it out from there. You as states figure out, you know, what an exchange looks like. You know, it's like, here's our parameters, but, you know, we wish you good luck. But what our Hospital Association has done...I've already mentioned the issues strategy group that we formed on this particular issue of exchanges, but we've also formed one on Medicaid and cost control or cost containment, but that, you know, that steps outside of Medicaid as well. How can we...it's formed at how can we redesign the delivery system as much as we can, whether it's using mid-level practitioners or medical homes or whatever the services may be. How can we do a better job of delivering the system as cost effectively as possible? And the things...and we formed this ISG. There are 16 representatives from our hospitals, and they're very bright people. But we are looking at, what do we do with utilization, and specifically, overutilization? What services in Medicaid should continue to be covered? Which ones maybe shouldn't be? What can we do to improve provider reimbursement rates under Medicaid? And what other forms can...or what other resources are there to gather funding for the state to help bring down the federal dollar match that goes with that? We also have, let's see, the enrollment issues, eligibility. But, you know, those are several topics that we're looking at, and as we form this thing, and I welcome their candid comments. But, you know, a lot of them are CFOs and payment managers and things like that in hospitals, and after our first meeting, one person said, "Well Bruce, as soon as we get this one done, are we going for world peace?", and I'm like, "Yep, we ought to do it." (Laughter). But we can't sit idly by. Otherwise, the whole system will die slowly on the vine, so we recognize what we need to do. Some of our hospitals have already adopted a goal that they are going to get their costs of care down to Medicaid rates. Now that is going to significantly change what

care may be available in some of those hospitals. And it's going to impact such things as wages and what equipment is available. You know, another thing I will say is that all of our hospitals don't have to have the 64-slice MRI, or we don't have to have the physician stand-alone MRI. You know, it's like we have an abundance of healthcare providers in the, definitely in the metro areas. And so we need to be looking at, you know, how do you control that? I don't know, but we need to be much more efficient with our dollars and our resources to provide the care. We've got a ways to go. [LR85]

SENATOR UTTER: A long, long time ago, I was a member of a...I was chairman of a hospital board. [LR85]

BRUCE RIEKER: I know that. [LR85]

SENATOR UTTER: So long ago I can't hardly remember. (Laughter) But, back in those days, we were in the certificate of need days, and it seems to me like this abundance of providing medical care, of everybody being everything to every patient, was somewhat circumvented, maybe, when the certificate of need legislation was there. Are we harkening back to that type of an environment as opposed to...I guess I'm, the question I'm really asking, is the free, which I'm an advocate of almost everywhere, is the freedom of delivery, everybody going as far as they think they need to go and providing medical care to everybody, and they, with the best equipment and the newest thingamajigs and all of those things, are we...is that hurting...is that raising the cost and hurting the delivery of efficient medical care? [LR85]

BRUCE RIEKER: Okay. On your question about certificate of need, I don't know any of our members who want to go back to that, because it became a very political process, but... [LR85]

SENATOR UTTER: I went through that and it was. [LR85]

BRUCE RIEKER: Yeah. (Laugh). There probably...yeah, our members mention the fact that there needs to be some sort of coordination, you know. And we don't want to get into the antitrust or any of those things that's saying okay, well you hospital, you're going got do this, and you're going to do this, and so we have to be very careful about those sorts of things. But there is a growing discussion within our membership of how do we better utilize these things, so that is one. And I will say this, that, you know, when healthcare reform mandated utilization rates of some of our equipment. So healthcare reform actually didn't do us a real good service in the rural areas where, okay, let's say you have Broken Bow and Valentine, a long way apart. They both need MRI machines, very sophisticated ones. But if you don't run them at a certain level or the activity of that machine isn't at a certain level, you get a lower Medicare reimbursement. So what do you do? I mean, it's like so they're trying to, you know, run the machine where they need to, to make sure that they're getting the Medicare reimbursement. So those things complicated the situation a little bit. As for your question about, you know, the proliferation. I'll describe it that the Dartmouth Institute recently released a study, and it is mind-blowing to me to see how the cost of care escalate in metro areas where you have a high population of many physicians and stand-alone facilities. The cost of care in those areas is exorbitant. I mean, Nebraska, by far, is less than most of these rural...or these urban areas on the coast and things like that, but nonetheless, we do not have anything in the system that controls that sort of proliferation, and the cost of care per recipient goes up. [LR85]

SENATOR PAHLS: I think I'm going to move on, because I'm wearing you out. (Laughter) [LR85]

BRUCE RIEKER: I'm probably wearing you out. [LR85]

SENATOR PAHLS: And also, we have we have other...just a couple of things I want to point out in your conversation, in your discussion with this. It seems like there is an implied by your conversation that we're just going to stop. I don't see this as this issue

dying out within the next few days. I mean, or waiting until special session. I mean, this is going to be an ongoing procedure, to be honest with you. So I want to dispel that idea that, you know, after the hearing that we're going to wait until special session. I think if you read, again, if you read what the director had in the newspaper, there is going to be a methodical look at what is going on, because they hit at $5.5 million that we need to...Also, I just have one question. Did you have an opportunity, again, this is not a test, to go over part of what the report... [LR85]

BRUCE RIEKER: I did. [LR85]

SENATOR PAHLS: ...from the department of...and I heard you say earlier that you, uh, you were impressed with this. [LR85]

BRUCE RIEKER: Yes. [LR85]

SENATOR PAHLS: I'm not necessarily saying you agree with all the recommendations, but here's the thing that I'm concerned about because...to me it's been implied that the integrity of this report is, or we should question parts of it because of the people who helped come up with it. But you can tell me face-to-face that you think this is a pretty decent report. [LR85]

BRUCE RIEKER: Yes. We have not questioned the integrity of it. We don't agree with everything in it, but we have never questioned the integrity of it. [LR85]

SENATOR PAHLS: Right I am not asking for an agreement. [LR85]

BRUCE RIEKER: No. [LR85]

SENATOR PAHLS: But, okay. That is all I needed to hear. Thank you. [LR85]

BRUCE RIEKER: You bet. [LR85]

SENATOR PAHLS: Just by a show of hands, how many more people do we have? One, two, three, four, five? Okay. Come on down. [LR85]

MARK KOLTERMAN: (Exhibit 7) Senator Pahls, Senator Campbell, and remaining senators. My name is Mark Kolterman, M-a-r-k, K-o-l-t-e-r-m-a-n. I'm from Seward, Nebraska, and I'm speaking on behalf of the Nebraska Association of Insurance and Financial Advisors. They're passing out to you our association guiding principles for the creation of a health insurance exchange in the state of Nebraska. I'm not going to go through that in its entirety, but I'm going to go through some highlighted items. We, as an association, know and understand that healthcare reform is changing the way health insurance will be delivered, and it's changing it dramatically. We also know that, and we feel very strongly that a state-based exchange should be the way that the state of Nebraska should approach this rather than a federal exchange. I think that has been kind of a underlying theme with most people that you've heard from. We think that exchanges, as they are created, should maximize health plan participation and consumer choice, and so we think exchanges are going to be best served from consumer...best serve consumers with a broad array of plans and options inside the exchange. We believe that the state Department of Insurance is the organization that should be in charge of the exchange, and they should be the people that determine qualified carriers and health benefit plan characteristics. Our role, we believe that, that enabled licensed insurance agents and advisors should be compensated for selling products through the exchange. We think that we can be the arm, the delivery arm. We are licensed professionals. We're in...in the state of Nebraska, we have representatives in all 94 counties currently. We're already subject to rigorous licensing, continuing education. We carry errors and omissions coverage, and we provide a high degree of consumer protection for our clients. As far as navigators are concerned, we believe that the navigator should not be held any less responsible than we are as agents. In other words, there should probably be a licensing requirement if you're going to be a

navigator. We believe also that if an agent decides that they want to be a navigator, they should have that option and should have the same licenses, or be licensed. And then, from a governance standpoint, we believe that it should be with the Department of Insurance, but if it's a quasi-board, we would like to have an agent, at least agent's representation on a board as well. And then finally, we believe that there should be a broad exchange of information and sharing of data between agencies so the transition of CHIP to children to Medicaid, all of those items, we should all be on the same page and try and work through some of the challenges that exist there. You have the report there. If you have any questions, I'd be glad to try and answer them for you. [LR85]

SENATOR PAHLS: I have one because governance seems to be an issue. You're just saying a quasi board, is that what I heard you say? [LR85]

MARK KOLTERMAN: Well, we believe that it should be vested with the Department of Insurance. We have a very reputable Department of Insurance, highly qualified. They could handle this. But if there is a quasi-board... [LR85]

SENATOR PAHLS: You want to be involved. [LR85]

MARK KOLTERMAN: ...we would like to have involvement in that. Correct. [LR85]

SENATOR PAHLS: Okay. Seeing...oh, Senator Utter. [LR85]

SENATOR UTTER: And I don't know that this is necessarily a question for you, Mark, but we've heard this morning so far from the Independent Insurance Agents, from NAIFA, Hospital Association, from the Health Care Association. Have...to you knowledge, have any...and each of you have presented us with a list of criteria you think for a...and by and large, an awful lot of them seem to agree, but I'm wondering, have these groups ever gotten together... [LR85]

MARK KOLTERMAN: Yes, we have. [LR85]

SENATOR UTTER: ...and tried to hammer out a single document that... [LR85]

MARK KOLTERMAN: Well, we've gotten together once, and it was at the...there were several legislators involved, and to talk about governance, to talk about...everybody kind of laid their cards on the table, and it was very productive, I thought. I think that the underlying theme that came out that everybody could agree upon was that we should have a Nebraska-based exchange. As far as governance, there's probably some areas to work on there. Who is going to run it? Should it be with the Department of Insurance? Should it be with Health and Human Services? Should it be a privately run organization? I mean, I think there is a lot of room to work there. But yes, we have. We started that dialogue, and ultimately, this is all about getting more involvement with people throughout the state. You know, there are a lot of people that are uninsured, but a lot of them are uninsured by choice. They choose not to come in and see us and get their insurance. I can't speak for NAIFA on this, but from a personal point of view, we have a lot of people that are of low income that come into our office on a weekly basis and ask us about insurance. They can't afford it, but there is no reason why our staff can't be trained to channel those people to the right places or help them enroll in Medicare or Medicaid. I don't see why we couldn't do some of that. I mean that is a delivery system. You've got people all across the state. I don't know if the rest of my colleagues would agree to that, but we're doing it now, so I don't know why we shouldn't enlarge that. [LR85]

SENATOR UTTER: Thank you. [LR85]

MARK KOLTERMAN: Yes. [LR85]

SENATOR PAHLS: I have a question. Has your association dealt with the Department of Insurance? [LR85]

MARK KOLTERMAN: Yes. We've worked very closely with the Department of Insurance. We have probably had four or five meetings with them already. [LR85]

SENATOR PAHLS: Okay. So you are meeting with, and you're talking to them about your concerns about governance and whether you're qualified and all this kind of... [LR85]

MARK KOLTERMAN: Exactly. I can't speak...they have a great, they put out a great program there. [LR85]

SENATOR PAHLS: Okay. [LR85]

MARK KOLTERMAN: We're behind that. We endorse that. [LR85]

SENATOR PAHLS: Okay. So there are some issues that we need to resolve, but it's not like we're day one just getting out of the starting blocks. [LR85]

MARK KOLTERMAN: They probably share the same concerns that we have. There are a lot of unknowns that are being handed down to us on a regular basis. The federal government hasn't got all this put together, and you know, it's kind of hard to operate when you don't know what you're going to get next. There are guidelines and time frames, but... [LR85]

SENATOR PAHLS: Yeah, and I appreciate that, because I have some people putting pressures on me. Well, why aren't you this way? Well, we're waiting for the people upstairs to give us a little bit more direction. [LR85]

MARK KOLTERMAN: Exactly. We have a great working relationship with them, and we find them to be very easy to work with, and I think our counterparts NAHU and the Big I

and PIA all have the same working relationships. [LR85]

SENATOR PAHLS: Okay. Thank you. Senator Campbell. [LR85]

SENATOR CAMPBELL: Thank you, Senator Pahls. Mr. Kolterman, I'm particularly interested in the last bullet point on the second page that you have there just because I'm looking for good ideas about how to reach hard-to-reach individuals, because I do think that is going to be a part of a challenge for an exchange. What ideas would you have, in your experience, do you think, in how to get to those people? [LR85]

MARK KOLTERMAN: Well, what we're talking about here is the exchange of information so that we can qualify people in the right position. And one of our concerns is as these subsidies are brought down, I mean, 400 percent of poverty, I believe is, and you heard earlier that is going to include about 70 percent of our population. Well, how do we get that information as an agent? As agents and brokers, how do we acquire that and qualify people where they belong? Are they eligible for the CHIP program? Are they eligible for the other programs that are going on out there? That's where the sharing of information is going to be very difficult. You talked earlier about information technology, and that has got to be huge part. There is a program right now on a national level for people that don't have insurance and can't qualify, they've got preexisting conditions. They...that program has not grown to the magnitude that they think it should grow on a federal level, and one of the reasons, I believe, is: (1) It's a Web portal. Everybody has to...if you want to sign up for it, you go to a Web portal, and just...they assume that everybody has a computer and everybody is computer savvy and can deal with that. Well, the reality is now they've involved agents and gotten agents involved, and it's growing. In the past, it didn't grow. But that is our job. We do that every day. We look at computers. We look at how to access information. But to give you an example of how slow and cumbersome that is, we had a young man come into our office, and he couldn't qualify anywhere. And we had just found out about that. We applied to that federal program. It took us six weeks to get him approved primarily from the standpoint

of he had to go through Homeland Security, he had to go through Social Security and the IRS and get...I mean, they couldn't even verify that he was a U.S. citizen, and he lived here all of his life. That is where we think we can play a role as an agent in a smaller town. And as I said earlier, we have agents...between our four associations, we have agents all through this state that could do a lot of that. But being able to share that information between Medicaid, Medicare, the CHIP program, I mean that is going to be a...that is as difficult a challenge as I see. How do you qualify people for where they belong? [LR85]

SENATOR CAMPBELL: And Mr. Kolterman, your testimony would be backed up by what we heard yesterday, because much of ACCESSNebraska is supposedly through...expecting people to use a computer. And many of them testified, particularly from the elderly, that that one-on-one, somebody talking to them, is really what made a difference. And not everybody has a computer, nor the skills to use it, so you're backing up that point quite well today. Thank you. [LR85]

MARK KOLTERMAN: Thank you. Any other questions? Thank you. [LR85]

SENATOR PAHLS: Thank you. Appreciate it. [LR85]

BRIAN DEPEW: (Exhibit 8) Good morning. My name is Brian Depew. B-r-i-a-n, D-e-p-e-w. I live in Lyons, Nebraska, and I'm here today on behalf of the Center for Rural Affairs. I want to thank Senator Pahls and members of the committee here today. I want to start by saying simply, the Center for Rural Affairs supports legislative action to implement a Nebraska health benefits exchange in accordance with the federal Affordable Care Act. If we fail to enact legislation in the 2012 Session, we will begin to miss key benchmarks and dates in the process of implementing a Nebraska exchange. If that happens, the federal Department of Health and Human Services will step in and build an exchange for us. The Center for Rural Affairs' primary interest is ensuring that the exchange is implemented in a way that addresses the challenges rural stakeholders

face in the insurance market. In considering the best interests of rural people, there are three primary points I want to emphasize today. First, the exchange should be designed to help individuals and small businesses banded together into a larger pool to gain market leverage to get a better deal on insurance. This is what large employers do now. Whether Cabela's in Sidney or the University of Nebraska in Lincoln, these employers leverage their large pool of individuals to secure more affordable insurance plans. For too long, Nebraska's small businesses and people who buy coverage in the individual market have been denied the same benefit. Second, the exchange should be established as an independent or as a quasi-governmental nonprofit entity with an independent governing board. This is the structure being pursued in 34 other states. We are concerned about the alternative of locating the exchange within an existing agency. The functions of the exchange do not fit neatly within any single current agency, with both the Department of Insurance and the Department of Health and Human Services having equal interests in exchange functions. Additionally, only one state has enacted legislation placing the exchange in an existing state agency, and only three other states are considering this structure. And third, a high priority should be placed on enrollment, outreach, and integration with existing public health programs. The recent report from the Nebraska Department of Insurance estimates the number of individuals in Nebraska who lack insurance at more than 200,000, yet the same report suggests that initial enrollment through the exchange will be only about 50,000 people. This is far short of the enrollment we should seek to achieve. A higher enrollment will mean more Nebraskans receiving federal tax credits to support their premiums and fewer Nebraskans relying on uncompensated care within the system. Finally, it is critical that the exchange be seamlessly integrated with other public health insurance benefit programs administered by the state. This so-called "no wrong door" approach is important to ensuring consumers who are eligible for Medicaid or tax subsidies in the private market are not faced with a frustrating and confusing enrollment system. We are pleased with the progress the state has made so far. Nebraska's Department of Insurance has received a federal planning grant, and just yesterday, the Phase I implementation grant totaling more than $5 million. The next federal grant Nebraska can

apply for is as Phase II implementation grant. In order to qualify, Nebraska must enact legislation that addresses basics structure, operation, and financing of the exchange. As this process goes forward, we look forward to continuing to provide input into exchange planning and needed legislative action, especially in relation to the concerns and priorities of rural people, the self-employed, and small businesses. Thank you, and I would be happy to entertain any questions. [LR85]

SENATOR PAHLS: I noticed you had some concern that there are 200,000 people who could qualify, but the state department says only 50,000 initially... [LR85]

BRIAN DEPEW: Um-hum. [LR85]

SENATOR PAHLS: ...but that would go up. In their project...they projected that to go up. [LR85]

BRIAN DEPEW: They projected it to go up, but I believe they projected it to go up only to about 100,000. [LR85]

SENATOR PAHLS: Yeah, right. [LR85]

BRIAN DEPEW: And we would be supportive of more aggressive outreach initially to, so that we can get a stronger start than just 50,000, and we should reach more than 100,000 ultimately. [LR85]

SENATOR PAHLS: And I understand that and I agree with that but... [LR85]

BRIAN DEPEW: Um-hum. [LR85]

SENATOR PAHLS: ...one thing we find out in the state of Nebraska, a lot of people take a look at the government subsidizing them in any way is not the way to go, to be honest

with you. So you're concerned if we do not do anything that we will automatically turn it over, all over to the federal government. That is what you're saying. [LR85]

BRIAN DEPEW: Yeah. I mean, there's the January 13...or January 1, 2013, date that we have to meet for determination. We need to get the Phase II implementation grant ahead of that in order to be in a position to meet that. Otherwise, federal HHS will step in and build an exchange for us. [LR85]

SENATOR PAHLS: Okay, and you indicated that apparently you had read that Nebraska did receive Phase II, and if you read today's article, you would see that the department is going to go ahead. I'm taking a more optimistic point of view, to be honest with you. [LR85]

BRIAN DEPEW: Well, I mean the Phase I implementation grant is what we received just yesterday. The previous grant was a planning grant. It's excellent progress, but before we can receive a Phase II implementation grant, we have to pass legislation, enact legislation... [LR85]

SENATOR PAHLS: Right. Yeah. [LR85]

BRIAN DEPEW: ...addressing some of these basic points of exchange operation, and we have to do that before the January 1, 2013, date. Otherwise, Phase I grant or not, the federal HHS could still... [LR85]

SENATOR PAHLS: Right. And I'm just asking, just read the... [LR85]

BRIAN DEPEW: Yeah. Yeah, I saw that. [LR85]

SENATOR PAHLS: ...the news article... [LR85]

BRIAN DEPEW: Yes. [LR85]

SENATOR PAHLS: ...and it does...I need to get across that we're not just sitting... [LR85]

BRIAN DEPEW: Oh no, absolutely... [LR85]

SENATOR PAHLS: ...sitting around. [LR85]

BRIAN DEPEW: ...absolutely. No, it's excellent progress. [LR85]

SENATOR PAHLS: Okay. Okay. [LR85]

BRIAN DEPEW: I agree. [LR85]

SENATOR PAHLS: Seeing no more questions, thank you for your testimony. [LR85]

BRIAN DEPEW: Thank you. [LR85]

JENNIFER CARTER: (Exhibits 9, 10, 11) Good morning, Chairman Pahls, Chairman Campbell, and members of the committees. My name is Jennifer Carter, J-e-n-n-i-f-e-r, C-a-r-t-e-r. I'm the director of Public Policy and Health Care Access at Nebraska Appleseed. We really appreciate the opportunity to testify today with respect to the establishment of health insurance exchanges in Nebraska. You know, we are supportive of the efforts under the ACA. We know it's not a perfect law, but we think it's a really important first step, and what I think we believe is important is that to us, in reading the statute, the goal of the ACA is a focus on consumers, increasing access, and hopefully, some of the other things that have been discussed, like delivery system changes and some of the issues that have been covered already. But really, it's about the Nebraskans we all know who struggle to afford coverage or who are uninsured. And

so, it's through that lens that we view the establishment of an exchange in Nebraska. We are also supportive of a state-based exchange. We think it is the best way to tailor an exchange to the specific needs and challenges in Nebraska, and we also would be supportive of efforts to...we'd like to see passed, but at least debated legislation so that there is time for, as has been mentioned, a thoughtful and deliberative process. And we fully appreciate the DOI's efforts so far and are glad that they received that additional grant. I think the difference for us would be while their efforts continue, which is great, we would...we believe the legislators, the Legislature's involvement and debate on these issues is really key at this point. We have really appreciated the opportunity that the hearings have created so far to hear about the progress on implementation and hope to create a more transparent exchange planning process. Since there were a few issues that came up that we heard in those hearings, we wanted to pass out some information, particularly around what other states are doing. We heard that from several senators. So, the Center on Budget and Policy Priorities has been tracking legislation in other states, and we did provide two handouts there. Thirty-nine states have been considering legislation, 10 have enacted legislation, others, I believe, are still pending. And I'm sorry, I forgot to count that up, but we hope that's helpful. I think one of our key areas, and I think this has been brought up by a lot of people, is governance. We believe that the governing body should be consumer focused, and as others have said, include perspectives from all stakeholders in the process. And for this reason, we do not believe that the exchange should be housed in the Department of Insurance, at least not without a separate policymaking governing board. And it's my understanding...it's the second handout that we put out. As Brian just mentioned, there's only one state that has actually enacted a law in which the governance structure is within a state agency. And that law in Vermont, there is actually a very strong, separate governing board that actually does a lot of the policymaking and approval and, in terms of the board. But what it does do, and we understand this as a possibility, it leverages existing agency resources so you don't have to sort of recreate that, but it doesn't leave all of the policymaking and all of the decision making to the state agency, because we have a significant concern that while we've had a good working relationship with DOI, we have

appreciated how much they've talked to everybody. Without a governing board, I don't know that you would have the meaningful or consistent stakeholder input that we believe is necessary for running a good and healthy exchange in the state, and what we'd really like to see, which is that Nebraskans involved in this. And not just, you know, everyday Nebraskans, but we need to have providers, and insurers, and small businessmen, and rural folks, and, you know, as many people involved as possible. We also just, when, to the extent...when the board is created, we would like to see a majority of those members on the governing board be consumer representatives, and that means representing different constituencies, seniors, disabled folks, low-income folks, all of whom have different barriers, and I think different challenges that would need to be addressed by the exchange. Another big area for Nebraska Appleseed in particular, as consumer representatives, and particularly, low-income advocates, is the exchange working with Medicaid seamlessly. I would say actually even broader is how the exchange works as has been discussed. How easy is it for people to access? Do we have people that can be called? Do we have brick and mortar? Is it all just on-line? I think those are key issues. But specifically, on the Medicaid issue, making sure that we have this "no wrong door" policy so that when someone comes in, their eligibility is being determined either for a tax subsidy, or maybe just for buying private insurance, or for Medicaid, and they're not then sent somewhere else after the eligibility is determined is important. I think the recommendation for the Department of Insurance was to have eligibility determined but not necessarily enroll people through Medicaid. We have some significant concerns about that, although I think in our conversations with them, my understanding is that is more of a back-office issue, and if that is the case, then I think there may be ways to deal with this. Our concern is having somebody come in to an exchange office or on-line and be told, "Oh, you're eligible for Medicaid. Now go to ACCESSNebraska," which we know has significant problems, or be directed somewhere else. It's our understanding that that is not the intent or requirements under the law in terms of a "no wrong door" structure. So, I mean, if it happens that the exchange is technically not enrolling them but the consumer doesn't know that, they come in, they get their eligibility determined, and they're signed up for something before

they leave, I think that is fine. Separately, my understanding is that there are some populations that are currently eligible for Medicaid, so these are not the newly eligible people under the ACA, but that are currently eligible, whose eligibility would be difficult to determine under the exchange initially until the exchange is up and running, and things...because the exchange will be using a specific new eligibility determination criteria under the ACA that might be different from current eligibility criterias. So we understand that not everybody's eligibility might be able to be determined, but we would hope that it would be structured in such a way as to leverage all the information that was just given to the exchange shared with HHS, even possibly in a pre-populated form, if they have to go to ACCESSNebraska. Some way that we don't have everyone duplicating all their efforts, people who are in that position in those particular categories of Medicaid. So those are some of our more major issues. We certainly agree with a lot of what has been brought up today. We have concerns also about adverse selection and how to deal with that inside and outside the exchange, but I don't want to take up a ton of time, because there's about...there is many issues I know we can discuss, but I'm happy to take any questions. [LR85]

SENATOR PAHLS: I have one question. [LR85]

JENNIFER CARTER: Yeah. [LR85]

SENATOR PAHLS: You said that you had some disagreement with the department. Are they talking to you? Are they trying to resolve this? [LR85]

JENNIFER CARTER: Absolutely. [LR85]

SENATOR PAHLS: That is my concern. [LR85]

JENNIFER CARTER: I don't know...they are certainly talking to us and meeting with us, which we really appreciate. We had a helpful conversation about what they meant in

terms of Medicaid eligibility being determined but not enrolling folks and also I think we feel more comfortable with where they are going with that. [LR85]

SENATOR PAHLS: Okay. (inaudible) at least listening to you right now, your concerns. [LR85]

JENNIFER CARTER: Right. Absolutely. [LR85]

SENATOR PAHLS: Okay. Okay. Senator Campbell. [LR85]

SENATOR CAMPBELL: Thank you. Ms. Carter, I'm going to ask you the same question that I asked Ms. Skolkin, and that is the whole question of some of the folks who might be eligible for Medicaid do not have an income tax form. And she talked about their using a proof. In your research with other states, have any of them tackled that question? [LR85]

JENNIFER CARTER: You know, I have not looked at that specifically, but I am happy to. And to see...because I do...I mean, I understand that is an issue unless there is some new requirement, which, I mean, to some extent, there might be some members of that population that are filing tax returns like you need to do to get an earned income tax credit. Even if you don't have really taxable income, you're filing it, and so there would be some information. But clearly, not a lot of people who are eligible for Medicaid are not going to be used to doing that. And I don't know if there are existing verification tools that are used now that can somehow be used in a similar way for this. But again, we're talking about the modified adjusted gross income. Methodology is a little bit different, and I don't...so I'm happy to take a look at that, but I'm saying I don't have a good answer right now. [LR85]

SENATOR CAMPBELL: That would be helpful, because as I mentioned earlier, the department has had some discussion with several of us on the committee about that

issue, and I think they too are struggling with that question, so whatever research you might find, of course, would be helpful. [LR85]

JENNIFER CARTER: Sure. [LR85]

SENATOR CAMPBELL: Thank you. [LR85]

JENNIFER CARTER: I'm happy to do that. Anything else? Thank you. [LR85]

SENATOR PAHLS: Thank you. Thank you for your testimony, and I appreciate your handouts. [LR85]

JOHN LINDSAY: (Exhibit 12) Good morning, Senator Pahls, Senator Campbell, members of the committees. My name is John Lindsay, L-i-n-d-s-a-y appearing as a registered lobbyist on behalf of Blue Cross and Blue Shield of Nebraska. Blue Cross and Blue Shield of Nebraska insures over 700,000 Nebraskans, and therefore has a strong interest in the development and implementation of a state-based health insurance exchange in Nebraska. Blue Cross and Blue Shield strongly supports the concept of creating a state-based exchange in Nebraska rather than allowing the federal government to control Nebraska's health insurance market. As you know, if Nebraska does not choose a state-based exchange, the federal government will build one for us. A state-based exchange model is necessary to maintain state regulatory, financial, and political control, as well as uniquely tailor the exchange experience for consumers and small businesses to shop, compare, and enroll in coverage that best meets their needs. One exchange model approach that has recently come about is the federal-state partnership model. While few details are known, the partnership model breaks the exchange into five core functions: consumer assistance, plan management, eligibility, enrollment, and financial management. States would have the authority to run the consumer assistance and/or the plan management functions. Exchange functions other than the selected consumer assistance or plan management would be performed

by the department of,the United States Department of Health and Human Services. If the state chooses a federal-state partnership model, the federal government would control eligibility, enrollment, and financial management exchange operations. The eligibility function includes determining eligibility for qualified health plans, tax credits, cost-sharing reductions, and Medicaid and CHIP. The financial management function includes assessing user fees and ensuring the financial integrity of the exchange. Based on what little is known, if either a federal or a federal-state partnership model is chosen, the federal government would be responsible for exchange functions such as initial Medicaid eligibility determinations and financial self-sustainment beyond 2015. Currently, not enough details about the federal partnership model are available for this to even be a viable consideration. Blue Cross and Blue Shield of Nebraska commends the Legislature and the Department of Insurance's efforts to continue planning for an exchange. Unless the time lines are altered, we urge passing legislation before the June 29 federal grant application deadline to receive funding for the first year of exchange operations. In order to receive the funding, a state must have the necessary legal authority to establish and operate an exchange at the time of the application. In conclusion, Nebraska should build a state-based health insurance exchange in order to retain regulatory and budgetary control over an already state-regulated industry. Allowing federal control of the exchange would represent a significant expansion of federal regulatory approval...excuse me, authority. By designing a state-based exchange, Nebraska can create a more efficient marketplace promoting competition, choice, and transparency for Nebraska consumers. Thank you, and I would be available for any questions. [LR85]

SENATOR PAHLS: Let me just start out with, as everyone, it seems like state-based is what people are striving for. I'm a little bit surprised that you even started...you even talked about the federal-state relationship model. [LR85]

JOHN LINDSAY: Talked about it mainly to say it wouldn't work. (Laughter) [LR85]

SENATOR PAHLS: (Laugh) Thank you for enlightening me. [LR85]

JOHN LINDSAY: It was not a suggestion. (Laugh) [LR85]

SENATOR PAHLS: Senator Gloor. [LR85]

SENATOR GLOOR: Thank you, Senator Pahls. Well, that answers my first question. My second question is, if this has just come to light, my guess is that even if we wanted to pursue federal-state, we don't know enough about it now to put together enacting legislation before June 29, which makes me wonder if the June 29 date is solid. I mean, I've heard issues of the fed's failure to give enough specific direction so that it makes it difficult for states to sculpt the legislation necessary, which puts to question the June 29 deadline and whether that deadline is not quite a line, but somewhat elastic. Any comment on that? [LR85]

JOHN LINDSAY: I don't know if...don't know if that deadline will be moved, but I think it's prudent to continue to act under the assumption that it will not be moved, and if it moves, then there is additional time. [LR85]

SENATOR GLOOR: Thank you. [LR85]

SENATOR PAHLS: Senator Schumacher. [LR85]

SENATOR SCHUMACHER: We've heard this morning that one of the reasons the federal exchange idea isn't the best is because we have different demographics, different needs than the urban areas. At the same time, the Department of Insurance report seems to indicate that we're somewhat constrained and limited by the fact that we only have 1.8 million people in the state, and the economics for a lot of things just don't work out well. But between the Rocky Mountains and the Mississippi, there are several states with similar demographics, probably similar ways of life, and a larger

population base. Has Blue Cross done any study, or should we be doing a study to see whether or not the best model might be some type of a common model that spans several of those states for efficiencies of not only population size but administration and governance? [LR85]

JOHN LINDSAY: I don't know that Blue Cross has considered that. I suspect that they have. I can find that out and get that information to you. [LR85]

SENATOR SCHUMACHER: It just seems to me that there might be a happy medium. It would probably take longer than the time we have to develop, but it's something that long-term strikes me as something, at least, to look at. [LR85]

JOHN LINDSAY: I will check and get that information to you and to the committee. [LR85]

SENATOR PAHLS: To be honest with you, in my discussion with Blue Cross and other, that regional...there seems to be some major issues with that, just to be up front. Any other questions? Thank you, Mr. Lindsay. Good morning. [LR85]

AUBREY MANCUSO: (Exhibit 13) Good morning, senators. My name is Aubrey Mancuso, A-u-b-r-e-y, M-a-n-c-u-s-o, and I'm here on behalf of Voices for Children in Nebraska. Thank you to both the Banking Committee and the Health and Human Services Committee for taking the time to consider how Nebraska should move forward on implementing provisions of the Affordable Care Act. Access to healthcare, especially during the developmental years of early childhood, is critical for children and can have an impact on health outcomes well into adulthood. We hope that the Legislature will take steps to ensure that a new system of care adequately meets the needs of our state's uninsured children. In 2010, the estimated number of uninsured children in this state increased significantly to 47,000. Over half of these, 30,000 children, were considered low-income, meaning that they should qualify for Medicaid or Kids

Connection. The state could increase outreach and enrollment for this population now to help ensure a more seamless transition to universal coverage. One of our primary concerns in moving forward with healthcare implementation is how the new healthcare exchanges will interact with Medicaid. The "no wrong door" enrollment policies could be made as easy as possible by maximizing the use of data matching between different programs. Wherever possible, public benefit program requirements should also be streamlined to allow for ease of enrollment. Steps should also be taken to minimize disruptions in coverage based on fluctuations in income. Disruptions in coverage can be particularly problematic for children with chronic conditions and can delay well-child visits or immunizations. Nebraska could use 12-month continuous eligibility for all Medicaid enrollees as well as using projected annual income for Medicaid beneficiaries instead of monthly income in order to minimize coverage disruptions. And finally, as others have stated today, although there are still questions to be answered, we hope that Nebraska will move forward on beginning to design a new healthcare system for our state. We urge the Legislature to move forward as quickly as possible, as there are critical questions to be answered that require thoughtful consideration. And with that, I would be happy to answer any questions. [LR85]

SENATOR PAHLS: Senator Campbell. [LR85]

SENATOR CAMPBELL: I really don't have a question, but I just wanted to let Ms. Mancuso know that your question about the 12-month coverage, and you know, when you're (inaudible), people go off (inaudible). The department knows that that is a problem, and in discussion about health exchanges, have mentioned it as one of the things that is going to have to be solved. Because you can't just...now you can go off and come back, and with the exchanges, you're most likely are not going to have...you shouldn't have that because it will cause an administrative nightmare probably... [LR85]

AUBREY MANCUSO: Right. [LR85]

SENATOR CAMPBELL: ...for some of the people who will be helping individuals enroll, so that is a major question. If you have any, again like Appleseed, if you have any research or in your work looking at other states, that would be helpful. [LR85]

AUBREY MANCUSO: Okay. Thank you. [LR85]

SENATOR PAHLS: I have a question on the paragraph dealing with "no wrong door"... [LR85]

AUBREY MANCUSO: Um-hum. [LR85]

SENATOR PAHLS: ...enrollment policies. Has your group discussed this with the Department of Insurance about your concerns? [LR85]

AUBREY MANCUSO: You know, we've met them probably once. I don't think we've discussed this specifically with them, but it's my understanding that, you know, the intent and the regulations in the legislation encourage this "no wrong door" policy and encourage wherever possible to data match between different programs to make duplicative information not necessary to be obtained from the consumer. [LR85]

SENATOR PAHLS: Okay, but your concerns, you've given those to the Department of Insurance... [LR85]

AUBREY MANCUSO: Right. [LR85]

SENATOR PAHLS: ...whatever they happen to be... [LR85]

AUBREY MANCUSO: Yes. [LR85]

SENATOR PAHLS: ...other than just on the "wrong door." Okay. Seeing no questions,

thank you for your testimony. [LR85]

AUBREY MANCUSO: Thank you. [LR85]

SENATOR PAHLS: The reserve chairs are empty. Last call. Would anybody in the audience would like to come forth? If not, that closes the hearing on this resolution. Thank you. [LR85]

The Committee on Banking, Commerce and Insurance met at 1:30 p.m. on Friday, November 30, 2011, in Room 1507 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LR219. Senators present: Rich Pahls, Chairperson; Mike Gloor; Chris Langemeier; Paul Schumacher; and Dennis Utter. Senators Absent: Beau McCoy, Vice Chairperson; Mark Christensen; and Pete Pirsch.

SENATOR PAHLS: Good afternoon. It looks like we're all here. For those of you, we also had a meeting this morning. And I don't know if you've been aware of it, the pipeline took a look of people's days in the early part of November, so just getting everybody together sometimes at this time of year is a little more difficult. Well, first of all, I want to thank you for coming to the Banking, Commerce and Insurance Committee hearing today. My name is Rich Pahls. I'm from Omaha, Nebraska. The committee will take up LR219 as posted today. This is your chance to give some input, for the public to give some input to this resolution. And I'm going to ask you, to better facilitate today's meetings, just basically follow the rules over there. The only one rule that's a little bit different, we will not have proponents and opponents. This is you just come up and give us your opinions when you feel like it, I should say. What I'm going to do is, right now I'm going to start with the committee and I will have them introduce themselves. [LR219]

SENATOR UTTER: I'm Dennis Utter. I live in Hastings. I represent District 33. [LR219]

SENATOR SCHUMACHER: I'm Paul Schumacher. I live in Columbus. I represent

District 22. [LR219]

SENATOR GLOOR: Senator Mike Gloor, District 35, Grand Island. [LR219]

SENATOR LANGEMEIER: I'm Chris Langemeier, I live at Schuyler, and I represent District 23. [LR219]

SENATOR PAHLS: And Bill Marienau is our committee counsel. Jan Foster over there is the one who can make sure that everything we say is recorded forever and ever and a day. Emily Gilmore is over there--wave your hand, Emily--and Ben Blowers is also one of our pages. If you have anything to...any information to give to the committee members, give it to them. Now in order for you to speak today, we do need you to fill this form out, and we have forms by the doors, because we need that when we start double-checking the testifiers report. Today Ron Schroeder is going to open up the resolution. And I will begin with you, Ron. [LR219]

RON SCHROEDER: Thank you, Senator Pahls and members of the Banking, Commerce and Insurance Committee and staff. For the record, my name is Ron Schroeder, R-o-n S-c-h-r-o-e-d-e-r. I'm the legislative aide for Senator Pahls, and my purpose today is to open on LR219. And I'm here to place the resolution in context and the...so I'm not advocating today. And the purpose of this resolution before the committee is it's a study and a fact-finding mission on the issues that are being presented today. So I'm going to talk about how we got here, where we've been, and what's before us, and where we're headed on this. The purpose of the resolution is to study the insurance coverage of services to treat individuals with autism. I'm not going to talk about autism. There are people here who know a lot more about it if you want to get into the details of the disease. It's in the news almost every day, and so it's a very poplar topic. It's a very serious concern that we have. So the purpose of this resolution is to look at the extent of coverage that's currently available in Nebraska for insurance to cover treatment of autism. So let me go back to what happened before we got here. In

2007, there were two bills that were introduced, one in front of the HHS Committee, the other in front of the Appropriations Committee that were merged on the floor and was passed in 2007. It was called the Autism Treatment Program Act. Now this bill had a July 1 2007, operation date, so it was in 2007. And it had a deadline of July 1, 2008, in it for the Department of Health and Human Services to apply for a waiver under Medicaid to get service for treatment of autism. So there was a one-year period there for the state Department of Health and Human Services to apply for a Medicaid waiver. Under the bill, the waiver was going to be funded through a $1 million annual transfer from the Nebraska Health Care Fund, which is our tobacco settlement funds for five fiscal years. So $1 million a year for five fiscal years. The match required in a somewhat historic and unusual situation, it required for every $1...for every $2 from the Health Care Cash Fund, there had to be $1 of private funds raised to implement the program. So it was contingent on raising the private funds. The year deadline for implementing the program came and went by, and a problem developed and the Department of Health and Human Services indicated that they were having problems getting the waiver approved because of the way the bill was drafted. There was confusion as to who had the administrative functions--either the University of Nebraska Med Center, which was going to be the place where the services were going to be offered, or the Department of Health and Human Services. So in 2009, two years later, another bill was introduced to correct that problem. And another deadline was placed in statute for applying for the waiver. The deadline came and went and the waiver was not applied for. In 2010, in the interim in 2010, the offer for private funds was rescinded because of the disagreement between the people who are raising the funds and the department as to how those funds were going to be utilized. And so the program was never implemented. It's still in the statutes but there's no funding for it so it's never been implemented. In 2011, the Appropriations Committee and the Legislature ultimately adopted their recommendation that that original $5 million that was going to be the match on the state level, that money was then appropriated in this past session to fund the SCHIP program, the State Children's Health Insurance Program. So we...that's why we come here today because we haven't gotten anywhere yet going the other route. So this proposal is asking the committee to

consider whether or not there should be a mandate, an insurance mandate, to cover autism services. In a report that I looked at in September from NCSL, NCSL lists 33 states that have some form of mandated treatment of autism, including four states that border Nebraska--Colorado, Iowa, Kansas, and Missouri. Now there's a draft report from the AHIP, America's Health Insurance Plans, in 2010 that I have a copy of that shows 38 states as having some form of mandated treatment for autism. And in that report, Nebraska is listed in that report. So there's a difference between those two organizations as to who's covered and who's not. And the reason that Nebraska is listed in the AHIP report in 2010 is because of what is called our mental health parity law. Now our mental health parity law does not mention the word autism, but I'm going to try to explain to you why AHIP includes Nebraska under one of the states that has some kind of mandate for autism treatment. In 1999, the Legislature passed what's termed our mental health parity law. Now parity is a term that's not...it doesn't occur in the statute and it's a term that does not have a very specific defined meaning, so we have to look at...to see how we did it in our statutes. Our statute says for group insurance policies of 15 or more individuals--so it's 15 or more group policies only--that the policy, health insurance policy, has to state whether or not it covers mental health coverage. It doesn't require that mental health services be covered; it has to state whether or not the policy does cover mental health conditions. If the policy covers mental health conditions, then the rates, terms, and conditions for access to treatment of any serious mental illness must not be greater than the rates, terms, and conditions for access to treatment of any physical health conditions. That's the parity part of our state law. And the most important part about it is the fact that it talks about serious mental illness. And the statute has a definition of what a serious mental illness is. It is a mental health condition that current science affirms is caused by a biological disorder of the brain which substantially limits the life activities of the person with the illness. So it hinges on what the definition of a serious mental illness is, and the AHIP group believes that that triggers autism coverage in our statutes in Nebraska for those group policies of 15 or more that offer some coverage for mental illness. Then in their serious mental illness coverage, they have to cover those kind of services. And they can have...it does not prohibit separate

reimbursement rates or deliver systems. It does not prohibit preadmission screening or prior authorization of services, the kinds of things that you would normally see in a health insurance policy covering physical health insurance. And it can also be a part of a managed care organization. And the other requirement, though, that the out-of-pocket limits established for the physical health conditions shall apply as a single comprehensive out-of-pocket limit for both the physical and the mental health conditions under that statute that we have. So that's what our current law says. So as we look at if we were going to mandate that an insurer cover all autism services, if we were going to make that as a mandate for our health insurance and put it in the list of the other mandates that we have, we're presented with a problem, of course, as we look at the future because of the essential benefits package that we are waiting to hear from on the federal government for the PPACA. Because that law requires if the state has mandates that are beyond the essential benefits package, then the state has some liability in covering the cost of those. And, you know, I can't answer how that works because it hasn't been implemented yet so I don't know how it's going to work. But that's hanging over our heads if we were to even consider at this point whether or not we were going to do something like this. That's probably the biggest issue that's facing us today as we look at this issue is the unknown of how that is going to impact services like this. And then there's one other issue that I'm going to explain to you a little bit that if legislation like this comes about, that you will be asked to settle a little dispute that's going on in the mental health field about the kind of training and credentials that are necessary to successfully treat autism. There is a group that is asserting that a specific kind of behavioral training is what is necessary. And then there's the rest of the field that is maintaining that that's not a requirement. And so any legislation that comes through, there will be a battle on whether or not you would be asked to narrow the groups that would be allowed to treat under this kind of a provision. And so that's all I have for today for you. [LR219]

SENATOR PAHLS: Senator. [LR219]

SENATOR LANGEMEIER: Chairman Pahls. Ron, typically we don't ask you questions, but I just want to go over your little time line here. You talked about in 2007 a bill went through Appropriations and HHS. Do you know that number? What was the number that they've combined? [LR219]

RON SCHROEDER: Um-hum. The bill that ultimately passed was LB482. [LR219]

SENATOR LANGEMEIER: 82? [LR219]

RON SCHROEDER: Uh-huh. And then I think the one that went through Appropriations was just one number different, it was either LB483 or LB481. [LR219]

SENATOR LANGEMEIER: And then in 2009 we passed a corrected bill that came out of... [LR219]

RON SCHROEDER: LB27, it went through HHS Committee. [LR219]

SENATOR LANGEMEIER: And then as a result of that we did not get the Medicaid wavier. [LR219]

RON SCHROEDER: The waiver is... [LR219]

SENATOR LANGEMEIER: Was it never applied for so we didn't get it or it was applied for...and you don't have to answer this. [LR219]

RON SCHROEDER: They never applied for it. [LR219]

SENATOR LANGEMEIER: Never applied for it. [LR219]

RON SCHROEDER: As far as I know. Well, we made an application but we never...it

was never granted as far as I understand it. The process was never completed, let me put it that way. [LR219]

SENATOR LANGEMEIER: To obtain the grant we didn't do all the steps we needed to do... [LR219]

RON SCHROEDER: Right. Right. [LR219]

SENATOR LANGEMEIER: Okay. Thank you. [LR219]

RON SCHROEDER: Um-hum. [LR219]

SENATOR LANGEMEIER: ...or HHS needed to do. [LR219]

SENATOR PAHLS: Thank you, Mr. Schroeder. What I need to do is just a show of hands, how many plan to speak today? One, two, three, four, five, six, seven, eight. Okay. You may begin whomever. [LR219]

CHRISTINE McNAIR: (Exhibit 1) Hello. My name is Chrissy McNair, C-h...do I need to spell my name? [LR219]

SENATOR PAHLS: Yes, please. [LR219]

CHRISTINE McNAIR: C-h-r-i-s-s-y M-c-N-a-i-r. I'm here today representing myself as a parent of a child with autism, as well as the chairperson of a steering committee that has been organized from grass-roots organizations to try to spearhead some legislation helping people with autism in obtaining insurance coverage. First of all before I get started, I want to thank Senator Pahls especially for all of his support over the last several years. We owe you a lot of gratitude and you've really stepped up for us and we appreciate that very much. Today is a very significant day for a couple of reasons. First

of all, it's significant because the issues that as parents we deal with everyday because we don't have the proper insurance coverage for our kids is something that we think about when we wake up in the morning and it's the last thing we think about when we go to bed everyday. And so for us to have the opportunity to be in front of you today and help you understand a little bit more about what that means in our lives, we view that as an opportunity. So we're incredibly grateful for that opportunity. Secondly, it's kind of a significant day for me, if I can be a little indulgent. My son tied his shoes today for the first time. (Applause) Yea! (Laugh) The applause is, you know, funny because it's a significant event in any child's life. Well, my son is going to be 12 next month. And the reason he tied his shoes is a little bittersweet. The sweet is obvious; the bitter maybe not so much. The bitter is because we have...it's taken us years to figure out how to get occupational therapy covered for my son who has autism. And we finally creatively figured out how to do that. So here he is, 12 years old, took about ten visits, and he's now tying his shoes. So the mind goes to that dark place where we go, and that's what if, what if he had had the services when he was younger? What would he be doing today that other 12-year-old boys are doing? Would he be riding a bike? Would he be having social skills that would allow him to get invited to birthday parties? Would he be on a sports team or play a musical instrument? I think he would be if he had had services at an earlier age that helped him be able to overcome some of the challenges in his life. So many parents are living with those what ifs everyday. And the truth of the matter is we know that the therapy is out there. Behavior therapy we know works and we've seen it work. It's worked with my son. We've paid out of pocket for behavior therapy for the last ten years. And it works, there's no doubt about it. And you'll hear a lot more about that today. But the what ifs drive us crazy. The living with that everyday, the guilt and the regret is really tough to live with. And so today I'm here to kind of enlighten you maybe a little bit to really the reality of what services are provided in the state of Nebraska and answer questions of course. So the truth in Nebraska is that we have a serious problem. And the problem is that everyone thinks treating kids with autism is somebody else's problem. The education system says we're doing all we can but this is a medical issue, Medicaid needs to step up. And I know because I've been

talking to people at the Department of Ed. So this is what is said. Medicaid says, no, this is a learning issue, this is an educational issue. And insurance is flying under the radar hoping that they're not going to be targeted next. So what happens in the meantime while all of we adults are trying to figure out whose responsibility is it to provide proven therapeutic treatment for kids with autism, days turn into weeks, weeks turn into months, months turn into years, and these children miss the windows of opportunity for intervention. And we can't afford to spend any more time deciding whose problem it is. It's everyone's problem. This group of parents that were behind me and have been filling this Capitol Building for the last four and five years are a very motivated group of people. I have a bunch of letters that people have sent that I want to submit to the committee. In these letters, you're going to hear a lot of stories about people who have not received the proper treatment for their kids and the effect that that's had on their lives. You'll hear about some parents who paid for it out of pocket and the wonderful results that their children have experienced, so as a group of parents who are extremely motivated group of people, to see something happen. One thing that I think as chairperson of this, you know, grass-roots, informal steering committee is I can promise to you is that we are going to be coming to you with open minds and with creative solutions. The solution of the private money match was something that we, in collaboration with Senator Pahls and Senator Johnson, came up with to be part of the solution. We want to work with you. What I ask in return is that you don't say to yourselves this is not the time. That unknown that Ron was speaking about of the Health Care Act and what's going to happen makes it understandable, I suppose, to say let's wait and see. But I implore you to not do that because these kids cannot wait. They just can't. So there are other states in the country that they've chosen not to wait. Since healthcare reform was passed, they're still passing laws to help kids with autism. So that's my request of you is that you listen to what you're going to hear today, keep an open mind. We know this is going to be really tough to get this passed. We want to work with you to make that happen. We have experts from Autism Speaks that are going to talk about the cost and what it really...the true cost data of how premiums go up and it's very minimal. We have someone talking from the professional community who delivers

the treatment for kids with autism. And a couple of parents that want to tell you a little bit about how their families have been split up and had to seek services in other states. I'll tell you, I got home at 1:00 this morning from a trip to Denver. I went to the Joshua School, which is a school in Denver that specializes in treating kids with autism. And it was one of the most inspiring days of my life because to see the difference they're making is incredible. But it was so incredibly sad because to see what Colorado has, our neighboring state, what they have and what they're doing for kids with autism, and then to come back home where services are just almost nonexistent really was like a knife to the heart. So I ask that you listen to what we have to say, I know you will, and I thank you very much for the opportunity. And I'm happy to take any questions. [LR219]

SENATOR PAHLS: Senator. [LR219]

SENATOR SCHUMACHER: Are you aware of the type of programs, say, South Dakota or Iowa have? Do they have programs comparable to Colorado or...? [LR219]

CHRISTINE McNAIR: I think that Mike from Autism Speaks can probably answer that better than I can. I do know that in South Dakota, I believe, there's more services, but I'll let him answer that. And if he doesn't know, we'll find out. [LR219]

SENATOR SCHUMACHER: Okay. Thank you. [LR219]

SENATOR PAHLS: Thank you for your testimony. [LR219]

CHRISTINE McNAIR: Thank you. [LR219]

SENATOR PAHLS: Thank you. [LR219]

MARK HIRSCHFELD: (Exhibit 2) Good afternoon. My name is Mark Hirschfeld, that's M-a-r-k, last name is spelled H-i-r-s-c-h-f-e-l-d, and I am testifying today about

insurance and the cost of therapeutic services for individuals on the autism spectrum. I'm a dad, by the way. (Laugh) We'll hear from the other experts, but we thought it might be good for you to hear from us. I live in Omaha. My wife Nancy and I have two children: a daughter who is a senior at the University of Nebraska, and our son Jacob, who was diagnosed on the autistic spectrum in March of 1999 when he was four. At the time of his diagnosis: Jacob was not potty trained; could not go to a preschool; could not sit and be attentive, even for a short lesson; was quite antisocial, only wanting to be with his immediate family; and sadly was occasionally violent, injuring himself and others. We still have the scars. Additionally, our son could not speak, offering only a few one-syllable utterances at best. Based upon the diagnosis from this physician, we were told that we should prepare for the fact that he would likely be headed for institutionalized care, and the sooner we got used to that idea, the better it would be for him and for us. And as we look back on that time, we could see why the physician would say that because he truly was a mess. Thankfully, my wife didn't take that particular advice of the doctor and she began talking with other families and getting on the Internet and talking and we began a search for resources. In April of 1999, my wife came home after visiting a mother who also had a child on the autism spectrum. She announced that she had good news and bad news. The good news was that this mother had told her about a behavior-based early intervention therapy that could significantly improve the outcomes for children like our son. I later learned that these services had been endorsed in a report published by the United States Surgeon General, which indicated to me that these therapies had been studied and tested for their effectiveness. They had been in use for over 30 years in some parts of the country, so they certainly weren't in that view experimental or fads. That was the good news. The bad news was that at that time, these services were not available in Nebraska and the closest location that had these resources was a program in Madison, Wisconsin, started by psychologists who came off the university campus. This therapy, as some of you may know, is called applied behavior analysis. And we also had our son work with occupational therapists, speech therapists, and auditory therapists. And that therapy in its early stages given the protocol meant that he was in some cases in therapy up to 35

and 40 hours a week. So over the Memorial Day weekend of 1999, I moved my wife, daughter, and son to Wisconsin for what we were told would be a two-year program while I stayed here in Omaha and worked. The program was remarkably successful for our son. In fact, I was able to bring my family home in about 18 months because Jacob responded so well to the therapy. If you fast-forward to today, you will not find our son in institutionalize care. Instead, he's a freshman at Westside High School. He's on a bowling league on Saturdays, loves little league baseball, and attends a weekly youth group at our church. He's the kid who now gives hugs freely, has good friends, and through Westside is now starting vocational and life skills training that can help him live more independently. And the nonverbal thing that was back there, that's been fixed. (Laugh) He now talks nonstop. To be sure, our son will need some support throughout his life, but he is not headed for institutional care like the Beatrice Center, which is what our physician told us some 12 years ago. And I have to tell you, given some of the news that I hear about BSDC, I'm grateful for that. The therapies we were able to provide have made all the difference in the world for Jacob in terms of helping him to discover and develop his full potential. These successes, however, have not come without a substantial price. None of the therapies described above were reimbursed by insurance. Personally, we have invested hundreds of thousands of dollars out of pocket to help our son. Sadly, there are many families in Nebraska who cannot afford this extreme cost. Insurance, in my view, is a way for people to pool risk. But to date, families like mine pay into the insurance pool but receive no benefit for the services families like ours really need. We believe these services should be part of that pool, which a mandate would provide, something that, as you know, is already in place in many other states. Numerous studies have shown that providing these therapies can reduce the burden of the state later down the road. It's a good example, in my view, of "pay me now or pay me later." Getting these services to our families earlier is better for everyone, emotionally and financially. So on behalf of our family and others, thank you very much for considering this important matter. [LR219]

SENATOR PAHLS: Seeing no questions, thank you, Mark, for your testimony. [LR219]

MARK HIRSCHFELD: Thank you, Senator. [LR219]

WAYNE FISHER: (Exhibit 3) Good afternoon. My name is Wayne Fisher, W-a-y-n-e F-i-s-h-e-r. I'm a psychologist with expertise in the behavioral assessment and treatment of autism. I direct the Center for Autism at the University of Nebraska Medical Center, but I'm testifying today as a private citizen. I wish just to thank Senator Pahls and the other members of the committee for granting us this hearing. I'm presenting the committee with a detailed, written report by the committee that Chrissy spoke about, and I'll also just provide a brief summary of its contents now. The term "autism spectrum disorders" is used to describe a group of behavioral disorders that are characterized by aberrant behavior patterns in three major areas. These children have delayed and/or unusual communication or language. The second area is they have major impairments in social interaction and knowing how to get along with and interact with other people. And then the third major area is that they have repetitive activities, interests, and behaviors. The estimates from the CDC are that currently 1 in 110 children are affected by autism. Boys are four times as likely as girls to have autism, and it also tends to run in families. For example, a recent study has shown that if an older sibling has autism, a younger brother has a 1 in 4 chance of having autism; a younger sister has a 1 in 11 chance of having autism also. And so it's not uncommon for these families who are affected by autism to have more than one child with the disorder. And without intensive and appropriate treatment, the long-term outcomes for children with autism remains bleak. In a follow-up study of adults with autism: only 26 percent had one or more friends; 13 percent had independent jobs; and only 4 percents lived independently. Individuals with autism commonly live with and are dependent upon their parents and/or siblings throughout their adult life. There are two major approaches to treatment for children with autism: One involves drug treatments and the other involves behavioral and psychosocial interventions. There are two medications that have been approved by the FDA for the treatment of autism for symptoms of irritability, aggression, self-injurious behavior, and those are risperidone and aripiprazole. Other medications are prescribed

on an off-label basis. And these medications can be helpful for treating problem behavior in autism and also for treating comorbid symptoms, such as depression. However, medications do not address the behavioral deficits in autism in the areas of higher cognitive functioning, their language impairments, their social and interpersonal difficulties, and their problems with self-regulation and management. These deficits require behavioral and psychosocial interventions. In 2009, the National Autism Center published the largest and most comprehensive evaluative review of the research literature on behavioral and psychosocial interventions for children with autism. This review was called the National Standards Project, and it was based upon a systematic examination of evidence-based practice guidelines and publications. The National Standards Project identified 11 interventions as established, meaning that their effectiveness was established through empirical research. Private insurance and Medicaid both pay for drug treatments for autism regardless of whether they involve the two medications that have been approved by the FDA or whether they involve off-label medications that have no scientific evidence regarding their effectiveness for the treatment of autism. In contrast, the 11 behavioral and psychosocial interventions for which there is established scientific evidence regarding their effectiveness are rarely paid for by private insurance or Medicaid, except in those states where payment has been directed through legislation or court decisions. These behavioral treatments are medically necessary and they effectively reduce, correct, and ameliorate the developmental and behavioral effects of autism spectrum disorders. Several cost-benefit analyses have been conducted of these treatments, and they have all found that the lifetime costs of caring for an untreated individual with autism is over $3 million. Effective treatment can cut this cost by more than half. This means that for every $1 spent on effective treatment, more than $10 are saved over the course of an affected individual's lifetime, and that's not a bad return on one's investment. Data is also now available from a number of states on the additional costs associated with insurance reform legislation for autism treatment, and the costs are surprisingly low. They range from about 40 to 83 cents per person per month. This would raise the annual cost for a family of four from about $19,393 to no more than $19,433, or roughly the additional

cost of eating out once a year at a Denny's Restaurant for a family of four. And if there are any questions, I'm happy to try and answer them. [LR219]

SENATOR PAHLS: Yes, and thank you for your testimony. The last piece of information you gave me, you're saying there will be an insignificant cost to the rate... [LR219]

WAYNE FISHER: The per person, yes, spread across insured individuals, the additional cost person is quite minimal. And we'll have another member from Autism Speaks providing more detailed information on that. [LR219]

SENATOR PAHLS: Okay. For the state of Nebraska, you have more information is what you're telling me. [LR219]

WAYNE FISHER: From other states in which there have been insurance mandates... [LR219]

SENATOR PAHLS: Yeah, right. [LR219]

WAYNE FISHER: ...is where that information comes from. [LR219]

SENATOR PAHLS: Okay. Because I do see some of the examples here, like South Carolina... [LR219]

WAYNE FISHER: Yeah. Um-hum. [LR219]

SENATOR PAHLS: Okay. I'll see if there's some more information. Yes, Senator Schumacher. [LR219]

SENATOR SCHUMACHER: Thank you, Senator Pahls. Is the behavioral treatment then basically operant conditioning, is that...? [LR219]

WAYNE FISHER: That is the most common treatment, but there are also cognitive behavioral interventions that are used with higher functioning individuals with Asperger syndrome and higher functioning autism. There are also developmental-based interventions that kind of integrate developmental principles and the principles of applied behavioral analysis that have now been demonstrated to be effective as well. So it is not the sole treatment for autism. [LR219]

SENATOR SCHUMACHER: What is the educational level or the skill set that's required to administer this treatment or structure? [LR219]

WAYNE FISHER: Typically the applied behavior analytic treatments are implemented by behavioral technicians that are usually...have some college training, and then very specialized hands-on training. And they are typically supervised by a behavior analyst with a masters or doctoral degree or a licensed psychologist. [LR219]

SENATOR SCHUMACHER: Thank you. I have nothing further. [LR219]

SENATOR PAHLS: You are representing yourself... [LR219]

WAYNE FISHER: Correct. [LR219]

SENATOR PAHLS: ...no organization today. [LR219]

WAYNE FISHER: Correct. [LR219]

SENATOR PAHLS: And just one more, I know Ron Schroeder indicated that there's some discrepancy on what therapy is better. That's not an issue with you? [LR219]

WAYNE FISHER: The model legislation that most states have used from Autism

Speaks specifically refers to applied behavior analysis as one treatment that has been shown to be effective. But the mandate is for any empirically-supported intervention so that other treatment approaches for which there is scientific evidence would also be covered if that was the approach that was taken in Nebraska. [LR219]

SENATOR PAHLS: Okay, okay. Seeing no questions, thank you for your testimony. [LR219]

WAYNE FISHER: Thank you. [LR219]

KRISTIN MAYLEBEN-FLOTT: (Exhibit 8) Hi. My name is Kristin Mayleben-Flott, it's K-r-i-s-t-i-n, and then M-a-y-l-e-b-e-n-F-l-o-t-t. Now there's a mouth full. I am here representing parents or myself, and I just wanted to thank you very much for having me today, and I wanted to I guess tell my story. I have a son on the autism spectrum and he is currently seven years old. About seven years ago, we welcomed a new little boy into our family who would change our lives forever in more ways than we could have possibly imagined. In the first couple of months of life, we almost lost Jack three times. In the first year of life, we were faced with some challenging decisions. The following are some examples of how the state of Nebraska thought they could help us: (1) Jack's prognosis was that he would most likely not walk or talk. The state recommended that we put Jack in an institution, much like another parent had talked about previously, which would mean giving up our parental rights. We would be off the hook financially, however, we would have no rights nor would we be able to advocate for our son Jack. (2) The state also suggested that maybe my husband and I get a divorce because then I could become a single parent. I would then qualify for some services, but not necessarily the ones that Jack needed. When we tried to apply for DD services or to get him on the waiting list, I was told by the intake person that I should do nothing, and this is quotes, and to stop providing interventions because he was making too much progress and I, as his mother, was hindering his ability to qualify for current or future services. That was a little de-incentivizing for me to continue going, to continue to

provide the type of therapies that I was doing with him. When Jack was 18 months old, he was diagnosed with autism. We received this diagnosis at the University of North Carolina, Chapel Hill. We went to North Carolina because we could not get anyone to listen to us about our concerns and we were unable to navigate the system in Nebraska, and the Department of Education Early Intervention Program was providing less-than-adequate services. We were trapped between the school saying it was medical issue and the medical community saying it was the school's responsibility to provide Jack's necessary treatments. While we were in North Carolina, we were given options, choices, information, resources, reassurance, expertise, someone who cared about our input and perspective. They helped us develop ongoing treatment plans which were reviewed every 90 days. They also gave us credibility back here in Nebraska because we were seen as more of an expert on our son. We were armed with information that enabled us to better advocate for Jack. Another challenge arose when we returned from North Carolina because Nebraska did not have a system in place to support what we were doing. We had to build our own network of providers, therapists, resources, and supports in order to implement the treatment plan. We spent $30,000 training me to become his primary therapist because we could not afford the $60,000 to $100,000 we were quoted for an in-home therapist that was trained and licensed. In the first five years of Jack's life, we spent approximately $2 million to $2.5 million on travel, hospital and medical expenses, tests, therapies, training, etcetera. This amount includes the loss of income over the five years because of the demands on both my husband's and my time. I think sometimes that gets lost in the shuffle that our kids demand so much of our time or if we cannot find somebody else to provide those therapies, it rests on the parents, and sometimes that pulls you away from work. These costs created incredible stress, obviously, on our family. I can only imagine what it would have been like to have insurance that would have covered some of Jack's therapies and interventions. At a minimum, the insurance company would have at least had a list for us to choose from of providers. Insurance coverage would have alleviated some of the financial burden and stress that we still feel today. However, I am happy to report that I did not take any of those recommendations from the state or Nebraska. I

am also happy to report that Jack is currently in first grade, with typically developing peers and very unique talents. I treasure him and he is a gift to our family. Jack is my inspiration and my hero. We created the opportunities for him to practice his skills, however, he did all of the work. It should not be this hard for our kids to get this kind of intervention and services that they need. Many families need our help. Please give them an opportunity for success or at least some hope for a better future for their children. And I thank you. Does anybody have any questions? [LR219]

SENATOR PAHLS: I see no questions. Thank you for your testimony. [LR219]

KRISTIN MAYLEBEN-FLOTT: Thank you. [LR219]

MIKE WASMER: (Exhibit 4) Good afternoon. [LR219]

SENATOR PAHLS: Good afternoon. [LR219]

MIKE WASMER: My name is Mike Wasmer, M-i-k-e W-a-s-m-e-r, and I am the associate director of state government affairs for Autism Speaks. Before I get started, I did want to follow up on a couple of the questions that were left unanswered from previous conferees. Regarding South Dakota, I don't know what other services they have, particularly with regard to any sort of state Medicaid waiver, but they don't have an insurance mandate. However, four of the states that border Nebraska, including Iowa, Missouri, Kansas, and Missouri (sic) do. The other question with regard to passing mandates after federal healthcare reform was passed, it's actually 14 states have enacted autism insurance reform laws since March of 2010 when the PPACA passed. Autism Speaks in the world's largest autism advocacy organization, and we've been involved in most of the now 29 states where autism insurance reform has been enacted. The other point of clarification with regard to the number that we're seeing, 29 versus 33 or 34 which some of the other folks have thrown out, we only list the state as having an insurance reform bill passed if that includes behavioral health treatments

such as applied behavioral analysis, which Dr. Fisher mentioned. I'll be providing a brief history of autism insurance reform and share the highlights of what we have learned from other states that have preceded Nebraska in this effort. Early diagnosis and treatment of autism is critical to a positive outcome for children with autism. With appropriate treatment, approximately 50 percent of children will be able to mainstream into regular education by early elementary school. My daughter Kate (phonetic) is among this 50 percent. She was born in 1999 and appeared to be typically developing until her first birthday when she slowing began to regress. She stopped saying daddy. She would not interact with our family or her peers. Her play skills were limited to lining up her little people figurines in a perfect row and carefully studying grains of sand as it slowing drained, grain by grain, from her hands back into the sandbox. Any attempt to enter her world and engage her attention resulted in full-blown tantrums. Family outings became a nightmare of meltdowns and disapproving stares from the community. When diagnosed with autistic disorder shortly after her second birthday, my beautiful girl had stopped speaking completely and retreated into a world of her own. At the same time, we learned that my wife was pregnant with our second child. Kate's (phonetic) developmental pediatrician prescribed applied behavioral analysis, speech therapy, and occupational therapy, none of which was covered by our health insurance. We hired a board-certified behavior analyst to develop a treatment program and oversee a team of therapists, including well-trained paraprofessional ABA providers, speech therapists, and occupational therapist. At an out-of-pocket cost of over $35,000 a year, Kate received 25 to 30 hours a week of intensive in-home therapy for two and a half years. Her treatment drained our savings account and we struggled to coordinate the daily stream of service providers into our home. We lived in a constant state of anxiety watching our newborn son, every movement, for any sign of a developmental delay. We struggled to give him the attention he deserves while his sister required so much of our time. At that time, I was a practicing veterinarian in Kansas City. My productivity at work fell sharply as I was forced to ask coworkers to cover for me more and more often as I had to leave to deal with crises at home. My wife and I struggled to maintain a healthy marriage. Our closest friends and family couldn't relate to what we were going through

and we struggled to find a new system of support within the autism community. But we refused to give up. Today, Kate's (phonetic) in the seventh grade and earning straight As. She's been in a regular ed classroom without an aide since first grade. Although she still struggles with some of the social deficits associated with autism, she has a small group of good friends and she's a happy young lady. She plays the violin. She's an avid reader and writer. She plans to go to college and become an author. She tells me every night that she loves me. Recognizing the importance of early intervention for autism since 2001, 29 states have enacted autism insurance reform laws. Each of these states require that health insurance cover medically necessary treatment for autism, including behavioral health treatments such as applied behavior analysis. You may hear from opponents that this legislation, as we've heard in every other state trying to get this bills passed, frightening but very exaggerated estimates of the impact on premiums. In order to determine the fiscal impact of autism insurance reform, Autism Speaks is collecting actual claims data now from the states where such laws apply to the members of the state employees health plans and have been in effect for at least a year. A detailed spreadsheet of the data we've collected so far has been distributed for your review. Some of our findings include autism insurance reform laws have been in effect for at least a year in 15 states; 13 of these states include coverage for their state employees. The terms of coverage vary and include age or financial caps in all states but Indiana. Some states have tiered coverage that impose higher financial caps on younger children and lower caps as the children ages. Claims data has been requested from all of the 13 states and we've been able to receive data from 7 of them so far, and that's presented in Appendix 2 of the information I've submitted. Claims data is available for the first year of implementation in five of the states. The first year cost of coverage range from 5 cents per member per month to 19 cents; the average first year cost of coverage is 10 cents per member per month. Claims data is available for the second year of implementation in six states. The second year cost of coverage ranges from 7 cents to 43 cents per member per month; the average second year cost being 27 cents per member per month. Texas is the only state where we have third-year data available. The third year cost of coverage was 6 cents per member per month. There are a couple

of important things to note about Texas. One is that the third year total claims cost is actually less than the second year total claims costs, as well as the per member per month cost. It's also important to note that despite there being no dollar cap on coverage for autism in Texas, the cost per member per month has remained less than 10 cents per member. Autism is treatable. While financially devastating to individual families if these treatments are paid for out of pocket, actual claims data demonstrates that enacting autism insurance reform legislation is very cost effective. Without effective treatment, the lifetime costs to the states has been estimated to be $3.2 million over the life span of each child with autism. In Nebraska, inequities in health insurance coverage remain one of the most significant barriers to appropriate treatment for children with autism. No private health insurance carrier consistently covers the diagnosis to medically necessary treatment for autism. Investing pennies per month by enacting autism insurance reform this session, the state of Nebraska will save millions of dollars for years to come. You'll also be giving Nebraska's children the chance of becoming productive, tax-paying computer programmer, truck driver, an engineer, or perhaps an author like my daughter. And I appreciate your time today, and I'd be happy to answer any questions. [LR219]

SENATOR PAHLS: Let me start with just a question, Michael. Okay. I see there are 29 states, just to make sure I understand this, 29 states the insurance reform, that's what you're telling me. [LR219]

MIKE WASMER: Right. [LR219]

SENATOR PAHLS: And you collected information from 15. [LR219]

MIKE WASMER: Well, what we attempted to do is we determine...we didn't think that it would be statistically significant to get data from states who haven't been implemented for at least a year, so we narrowed it down to 15 of those have been implemented for at least a year. We got our data from a state employees health plan. We contacted the

state employees health plan of each state and requested the data from them. However, two of the states, while they require coverage for other fully-funded health insurance policies, they don't require coverage for their own state employees. So that narrowed it down to 13. [LR219]

SENATOR PAHLS: Okay. [LR219]

MIKE WASMER: So we sought data from those 13 available states and we received it so far from 7. It's an ongoing process. As we receive more data, I'd be happy to share it with the group. [LR219]

SENATOR PAHLS: Right. So as you get more requests that you'd have available... [LR219]

MIKE WASMER: Absolutely. Yeah. [LR219]

SENATOR PAHLS: And by this, you're trying to point out to the committee or at least to me that there's an insignificant, in your estimation, cost to the... [LR219]

MIKE WASMER: Absolutely. [LR219]

SENATOR PAHLS: Now you know the argument is usually on the other side. [LR219]

MIKE WASMER: I know what the argument is going to be. And I guess my request to you would be when you hear the inflated suggestions about how much is going to affect premiums, put their feet to the fire; ask them to show you the data. We've heard in state after state anywhere from it's going to increase premiums by 3 percent up to 20 percent in one state. But they have no documentation to base their assertions on. So in order to combat that, we have now gone...you know, we've got actual claims data, so we don't need to assert anymore. We just show the data from the states that have done this now

for the longest. [LR219]

SENATOR PAHLS: Okay, okay. Senator Schumacher. [LR219]

SENATOR SCHUMACHER: Thank you, Senator Pahls. If there is an early and intense intervention, can the problem be turned around much more efficiently than if it's something that's allowed to drag out? [LR219]

MIKE WASMER: Absolutely. There's clearly a window of opportunity where, you know, a child is going to be more receptive to the treatment. You know, as the brain ages, it becomes less pliable, less receptive to the training. That's not to say, however, that an older child wouldn't benefit from applied behavioral analysis because they absolutely do. Behavioral health treatments, such as applied behavioral analysis, are used in older children with, you know, Asperger syndrome, you know, other developmental delays and show positive improvement. Absolutely. It's used for disorders other than autism spectrum disorders as well. So, yes, to answer your question, it is most effective earlier on, but it is also effective for older children. [LR219]

SENATOR SCHUMACHER: So an early intervention with adequate resources may reduce the total cost of the disease? [LR219]

MIKE WASMER: Absolutely, absolutely. The $3.2 million estimate that I quoted with regard to the cost of not providing appropriate treatment for a child with autism over the life span, that includes both direct and indirect cost, meaning, you know, direct costs such as intense special education K-12, you know, adult support, adult assisted living services. The cost of special education for a child is three times that of the cost of a child in regular education. I was able to pay for that out of pocket. I'm very fortunate, and I recognize that. But by doing that, you know, turning my child around so that she is now in seventh grade--she's been in regular education since first grade--I saved the state of Kansas that much money in special education alone. So in addition to the direct

cost that I mentioned, the indirect costs, you know, as Kristin mentioned, are lost productivity of not only the individual with autism but that individual's parents. [LR219]

SENATOR SCHUMACHER: Probability of success of intervention? 50 percent? 90 percent? 10 percent? [LR219]

MIKE WASMER: Based on all available data, 50 percent of children with the appropriate treatment are going to mainstream into regular education by early elementary school. However, it's also important to note that an additional 42 percent of those children are going to improve enough that they're going to require much less intense special education than if they had not received treatment at all. So although they're not necessarily mainstream, they're still going to save the state that cost in special education. There is a small percentage of children, 10 to 11 percent, that despite therapy are still going to require intensive special education and adult assisted services. [LR219]

SENATOR SCHUMACHER: Thank you. [LR219]

SENATOR PAHLS: I'm just curious, what would you suggest the terms of coverage? [LR219]

MIKE WASMER: My suggestion would be that it be unlimited as far as age and dollar caps because, you know, based on the...you know, we've got Texas, like I mentioned, who, although they do have an age cap, they've actually passed two bills. They passed their first bill in 2008 that was zero to six with no financial caps on it. They went back two years later after recognizing that it wasn't bankrupting the state, how valuable a service it was, they went back, reintroduced legislation and passed it that raise the age cap from six to ten. And if you look at the claims data, you'll see that actually even by raising the age cap, the cost per member per month and the total claims cost dropped from the second to the third year. And despite no financial cap on services, the total, the

per member per month cost remained less than the dime. [LR219]

SENATOR PAHLS: But as I see it, though, the majority of the states have put a cap of... [LR219]

MIKE WASMER: The majority of the states have done that. [LR219]

SENATOR PAHLS: ...$36,000 to $50,000. [LR219]

MIKE WASMER: Yep. And I think primarily the reason that they did that is because they were scared that it was going to bankrupt, because until now they didn't have the claims data, so they were kind of going into uncharted territory. But I would say, you know, from here on out, now that we've collected the data from the states who have done it the longest, there's no reason to put a financial cap on services. You know, if you have reservations about it, you know, that's something and I'm certain as Kristin mentioned, you know, the state of Nebraska wants services for their children and they are open minded and they'd be happy to, you know, consult and come to an agreement. [LR219]

SENATOR PAHLS: Any other questions? Thank you for your testimony. [LR219]

MIKE WASMER: Thank you very much. [LR219]

SENATOR PAHLS: Just curiosity, how many, would you hold your hands up so I can have a judge? One, two, three, four. Okay. Come on down. I have some reserved seats here in front if you so choose. Looks like we have four more. Okay. [LR219]

MICHELLE FIEDLER: Hello. My name is Michelle Fiedler, M-i-c-h-e-l-l-e F-i-e-d-l-e-r. I'm no expert, no head of any committee. I'm just a mom of an 11-year-old boy with autism. He was diagnosed just under two. While I'm grateful for the insurance coverage that my son does receive, his necessary therapies range anywhere from four to five

visits per week. His insurance allows him 20 visits per calendar year. So the past nine years we have really good January and Februaries. But the remaining ten months of the year are a constant struggle. This last year, for example, we spent our 20 calendar visits on recognizing when we need to use the rest room. The year before that, we spent our 20 calendar visits on being able to recognize emotions and how to appropriately react to those emotions. The year before that it was how to not absolutely freak out when you saw a sock that wasn't completely white. These are struggles that my family has to deal with every single day. I'm looking forward to January coming up and I don't know what our battle will be this year. There's many to choose from. But I do know that the services that he is able to receive through his insurance is not enough. Autism is a regressional disease. And for every month that we don't receive therapy, we take that many steps backwards. We're almost working towards nothing because every month we lose services is steps and steps and steps back. My son is in public school. It's gotten so bad this year that he has now been placed with a full-time para. I'm certainly not paying for that, the state is. Of course his disability claim was denied. We've tried all kinds of sneaky ways to get different therapies in, but the fact is it's just not happening. He needs those therapies. I don't know how long I'll be able to hold onto my job. I'm divorced, as a lot of families with autism end up divorced. Single mom. My boss is very compassionate as far as letting me leave work the two to five times per week that I get called to school, whether it be a bathroom issue, a social issue, whatever it is. I've now gone to under 20 hours a week at work, which ironically enough qualifies me to receive all state services. I don't want to do that. I don't want to get food stamps. I don't want to get Medicaid. I want to be able to give my son the services he needs. Had he been diagnosed with any other disease--schizophrenia, cancer, Alzheimer's, or God forbid he was in a horrible accident--he would be able to receive all necessary therapies through insurance. But because his label is autism or anywhere on that spectrum, he gets 20 visits which in turn equals one good month at the Fiedler household. I know so many families that are touched by this disease, affected by this. We have to start somewhere. My son deserves a chance. I've seen the progress that therapy can do. And without constant therapies, we're...the past 11 years have flown by. In 11 more years, where will

he be? Will he be able to function on his own or live on his own? I don't think so, not without getting the therapy that he needs because I know that he just regresses without it. So insurance would...having the insurance coverage available to him would make a huge difference in his life, in my life, in my other son's life who...he's a freshman at Southwest. I'm very proud of him, but he has had to take a backseat. He doesn't get hardly any of my attention because I'm dealing with bathroom issues and sock issues, which may seem petty but they completely disrupt every part of our lives. So I'm just a momma who needs the coverage for my baby. And that's it. [LR219]

SENATOR PAHLS: Thank you. Yes, Senator. [LR219]

SENATOR SCHUMACHER: Just one question. Have you gotten any professional guesstimates that if you are not limited to the 20 visits, if it were allowed to go through a course of treatment for however long that would be... [LR219]

MICHELLE FIEDLER: Yes. [LR219]

SENATOR SCHUMACHER: ...and you had a year's worth of this, would that solve the problem or would we still be spinning our wheels? [LR219]

MICHELLE FIEDLER: No, it would because we have so many...you know, there's sensory issues, behavioral issues, he needs occupational, physical therapy. But having those constant therapies greatly changes his behaviors and his behavior patterns. But it is something that we constantly have to work at. He needs, you know, constant reminders, things like that. I, unfortunately, can't be with him 24 hours a day to do it. I wish I could, but it's estimated from the therapies that he does receive and from the experts that I've spoken with that three to four visits per week of any or all of the necessary therapies would make a significant difference in his life, in his behavior, in his ability to just get through a day. [LR219]

SENATOR SCHUMACHER: Thank you. [LR219]

MICHELLE FIEDLER: Is that it? [LR219]

SENATOR PAHLS: Thank you, Michelle. [LR219]

JOHN LINDSAY: (Exhibit 5) Good afternoon, Senator Pahls, members of the committee. My name is John Lindsay, L-i-n-d-s-a-y, appearing as a registered lobbyist on behalf of Blue Cross Blue Shield of Nebraska. Blue Cross insures over 700,000 Nebraskans. At the outset, I would state that while Blue Cross and Blue Shield of Nebraska appreciates the work of this committee in conducting LR219, we oppose all health insurance coverage mandates in the state of Nebraska because of the potential effect mandates have on premiums. Blue Cross is a not-for-profit, mutually-owned company. It does not have shareholders and it's not publicly traded. Because of this, Blue Cross pays out approximately 87 cents of every dollar in medical claims; only 12 cents approximately for administrative costs and about a penny going to reserves. There is, as you're aware, very familiar from the hearing this morning, there's language in the Patient Protection and Affordable Care Act, and I believe Mr. Schroeder made mention of it in his opening, that requires Nebraska to pay for any additional state mandated benefits that are not included in the essential benefits package as it will be defined by the federal government and that will apply to individual and small group health coverages. Those benefits will be defined within the ten categories that insurers must cover beginning in 2014. While the institute of medicine released its methodology for deciding which benefits to cover, we still have not seen that essential health benefits package. And any state mandates that are required in addition to that package will be costly to Nebraska taxpayers. In conclusion, Blue Cross Blue Shield is concerned with any behavioral analysis or autism spectrum disorder coverage mandates. We thank you for the opportunity to testify on LR219 and be happy to answer any questions. [LR219]

SENATOR PAHLS: Does your insurance currently cover autism in any way? [LR219]

JOHN LINDSAY: It does not specifically cover nor does it specifically exclude autism. It would depend on...reimbursement would depend on the CPT codes that the healthcare provider submits to see whether they would be covered. It's my understanding that there is. I think it was mentioned by a couple of the prior testifiers that it becomes a question...and maybe sometimes a ball that's hit back and forth, but a question of whether the treatments are medical or educational. And it...I believe there's disagreement even among experts as far as how that would...how those would be classified. So it's kind of a roundabout way. I mean, there's not a general we cover autism...we provide autism benefits. That's not specifically in our policies. [LR219]

SENATOR PAHLS: And these essential benefits, they...I've heard that perhaps the government is going to come out in May. [LR219]

JOHN LINDSAY: Yeah. There's...as I've mentioned, they've got skeletal...but really we haven't seen that yet, so we don't know what will be included in there. But it's something the committee should be aware of, that if it is mandated that it will become a cost to the state eventually unless it's included in that package. [LR219]

SENATOR PAHLS: Unless it's included. [LR219]

JOHN LINDSAY: If it's included in the essential benefits package, then the issue becomes resolved; if it's not, then it becomes an issue for the state as far as cost. [LR219]

SENATOR PAHLS: With over 29 or at least 29 states looking at autism, would that send a signal at the federal level that that's a significant factor for that many states or you don't...that's pure speculation? [LR219]

JOHN LINDSAY: I've learned a long time ago not to predict what the federal

government will do, so I don't know. [LR219]

SENATOR PAHLS: I hear you. Okay, okay. Senator Langemeier. [LR219]

SENATOR LANGEMEIER: Chairman Pahls. Mr. Lindsay, thank you for your testimony. You talked a little bit about how they code it whether you pay for it or you don't. And you said some is treatments, some is education. If there is a mandate by Nebraska or any other state, is that not a battle that's going to continue? [LR219]

JOHN LINDSAY: I guess that would depend on how... [LR219]

SENATOR LANGEMEIER: Even if we mandate autism coverage, do... [LR219]

JOHN LINDSAY: I guess it would depend on the language of the mandate. But that's... [LR219]

SENATOR LANGEMEIER: So we'd have to define what education is and what medical treatment is to make it clear. [LR219]

JOHN LINDSAY: I think that...yeah, I think that line would have to be somehow clarified. [LR219]

SENATOR LANGEMEIER: Okay. Thank you. [LR219]

SENATOR PAHLS: Senator. [LR219]

SENATOR SCHUMACHER: Thank you, Chairman Pahls. It seems to me that the debate whether it's education and should be paid for by the taxpayers and the school system or some mechanism that way and insurance is kind of academic because if you were dealing with a two-year-old kid and you could intervene, from the testimony we've

seen so far today, with an intense intervention and solve a problem if the means are available to do that, you can't wait until that kid gets to kindergarten. I mean, is there some what that Blue Cross, which has a large population base, and the state of Nebraska can come together with a program so that we basically save everybody money? [LR219]

JOHN LINDSAY: I think you're correct. It's a question of...and it always is, of how is it paid for. The state certainly in its own policy could provide that coverage. The state could make that policy decision that it's an essential benefit...or, excuse me, it's a mandate beyond the essential benefits that the state would be willing to pay for. Mention that we pay 87 cents of each dollar on premiums we pay out in medical claims. So if we have additional...if there's additional claims, obviously there's one place to get that and that's from premiums. And so it will cause an increase in premiums. To what level? We haven't done any analysis within the state of Nebraska to see what that would be, so I'd be guessing if I... [LR219]

SENATOR SCHUMACHER: Whether there's such an overwhelming coverage of Blue Cross in the state, whether it's paid for by subscribers or taxpayers are kind of looking to the left or the right pocket as far as how we get this thing paid for. Have you done a study as to what actually it would take in additional premium money in order to cover autism and some early intervention? [LR219]

JOHN LINDSAY: We have not done that analysis at Nebraska to see what it would cost. And it's...make clear, while we do insure over 700,000, those are not all coverages that would be covered by a state mandate. If we're dealing with ERISA plans, for example, state mandates would not apply to those ERISA plans. So it's...so should the state mandate that, again, have to understand that it's not...really have to understand how many...what the numbers are that we're driving. And so if you break that down by company, then break it down by the number of people who are covered under plans subject to state mandates, that number would continue to get a little bit smaller. [LR219]

SENATOR SCHUMACHER: So basically we really don't have a good guesstimate on what social cost as is in Nebraska and the social cost as would be if we had a mechanism to facilitate early and firm intervention. [LR219]

JOHN LINDSAY: We don't. I think it's probably...and I think you heard some testimony earlier. You'd look to other states that if they have done it, if they have provided that coverage, to what extent, it's probably the best number we would be able to get. But it's my understand we have not done analysis for autism in Nebraska. Blue Cross has not done that analysis. [LR219]

SENATOR SCHUMACHER: Thank you. Thank you. I don't have anything further. [LR219]

SENATOR PAHLS: As I'm reading some of the literature that was handed to us, this happened in Minnesota since apparently you have to have a settlement, Blue Cross and Blue Shield. It says: After six years of premium impact on the commercial market resulting from unlimited coverage...was 83 cents--if I'm reading this right--PMPM. So apparently there's been...Blue Cross and Blue Shield have been involved in some litigation in the past, at least in Minnesota. [LR219]

JOHN LINDSAY: Blue Cross Blue Shield of Nebraska is not... [LR219]

SENATOR PAHLS: I understand you're separate. [LR219]

JOHN LINDSAY: We're separate, right. [LR219]

SENATOR PAHLS: You're separate but you guys know each other. [LR219]

JOHN LINDSAY: I don't hang out at those conventions, but they do, yeah. [LR219]

SENATOR PAHLS: I know. (Laughter) [LR219]

JOHN LINDSAY: Yes, Senator, they would. [LR219]

SENATOR PAHLS: I know Blue is Blue no matter where you go. [LR219]

JOHN LINDSAY: Yes. There is...certainly people talk to each other within the industry, so it would not be limited to Blue Cross. They would deal with other insurers as well. [LR219]

SENATOR PAHLS: Yeah. Okay, okay. Thank you, John. [LR219]

JOHN LINDSAY: Thank you. [LR219]

SENATOR PAHLS: Thank you for your testimony. [LR219]

MICK MINES: Good afternoon, Chairman Pahls, members of the committee. For the record, my name is Mick Mines, M-i-c-k M-i-n-e-s. I'm a registered lobbyist representing the Nebraska Association of Independent...of Insurance and Financial Advisors or NAIFA. NAIFA is an organization with 1,100 members across the state. We are the frontline. Our members serve the public. We are the frontline of insurance to the public in Nebraska. As this committee is more than well aware, we routinely testify in opposition to mandates. And certainly the testimony today was compelling and I can only imagine, I can only imagine what parents are faced with. But I think the real question that hasn't been talked about is, it is a mandate and there is a cost associated. And more than just this issue, there are additional mandates that this committee would be...would have to...would be tasked to look at as are they fair as well. In other words, cochlear implants. We've had hearings on cochlear implants. Certainly there are many, many children and people affected by loss of hearing. Cochlear implants can be very

effective. Prosthetics has been another one of those mandated benefits that this committee has talked about. Very expensive prescription drug mandates have been discussed here. These are all mandates and I believe that you should think of the entire picture than perhaps just singly autism, although that's why we're here today. So with that, I'd like to just reiterate that NAIFA is...would caution this committee to deeply think their support of a single mandate for a single purpose. And with that, I'll answer any questions. [LR219]

SENATOR PAHLS: Senator Schumacher. [LR219]

SENATOR SCHUMACHER: Thank you, Chairman Pahls. But in this case mandates are a little different because come or go we have a mandate. If we don't have a mandate at the insurance level for early effective intervention, then we have a mandate from the feds and from our state constitution for very expensive special education intervention. And, you know, we live between a rock and a hard place there. So is there some reason to differentiate this from maybe a cochlear implant? [LR219]

MICK MINES: Oh, I think the same argument could be made for the other incidents as well, a cochlear implant for instance. I think that you could prove that catching that at an early age will benefit the child and make them more productive later in life. I think you can do the same with prosthetics and prescription drugs or pick a mandate. Certainly there's...you can draw that nexus with autism. And believe me, I don't understand the success rate or the process that these folks go through, but I'm boiling it down to it's always about money, and I'm boiling this down to a very simple issue. Is this a mandate or is this an expense that insurance subscribers, all of us that have insurance, are willing to pay for this particular issue and the next one and the next one and the next one? I think that's the picture I'm trying to draw is it's more than just this particular disease. [LR219]

SENATOR SCHUMACHER: But rather than a dogmatic position, mandate or no

mandate, don't we have to do a social cost benefit analysis? [LR219]

MICK MINES: Well, I think yes. I think that's wise from the committee's standpoint is, let's determine if in fact there is a cost benefit. And I don't know that there is and I think some of the proponents are...they all agree that there is, but as an individual I don't know that. And I think that's something the committee needs to evaluate. [LR219]

SENATOR SCHUMACHER: Thank you. [LR219]

MICK MINES: Sure. [LR219]

SENATOR PAHLS: Seeing no more questions, thank you, Mr. Mines. [LR219]

MICK MINES: Thank you. [LR219]

SENATOR PAHLS: I think we have two more. [LR219]

CATHY CLARK-MARTINEZ: My name is Cathy Clark-Martinez, C-a-t-h-y C-l-a-r-k-M-a-r-t-i-n-e-z. I'm the president of Autism Family Network, the support group for Lancaster County, and we also serve other southeast Nebraska counties. We serve nearly 400 families in southeast Nebraska. And from a support group's perspective, we see so many parents that have to quit their jobs or get divorced because they don't...they're not provided adequate support, and children given to group homes that the state is paying 100 percent for so those kids can get Medicaid coverage because their parents couldn't get that individually. But I'd like to speak from a personal perspective. I have four children. My youngest child Jacob (phonetic) is eight and a half. He was diagnosed at 24 months with sever autism. Jacob (phonetic) went from a normally developing toddler to a child who sat in a corner and banged his head on the wall until he left dents in our sheetrock. We were left with the question of what if, as Ms. McNair had touched upon, because I am a day-care provider, my husband is a

construction worker. We're your working-class family. We had no way to pay for ABA therapy, but I didn't want my son to end up in an institution as his IQ has been assessed at a 42 on the Stanford-Benet fifth edition. So we bounced back and forth for months--do we provide ABA and bankrupt our family and empty the college funds for our other three children and our 401ks or do we allow our child to slip through the cracks and live at the state expense for the rest of his life. And the option that we could live with as parents were to provide ABA for our son and file bankruptcy knowing that there was no way we could afford the $60,000-plus annual cost of the therapy. From six years ago from the child sitting in the corner banging his head on the wall till today, we have seen vast improvements. I would do it all over again in a heartbeat if I was left with that choice. Meadow Lane Elementary is where he attends school, and his "sped" director said he is the most compliant child with autism they have ever seen walk through their doors. Where Jacob (phonetic) has never made verbal games and still remains nonverbal and was basically...a 42 IQ is pretty low. He now types and communicates with an augmentative communication device. He's very effective communicator with his device. He can eat with utensils. He is potty trained. He can dress nearly independently. And we don't have the aggressive behaviors and a lot of the violence that most of our families see in their households. That's all I have. [LR219]

SENATOR PAHLS: Cathy, I have a question. Now you say you're the head of a group. [LR219]

CATHY CLARK-MARTINEZ: I'm the president of the support group for Lancaster County for Autism Families, correct. [LR219]

SENATOR PAHLS: How many families are there in Lancaster County approximately? [LR219]

CATHY CLARK-MARTINEZ: I'm not exactly sure of the correct number, but in our group we have 373 families and some of those come from Nebraska City, Auburn, Sterling

because southeast Nebraska really doesn't have much in place as far as support groups. [LR219]

SENATOR PAHLS: Do you have any idea in the state of Nebraska roughly? [LR219]

CATHY CLARK-MARTINEZ: I don't know how many in the state of Nebraska. [LR219]

SENATOR PAHLS: Okay. [LR219]

CATHY CLARK-MARTINEZ: But I do know that LPS reports serving 600 children on the spectrum just in the district of Lincoln. [LR219]

SENATOR PAHLS: Thank you for your testimony. [LR219]

JUDITH BOTHERN: (Exhibit 6) Hello. My name is Judith Bothern, J-u-d-i-t-h B-o-t-h-e-r-n. I'm a licensed psychologist in the state of Nebraska and I've been in private practice in Lincoln for 19 years. My practice is exclusively with children, adolescents, and their families. And as such, I've worked with a number of the families like those that you've heard testify today. Not only is it difficult to get coverage through regular insurance, it's nearly impossible to get coverage with Medicaid. If there's even a tertiary diagnosis of a pervasive developmental disorder, they will deny services, even for comorbid issues. So working with these families requires, (1) creativity, and (2) a lot of pro bono work. I don't mind doing that, although I can't do it with everyone. Long after I'm gone and retired, these children will be here and their families. And what you folks do today is going to impact them for the rest of their lives and their families lives, and for many of them, their children's lives. Someone asked about the data and the prevalence. What I have on the front page are estimates. One is the 2008 state autism profiles from Nebraska, and you can see that ages 3 to 5, 161; but ages 3 to 21 is 1,184. At that time for November of...or 2006 to 2007, Fighting Autism came up with a 2009 school year prevalence in Nebraska of 1 out of 168 children. We can't turn our backs on these kids

and we can't turn our backs on these families. And it doesn't stop at the age of five. It isn't just early intensive behavioral intervention. It's beyond that. It's a life span. And we have to provide the full range of services that these people need. So while I totally and completely support a mandate for these children and adults, I want you to also consider that it needs to include the full range of services that they need and not a single approach or modality. I've included on the second page several references, and I've attached the literature to support. And in keeping with what Dr. Fisher said, there are several empirically support interventions and not just one. So when you do this, and I hope you do, please give them everything they deserve. I look into the eyes of...and I put this in here, I look into the eyes of Nebraska's children every working day for 19 years. They deserve more than we're giving them right now. Thank you. Questions. [LR219]

SENATOR PAHLS: Senator Gloor. [LR219]

SENATOR GLOOR: Thank you for being here today, Dr. Bothern. Looking at the listing of age categories that you have down here, and my question is sort of a follow up to Senator Schumacher's societal expense question I think. What happens to a 30-year-old autistic patient or a 60-year-old autistic patient for that matter? It doesn't disappear, so where does the care come from? Who provides the care as these individuals move through life? [LR219]

JUDITH BOTHERN: I don't work with children...people over the age of 18. My experience and knowledge just from my own practice is, as Dr. Fisher noted, it tends to run in families. And the children that I have worked with typically are able to function within the school system. Older family members have been either cared for by other family members through their adult and aging years. And this is in the same family. Does that answer your question? [LR219]

SENATOR GLOOR: Well, my guess is representatives of some of the associations

here, advocacy groups, may be able to answer that question. I'm just curious as to whether when family members can no longer provide that care they do end up at BSDC or whether they end up in other state institutions or what happens with these individuals. Because obviously parents get older, a lot of family members refuse to provide that care, and I'm sure some of these, many of these individuals can't provide care for themselves just because they've gotten older. If anything, the demands are problematic, so. [LR219]

JUDITH BOTHERN: Yes. May I add, though, the ones that get treatment, many, many, many of them can be functional. And I tell my families, an autism or Asperger diagnosis is not a death penalty. Your child may be able to function. Your child may be able to be employed. Your child may be able to function well within the school system. We need to start and we need to move forward. And many of the children I work with make it into the school system with minimal to no support. But without the services, they require a lot of support within the school system. So with help throughout the life span, many of these people can be functional. [LR219]

SENATOR GLOOR: I think that was made clear during testimony. Thank you. [LR219]

JUDITH BOTHERN: Okay. Okay. [LR219]

SENATOR PAHLS: Seeing no more questions, thank you for your testimony. [LR219]

JUDITH BOTHERN: Thank you. [LR219]

SENATOR PAHLS: (See also Exhibit 7) Seeing no more testimony, that will conclude this afternoon's meeting on LR219. Thank you. [LR219]