[LB239 LB479 LB655]

The Committee on Banking, Commerce and Insurance met at 1:30 p.m. on Tuesday, February 12, 2013, in Room 1507 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB239, LB479, and LB655. Senators present: Mike Gloor, Chairperson; Kathy Campbell; Tom Carlson; Sue Crawford; Sara Howard; Pete Pirsch; and Paul Schumacher. Senators absent: Mark Christensen.

SENATOR GLOOR: (Recorder malfunction)...Committee. I'm Mike Gloor, I'm the Senator from District 35 which is Grand Island. We have an agenda that's posted outside. We will not take the bills in the order posted. As a result of an unfortunate occurrence, we've allowed Senator Lathrop to move to first. So we'll take LB479, then followed by LB239, and then LB655. To better facilitate today's hearings, we have rules that we follow in this committee and every committee. Those rules are posted up there on the board to your left, but let me run through them quickly. Please do us a favor and check to make sure that that cell phone you turned off or put on silent really is turned off and put on silent. The order of testimony for the committee will be the introducer, proponents, opponents, those in a neutral capacity, and then closing by the introducer. I would ask that testifiers sign in. There are sign-in sheets by the front door. Also hand in your sign-in sheets before you testify, to the clerk. And then as you sit down, please state your name and spell your name for those people who are transcribing today's hearings. Be concise. We have a light system, but we don't use it that often, and don't intend to use it today. But try and limit your comments to five minutes each. If you're not testifying in the microphone, but would still like to go on record as having a position, there are white sign-in sheets by each entrance where you can list your name, and that way you'll show up on the report of the committee. Written materials can be distributed, but only at the time that you are testifying for us. Give those copies to the pages and they'll make sure to get them distributed for you. We need ten copies. If you don't have ten copies, now would be a good time to get a page's attention so we can make ten copies for each of you. To my immediate right is committee counsel, Bill Marienau, and to my left at the end of the table is Jan Foster who is the committee clerk. Committee members with us today will introduce themselves, and we'll start with Senator Crawford.

SENATOR CRAWFORD: Hi, Sue Crawford from Legislative District 45, that's eastern Sarpy County, Bellevue, Offutt.

SENATOR SCHUMACHER: Paul Schumacher, District 22, that's Platte and parts of Colfax and Stanton Counties.

SENATOR PIRSCH: Pete Pirsch, District 4, that's Boys Town, parts of Douglas County, and the city of Omaha.

SENATOR CAMPBELL: I'm Kathy Campbell, District 25, east Lincoln and eastern

Lancaster County.

SENATOR CARLSON: Tom Carlson, District 38, south central Nebraska, and I live in Holdrege.

SENATOR HOWARD: Sara Howard, District 9, I represent midtown Omaha.

SENATOR GLOOR: Senator Christensen is unable to be with us today. And our pages are Will and Nathan who are over there. And with that, we'll start with Senator Lathrop and LB479. Welcome back, Senator Lathrop.

SENATOR LATHROP: Thank you, Chairman Gloor and members of the Banking, Commerce and Insurance Committee. My name is Steve Lathrop, L-a-t-h-r-o-p. I am the State Senator for District 12, and I am here today to introduce LB479. I want to introduce it this way: by talking about a conflict between two policies and two different objectives. Most of us have a health plan. Sometimes it comes to us through an employer, sometimes you might buy it in the private market. That health plan has a deductible and a copay amount. My law firm has a $5,000 deductible which is our answer to the increasing costs of healthcare expenses. We also have one of those health savings accounts, so I don't want you to think I'm a complete miserable employer, but the $5,000 deductible is a commonplace deductible for health plans for people in small businesses. It's certainly common for people who buy their policies out on the market. Then there's the auto policy. We all buy auto policy; we're required to. The auto policy comes with different coverages, right? We're required by law to maintain $25,000 worth of liability coverage, but you can also buy collision coverage, and you can buy something called MedPay coverage. Maybe you're familiar with this. Also uninsured and underinsured. I want to while I'm talking, focus on the MedPay. The MedPay is something you pay a separate premium for, and the MedPay promise from American Family, if you will, basically is a promise to cover you or anybody in your car, or you in anybody else's car, pay for your medical expenses if you get hurt in a car accident. So the limits are typically $1,000 or $5,000--more common to see $5,000 in MedPay--and people pay a separate premium for that coverage. Really important when you understand this bill. People go out and buy MedPay coverage in their car, even when they have health insurance, for a reason. And they buy it to cover their deductible. Right? We have a health insurance plan with a $5,000 deductible and I go and buy my auto policy and get $5,000 worth of MedPay so that I'm covered. My deductible is taken care of in the event I'm in an accident. Here's what's happening in the health plan and what this bill is intended to address. I had somebody come into my office. This is the result of a conversation I had with a lady, had an accident, it was her own fault. This is not a claim that she's making, but she came into my office and she said, I have a health plan and I have the MedPay. I bought the MedPay to take care of my deductible and the insurance company--health insurance company--took my MedPay. They took my MedPay and did not credit my deductible amount, okay? So the health insurance carrier

has a reimbursement provision in the policy that says, in the event you're in an accident and you recover from some other source, including MedPay, we get to take it. Not reimburse after you've made a claim against somebody who caused an accident, but they're taking the MedPay and they're not giving them credit for their deductible. So the person who bought the MedPay just gave it to the health insurance carrier and got no credit for it. And the health insurance company--and you'll hear them today--will tell you that it helps hold premiums down. Maybe true for everybody, but it's not helping this person because that's a feature on their auto policy that they bought to cover their deductible and they never get to use it. And they're paying a premium, and it's...now, the bill would prohibit that practice. Okay? LB479 would say, if your health insured buys another policy, some resource--and it could be MedPay, it could be underinsured, it could be uninsured, or it could be an Aflac policy. Whatever you buy to protect yourself other than that health insurance, can't be taken by the health insurance just because they put it in their policy. It's that simple. Why is that important to this committee? It's important to the lady I represent who has to write a check for $5,000 to the...she ended up having a fractured vertebra; a lot of expense. She has to write a check for $5,000 to the hospital to take care of her deductible before her health plan will kick in, and the health plan took her $5,000. This would stop that practice. I think it is completely unfair to the insured. And more importantly, we should stop selling MedPay in this state if the only purpose in me paying a premium is to lighten the load of my health insurance company who I'm also paying a premium to. So the bill is broad enough to cover uninsured and underinsured. There may be policy arguments for that. Frankly, if I buy uninsured or underinsured and I have lost wages, I think I ought to get those paid before the health insurance company gets to take all of my uninsured and underinsured. But I can tell you this is at its most unfair when you take somebody's MedPay. And if we let it continue, people will stop selling MedPay. I'd stop buying it because there's no point in me buying MedPay if the person...I buy it to cover my deductible, and the health insurance company takes it from me and I still have to pay my $5,000 deductible. So that's the purpose of the bill. That's the reason I brought it, and that's sort of the inequity I'm trying to resolve with LB479. I'd be happy to answer any questions. [LB479]

SENATOR GLOOR: Senator Lathrop, have you done enough research on health insurance policies offered in the state to know whether this is common practice, practiced by a few, everybody does it? [LB479]

SENATOR LATHROP: I will...I found it in one policy. And I'm not going to sit up here and start identifying which company I found it in. It's somebody that writes an awful lot of health insurance in this state. But what I have seen, Senator Gloor, is those provisions in health plans that provide for subrogation or reimbursement, it shows up in one plan and pretty soon--within a year or two--it's common practice in the industry. So you asked me a question. I've seen it in one or one provider, but I would fully expect it to be something you'll see in every health insurance plan. [LB479]

SENATOR GLOOR: Okay. Thank you. Other questions for Senator Lathrop? Senator Pirsch [LB479]

SENATOR PIRSCH: Along those lines, do you know how other states approach this issue? Have you looked at any other states and seen if other...what they do? [LB479]

SENATOR LATHROP: I do not know if it is something that was hatched here in Omaha or in Nebraska and I'm at the very tip of the spear or if I'm, you know, this is something that's commonplace. It appears in a policy for an outfit that writes policies all over the state. [LB479]

SENATOR PIRSCH: And just a couple of follow-up questions. Do you have a sense that...I'm trying to get a flavor of how many people use this MedPay? [LB479]

SENATOR LATHROP: Everybody in a car wreck. Everybody in a car wreck because generally what happens is, you will start out using your health insurance plan which is going to have deductibles and copays, and the MedPay becomes the resource somebody that's hurt uses regardless of whether it's their fault or not. Understand, these aren't people that are tort claimants, necessarily. They use the MedPay to pay for their deductible, copay, and their noncovered expenses. [LB479]

SENATOR PIRSCH: Certainly, if they have MedPay, right? [LB479]

SENATOR LATHROP: If they have MedPay. [LB479]

SENATOR PIRSCH: And what...I guess my question is a little different, and I'm sorry I wasn't more clear. But how many people typically go out and get a MedPay? [LB479]

SENATOR LATHROP: Almost everybody. I generally will see a Geico policy is the one policy that oftentimes doesn't have MedPay. Every other policy that I run into will have at least $1,000, even a Progressive policy that's issued to a high-risk guy. [LB479]

SENATOR PIRSCH: Okay. [LB479]

SENATOR LATHROP: And then you get into an American Family or State Farm, some of the primary writers of auto policies, and they're going to have $5,000. [LB479]

SENATOR PIRSCH: Okay. Thanks. [LB479]

SENATOR GLOOR: Senator Carlson. [LB479]

SENATOR CARLSON: Thank you, Senator Gloor. Senator Lathrop, the way this is written the example you gave is very understandable because a situation where the

individual has a major medical plan with a $5,000 deductible and then has the MedPay...and I understand what the purpose of that is. Does this bill...what other kinds of circumstances would this bill cover or is it narrow enough that this is it? [LB479]

SENATOR LATHROP: No. It's not just MedPay, it's broad enough to cover uninsured. So if I can give an example of that: if I am in an automobile collision. I have health insurance and I have my own policy, and the guy who hits me keeps me from practicing law for the rest of my life. I have uninsured motorist coverage for that. And right now, those very policies say we get all your uninsured motorist money. Any recovery you make against your own uninsured motorist policy...so if I had $100,000--which is pretty typical in Nebraska--if I had $100,000 in uninsured and I had $300,000 in medical expenses, they would take all of my uninsured and I'd be there reimbursing my health insurance plan and no compensation; nothing for my lost wages. Nothing for the fact that I, you know, I can't walk any more or go to the office and work. [LB479]

SENATOR CARLSON: Okay, and this is...so this is meant to be wider than the kind of narrow example that you first gave? [LB479]

SENATOR LATHROP: It is wider. I think the most unfair application of this is to MedPay. I also believe that it would be appropriate for uninsured and underinsured and the Aflac situation which is the fixed indemnity coverage, I think. You know, if you get sick and you're in the hospital, they send you a check. I don't know if they do this. What's stopping them from taking your Aflac? And then that becomes a worthless product in this state. [LB479]

SENATOR CARLSON: Well, I'll ask another testifier, but I think in cases of a policy similar to Aflac, it's stated in the policy it pays in addition to other insurance. [LB479]

SENATOR LATHROP: Oh, but that's essentially what's in your MedPay, too. If you put it in the plan and they say, if you make a recovery from some other resource, they're going to take it from you or they'll take a credit for the amount you got from Aflac or from MedPay or from uninsured or underinsured motorist coverage. [LB479]

SENATOR CARLSON: Okay. Thank you. [LB479]

SENATOR GLOOR: Other questions? Yes, Senator Schumacher. [LB479]

SENATOR SCHUMACHER: Thank you, Senator Gloor. Senator Lathrop, thank you for a very clear description of a common situation of this. But along the lines of what Senator Carlson was asking, apart from a car accident where your health insurance pays and wants to get into some of your other insurance, are there other circumstances, other case examples that you could give us so we have an understanding of how broad this is? This doesn't just say in the event of a car accident and limited to medical.

[LB479]

SENATOR LATHROP: Well, the coverages are...typically come from your auto policy, so that would necessarily require that you be in an auto accident before you would have a conflict with a majority of the things listed here. I believe it's broad enough to get to Aflac or those things that purport to give you money on account of an illness or injury. I don't know that that's happened. I talked to the folks that represent Aflac in the state and they were unfamiliar with whether that had ever happened. They'd never seen an occurrence where Aflac has been taken and used by the health insurance company, but I don't know why it would be any different than MedPay. [LB479]

SENATOR SCHUMACHER: Thank you, Senator. [LB479]

SENATOR GLOOR: Senator Crawford. [LB479]

SENATOR CRAWFORD: Thank you, Senator Gloor. And thank you, Senator Lathrop. So when we were talking about asserting a contractual right to the proceeds, does that exclude the situation where if you have multiple health plans they would be focusing on what benefits you get from what health plan first and then the second health plan? [LB479]

SENATOR LATHROP: That I think is a different question. That is a coordination of benefits issue and not a reimbursement. Your health plan is going to have a coordination of benefits. If you and your husband are insured under separate policies and you're an insured under both, then your coordination of benefits plan...provision will say who's primary and who pays sort of...bats cleanup. And so this is a reimbursement provision in your health insurance plan. [LB479]

SENATOR CRAWFORD: So it's different because of the section of the statute that it's in or it's different because... [LB479]

SENATOR LATHROP: It's different because they're different policy provisions... [LB479]

SENATOR CRAWFORD: Okay. [LB479]

SENATOR LATHROP: ...in the typical health insurance plan. So your health insurance plan will say, in the event you are sick or injured, we'll pay these things... [LB479]

SENATOR CRAWFORD: Uh-huh. [LB479]

SENATOR LATHROP: ...reasonable hospital charges, doctor charges, physical therapy, prescriptions. Then towards the back of the plan is...then you'll have some exclusions. We're not going to pay for injuries from suicide or nuclear attacks. Then towards the

back will be the reimbursement, subrogation, and coordination of benefits provision. And that's where they try to coordinate between two health plans and secure reimbursement or subrogation from somebody who has made a recovery against a tortfeasor. That's sort of how the health plans are laid out... [LB479]

SENATOR CRAWFORD: Uh-huh. [LB479]

SENATOR LATHROP: ..and the difference between the policy provisions. [LB479]

SENATOR GLOOR: Other questions for Senator Lathrop? Seeing none, thank you. [LB479]

SENATOR LATHROP: Maybe to...well, I'll stay and close. I'll make my point then. Thank you. [LB479]

SENATOR GLOOR: You're going to stay and close? Could I see a show of hands of those who would like to speak in any capacity on this subject? Not many hands. Okay. We'll start with proponents. Right over there, please. Thank you. Good afternoon. [LB479]

JOHN FOWLES: Yes, Senator. My name is John Fowles. I'm here on behalf of the Nebraska Association of Trial Lawyers. I'm attorney practicing here in Lincoln. And I urge you to... [LB479]

SENATOR GLOOR: Mr. Fowles, could I ask you to spell your name for us, please? [LB479]

JOHN FOWLES: F-o-w-l-e-s. [LB479]

SENATOR GLOOR: Thank you. [LB479]

JOHN FOWLES: I...The NATA strongly supports the legislation proposed by Senator Lathrop. And I believe it's very important because it protects the purchasers of insurance and protects your constituents. This...what he has proposed basically reinforces what is the common law. And that is that when it comes to subrogation, the principle of subrogation was intended such that a subrogating party could subrogate against the tortfeasor, the person who caused the accident, and their insurance company. Now through contract, insurance companies have tried to expand subrogation. Basically, they stick this subrogation language in the insurance contract that you agree with or agree to them with. But basically, most people don't understand what they're agreeing to when they agree to these insurance contracts, they don't understand the principles of subrogation, they don't understand what the common law is. And basically, it's a contract of adhesion. You don't negotiate your insurance contract

with your insurance carrier, they give you a contract and you agree to it. And basically, through this contract language they have, over the years, tried to expand the pool of money to which they can subrogate against; in this case trying to subrogate against first-party insurance. Senator Lathrop talked about MedPay. I would like to talk about underinsured motorist coverage because that is coverage that you purchase, you pay a premium for that coverage. And what these insurance companies are trying to do is basically ride your back. They're trying to take advantage of the premiums you pay to reduce their cost. Now I think that's very important that everyone understand, for the underinsured motorist coverage you pay the premium for that. You choose how much premium you're going to pay each month based upon how much coverage you want. So if you happen to choose a big policy with a lot of coverage under an underinsured motorist policy and you get in a bad accident and you collect on that policy that you paid a premium for, they'll try to ride on that. They'll try to take advantage of those premiums you might have paid for 20 years hoping you'll never be in an accident. But when that unfortunate event occurs, they take advantage of those premium dollars you spent over the last 20 years. They don't refund any premium to you, they keep their premium and take the money you receive from the insurance company based upon the premiums you've paid for many years. And that's the fundamental problem with this, your honor, I mean, senators, is they don't do anything to reimburse any money to you, they just take advantage of the money you have paid. Now I think something that was commented on earlier before is how broad this subrogation language has become over the years. Since I've been practicing, which is almost 20 years, every year it just seems to get broader that the language that they use. And I would call the language insidious because I think they're trying to spread it to different areas, different coverages. Now I've never seen them apply this to life insurance, but I think it's coming because the language that they put in these subrogation contracts allows them to subrogate against any money you receive. I mean, this is right out of a policy that I had a legal matter with years ago. It basically says, we're entitled to subrogate against anything, any money you receive as a result of this accident. If I am in an accident, I die, my spouse would receive my life insurance. Now that would be a benefit that she would receive as a result of my accident. That language is so broad I think it could apply to life insurance, I think it could apply to disability insurance. There's no restriction on this language, and that's why I think it's very important that the Nebraska Legislature put some limits on this language and limit it to money received from a tortfeasor--the person responsible for the accident--and let you keep the benefit of the premiums you've paid for life insurance, underinsured motorist coverage, and any other type of Aflac coverage or any other sort of coverage that you pay for. And I think that is all I have to say unless anyone has any questions. [LB479]

SENATOR GLOOR: Senator Pirsch. [LB479]

SENATOR PIRSCH: Oh, thanks. You know, I've always wondered about that as well. I know he calls us your honors, but...I'm just kidding. But I do have a question about the

issue that Senator Lathrop had maybe raised and maybe have you kind of preaddress this... [LB479]

JOHN FOWLES: Sure. [LB479]

SENATOR PIRSCH: ...before somebody talks about that. But so two policies, two premiums, so there was kind of a preview that maybe the argument that one policy has built into its price structure the existence of another...of the other policy. Does it...when you're filling out the one policy, does it ask if you have such a policy? [LB479]

JOHN FOWLES: I've applied for lots of medical insurance over the years as a self-employed lawyer... [LB479]

SENATOR PIRSCH: Uh-huh. [LB479]

JOHN FOWLES: ...and I don't think that's the case. I've heard this over the years. I don't...I'm not going to testify to this because I don't know for a fact. I think that's something to be asked of the Blue Cross Blue Shield people. But that subrogation is basically...they don't factor that into their premiums. It's all kind of benefit to them, and so when you sign up for health insurance you don't get some benefit because you have a bigger underinsured motorist policy. I've never seen that, I don't think it exists, and I don't think they account for that. They don't know what kind of underinsured motorist coverage you have. So I think I'm answering your question by saying that I don't think they account for that, I don't think I've ever seen a policy where that's the case, and I think they're just taking advantage of your responsibility when they do that. [LB479]

SENATOR PIRSCH: So at least on the individual policy level, you don't believe that they take that into account whether or not... [LB479]

JOHN FOWLES: No, I don't believe so. I don't believe so. And I think as this language as written, Senators, I think it doesn't really...it wouldn't go into the ERISA area, but no, I don't think that's the case. [LB479]

SENATOR PIRSCH: Okay. Thank you. [LB479]

SENATOR GLOOR: Anyone else who would like to...Senator Crawford. [LB479]

SENATOR CRAWFORD: Thank you. I wondered if you could comment on the fact that the bill, as written, exempts policies for specified diseases or other limited benefit coverage. Would you...that'll be fine. [LB479]

JOHN FOWLES: Well, I don't know that I can comment on that. It may be something for Senator Lathrop. [LB479]

SENATOR CRAWFORD: Senator Lathrop could comment. Okay. [LB479]

JOHN FOWLES: Yes. I guess I didn't... [LB479]

SENATOR CRAWFORD: I didn't know if you had any familiarity with those kinds of plans or cases of those kinds of plans. [LB479]

JOHN FOWLES: No. [LB479]

SENATOR CRAWFORD: Okay. [LB479]

JOHN FOWLES: I can't say for certain. [LB479]

SENATOR CRAWFORD: That's fine. Thank you. [LB479]

SENATOR GLOOR: Anyone else who would like to cross-examine the witness? I see none. Thank you, Mr. Fowles. [LB479]

JOHN FOWLES: Okay. Yes. [LB479]

SENATOR GLOOR: Any other proponents? Seeing no further proponents, any opponents? Afternoon, Senator Gay. [LB479]

TIM GAY: (Exhibit 1) Good afternoon, Mr. Chairman, members of the committee. My name is Tim Gay, T-i-m G-a-y, with Husch Blackwell, representing Blue Cross and Blue Shield. Blue Cross and Blue Shield is...opposes LB479. The legislation will limit the ability of health insurers to prevent double recoveries and overpayments made to providers and insurance policyholders when healthcare claims are paid by the health insurers are also paid by another source. As legislators, it is important to be mindful of the impact of this legislation to the public; not just as claimants, but also to the health insurance players. Like most health insurers, Blue Cross includes in its contracts of insurance and health coverage administered for self-funded employer groups terms that allow for the right of reimbursement and subrogation. When Blue Cross Blue Shield of Nebraska uses to recover these funds paid by another source when the payment or settlement includes coverage for healthcare treatment which Blue Cross and Blue Shield of Nebraska has already paid these claims. For our insured business, Blue Cross Blue Shield enforces this term when a policyholder is made whole for his or her damages from the recoveries received related to an accident or other incident. The primary situation in which an insurer uses its right of reimbursement contract term is when an insured is in an automobile accident, as Senator Lathrop mentioned, and receives payment from automobile insurance for medical expenses, either medical payments coverage, uninsured or underinsured motorist coverage, and/or liability

coverage. When Blue Cross makes this recovery or coordinates coverages, it uses these funds to offset and reduce the claims paid for that policyholder. Premiums for all people in the pool are then calculated based on the claims paid less the recoveries. So any recovery made will reduce health insurance premiums for all insureds in this pool. While an individual recovery in any given case may be modest compared to the healthcare claims paid, the recovery offsets total claims paid and the savings are passed on to the consumers. Our self-insured employer accounts, the Medicare, Medicaid, and Nebraska Comprehensive Health Insurance Pool are very aware of the use of subrogation and coordination as a cost-savings tool to reduce the cost of health coverage. The limitations in LB479 prohibiting the assertion that any contractual right to the proceeds of any resources purchased by the policyholder would limit the sources of recovery from which insurers could pursue this recovery. As a result, this legislation will increase healthcare premiums because there will be fewer instances when the healthcare claims paid will be reduced by these recoveries made through the contractual terms. Also, LB479 will increase the administrative costs for physicians and hospitals that receive direct payment from the health services and the medical coverage and from health insurance coverage. These providers will need to determine how to account for and refund for these overpayments. Blue Cross opposes LB479 because it will increase the cost of health insurance by limiting sources of recovery. In addition, the legislation will create a burden for physicians, hospitals, and other providers who will need to sort out the overpayments from the automobile insurance and healthcare insurance. Thank you for your time. Mr. Chairman, also I'm pinch hitting for Russ Collins. He's the vice president of Blue Cross and Blue Shield, counsel, legal counsel, and he couldn't be here today. But any other questions...it's very technical what you're dealing with. Any questions that would come I'd be happy to try to answer, but I'd be speculating. But he'd make himself available at any time. So... [LB479]

SENATOR GLOOR: Senator Pirsch. [LB479]

SENATOR PIRSCH: Oh, thank you. I guess to "re-ask" that same question that I just asked the gentleman that testified on...John Fowles on behalf of NATA. When you talk about cost savings, you mean on an aggregate level, right? Not on an individual policy level? Is that what you're saying? [LB479]

TIM GAY: The way I understand it, on an aggregate level it's then spread out to keep all premiums down. [LB479]

SENATOR PIRSCH: And we've talked about a number of different mechanisms, you know, the MedPay and...well, I'll strike that question. I'll just ask...I'll let someone else. No other questions, Chair. [LB479]

SENATOR GLOOR: Senator Campbell. [LB479]

SENATOR CAMPBELL: Senator Gay, one of the questions I had in listening is, is there any way to ascertain the statistics and the number of cases that your insured company may have in which they do that and the amount of money recovered so we have some idea of the scope that we're talking about here? [LB479]

TIM GAY: Oh, I'm sure there is. Yeah, I'm sure there is. And then...but like I say, that's beyond my scope of what I could answer today. But, yeah, I'm sure they keep track of those things. [LB479]

SENATOR CAMPBELL: That'd be great. If you could let them know... [LB479]

TIM GAY: Absolutely. [LB479]

SENATOR CAMPBELL: ...because I think at this point, we're trying to figure out also what the scope is... [LB479]

TIM GAY: Uh-huh. Not a problem. [LB479]

SENATOR CAMPBELL: ...because you could begin then to see the magnitude that Senator Lathrop may be talking about. Thank you, Senator Gay. [LB479]

TIM GAY: You bet. [LB479]

SENATOR GLOOR: (Exhibit 2) Let the record also show that we have a letter of support for LB479 from the Nebraska Hospital Association, and copies of that are being passed out to the committee members. Senator Crawford, you had a question? [LB479]

SENATOR CRAWFORD: Thank you, Senator Gloor. Could you explain how the Blue Cross Blue Shield would subrogate the money and it would not...why it would not count toward someone's deductible? [LB479]

TIM GAY: Well, it would come in...it pays...they pay the premium, the way I understand it. And it would go to that...it subrogates all the costs that were already incurred as they went and had medical costs, is the way I understand it, Senator. But you...I'll be honest with you, I mean, you might be getting over my head on this. [LB479]

SENATOR CRAWFORD: Right. Yeah. Well, the example we heard was one where the...there was no credit against the deductible. [LB479]

TIM GAY: It goes to the total pool and then that's spread out amongst the group policies, is the way I understand it. [LB479]

SENATOR CRAWFORD: All right. So it's not given as a credit to the holder for their

deductible. Okay. [LB479]

SENATOR GLOOR: Senator Carlson. [LB479]

SENATOR CARLSON: Thank you, Senator Gloor. Senator Gay, I'm going to indulge in a little conversation, and it's not to trick you. I just want to make a point here. Let's suppose you have a...you buy a major medical policy with a $5,000 deductible and $10,000 out-of-pocket, which means after the deductible you're going to pay 20 percent for a while. And that would be, the next $25,000 you're going to pay 20 percent so that totals up to $5,000, plus the deductible. That's $10,000 out-of-pocket. If you buy that policy--and let's pretend something else even though it's not true--you and I are the same age and you buy that policy, and then you have a $100,000 claim. I'm not trying to confuse you now, but how much... [LB479]

TIM GAY: Yeah, you're getting there, but... [LB479]

SENATOR CARLSON: And it's all legitimate expenses. You've got a $10,000 out-of-pocket cost, and you've got a $100,000 claim. How much is your policy going to pay? [LB479]

TIM GAY: I mean... [LB479]

SENATOR CARLSON: Well, it's going to pay all but $10,000 because that's your out-of-pocket. [LB479]

TIM GAY: Yeah. Sure. [LB479]

SENATOR CARLSON: It's going to pay $90,000. Now I've got the same policy, but on my vehicle insurance I buy the medical coverage and I do pay an extra premium for that. And I have a $100,000 claim. We've got the same policy so my medical plan is going to pay $90,000 of the $100,000, just like yours. In addition to that, I've got coverage on my vehicle. I paid a premium for it. I understand why there should not be insurance in effect so that with my claim I could get instead of $100,000, I could get paid $120,000. That makes no sense. [LB479]

TIM GAY: Right. You can't benefit on the... [LB479]

SENATOR CARLSON: But I have trouble wondering or thinking why, if I bought that coverage for $5,000 on my automobile, why I wouldn't get the $5,000. Doesn't that sound reasonable to you that I should get that? [LB479]

TIM GAY: Well, what's reasonable? I have that, I think. I just checked my card when I was out here. So we have the uninsured, I have the medical, whatever. So we get that

going. How it's sorted out in the...how they're all working together after the accident happens and who does what. I mean, you're saying should that policyholder get the benefit? I think is what you're saying. Insureds...I mean, how it's working together...I assume when they write their policy--whether it be for your auto policy and your health policy--they take this into consideration when they're underwriting the premiums. So do I get completely the benefit from my State Farm policy and my Blue Cross and Blue Shield? I don't know how that's worked out in the back policy. What you're saying is, I should have got credit for this one and this one? Is that what you're trying to say? [LB479]

SENATOR CARLSON: You and I bought the same medical policy and we're going to pay the same premium because we're the same age. But in addition to that, I bought some more coverage. And I think I should get credit for that coverage, and I think I should be able to collect. Now most of the time, I'm going to support any phase of the insurance business because I've been in it a long time. But I can see where Senator Lathrop is coming from. And don't you see where I'm coming from? [LB479]

TIM GAY: I understand on the fairness level. The part that I don't understand and I think Russ Collins could...because he does the actual...when you're doing the two policies...I know what you're saying, but when we buy those...I mean, you're in the insurance business. I used to be in the insurance business. Do we understand every single thing that we're buying and sold? I don't know how it's settled up in the back office after the accident happens. And what you're looking into, what I'm saying and I think what Russ is trying to say here is, when those are all done the current policy is what it is. If you go changing that, it'll change the underwriting in the back office of how they're going to deal. I don't know exactly what the fairness is. I know what you're saying. Why have we been paying a premium on the auto, let's say. Shouldn't I get some credit for that? I think is what you're saying. How that's done, I don't know. And, you know, I don't know. Maybe Senator Lathrop knows exactly how that's done. What they're saying here is, pooled in your insurance premium to offset the cost. [LB479]

SENATOR CARLSON: The reason I'm kind of staying after you is because by hands raised there's not going to be any further testifiers. So I'm trying to make the point with you. [LB479]

TIM GAY: I know. [LB479]

SENATOR CARLSON: Thank you. [LB479]

TIM GAY: You bet. [LB479]

SENATOR GLOOR: Senator Howard. [LB479]

SENATOR HOWARD: Thank you, Senator Gloor. Thank you, Senator Gay, for your testimony. This may be a question for Russ as well, but do you know what type of language specifically that Blue Cross Blue Shield uses to subrogate? [LB479]

TIM GAY: On their contract? I do not. [LB479]

SENATOR HOWARD: So it's not a limit... [LB479]

TIM GAY: It would be in the contract and I don't have it with me. No. But we could certainly get you that. Absolutely. Absolutely. [LB479]

SENATOR HOWARD: Okay. That would be great. Just...it goes back to Senator Campbell's concern about scope. If it's only a few policies that are using this broad subrogation language, then maybe it's not as big of an issue. But if Blue Cross Blue Shield is using broad language that could reach into a life insurance policy, that is a concern. [LB479]

TIM GAY: Uh-huh. Yeah, I can get you a copy or definitely to everybody. So... [LB479]

SENATOR HOWARD: Thank you. [LB479]

TIM GAY: You bet. [LB479]

SENATOR HOWARD: Thank you. [LB479]

SENATOR GLOOR: Any other questions? [LB479]

TIM GAY: And maybe someday it will be judge, you never know. Thank you, Senators. [LB479]

SENATOR GLOOR: Thank you, Senator Gay. [LB479]

TIM GAY: Yeah, thank you. [LB479]

SENATOR GLOOR: Anybody in a neutral capacity? Anybody change their mind? Seeing none, Senator Lathrop to close. [LB479]

SENATOR LATHROP: I got a few things. You understand the issue, Senator Carlson, perfectly and I would use your illustration. Two people with health plans and one is in a car accident, has $10,000 worth of uncovered medical expenses. They are deductibles and copays that equal $10,000 and he has $10,000 in MedPay. This guy over here doesn't. Here's exactly why it's so unfair. It's Blue Cross--they'll take the $10,000 in MedPay and pay part of the $90,000 in bills, right? So they're taking the $10,000 in

MedPay, paying $10,000 of the bills with my MedPay, and not giving me credit for the deductible and copay. I still have to pay $10,000 out-of-pocket before I've met my deductible and copay so the guys who wrote the plan and take my MedPay pay $80,000 actually, because they're not paying the deductible and the copay. They've taken my $10,000 and paid $10,000 worth of their obligation. And their answer is this: it lowers the cost of healthcare. It may. It may, but it doesn't lower the cost of healthcare for the guy who bought the MedPay. It may lower the cost of health insurance for everybody so when you make a claim for going to the doctor, it may make yours a couple cents less perhaps. But it doesn't change the fact that I'm the guy that bought the plan and I get no benefit from it. The scope of this problem is, it is...I'll describe it this way. When I first started practicing law 30--in 1981, so 30 some years ago--we never saw a subrogation provision in a health insurance plan. They'd pay the bills and, you know, you'd make a recovery, the client would walk away and they wouldn't have to pay back the health insurance company. Then we started to see the subrogation language show up in health plans and in MedPay. So if somebody who's not responsible for the accident pays the medical expenses and you recover from the guy who caused it, you had to pay them back. It's getting broader and broader, and now we see something called the reimbursement agreement which is where this problem originates, and it is growing. And I suspect, though I don't know, that these insurers all get together and they talk about the latest way to defer costs. It's growing. You can expect it in every health plan in a couple of years. It's that big. This isn't an isolated plan issue. I think it's important that you see the hospitals support this bill. And why would they? Because you don't have the $10,000 to pay your deductible with, so now Blue Cross pays $90,000--$10,000 of which was your own money--and the hospital now has a $10,000 uncompensated amount. Now they can go to the guy and hopefully get it from him, but the hospitals recognize this isn't going to cause administrative problems, it's going to cause more providers to get paid in full. It's quite the opposite of what Tim told you. This is a result...this doesn't prevent a double recovery either. There are provisions, mostly subrogation provisions which is a little bit different critter. It's kind of similar. That's where you, if you make a recovery from the tortfeasor you shouldn't make...you shouldn't be double recovered. You know, keep the...have your health insurance paid and then be able to make a claim against a liability carrier like State Farm and recover your hospital expenses and not have to pay the guy back who paid the bills. I understand that. This isn't about a double recovery, and I think you can see that from the illustration. It's about getting the benefit and ultimately whether these products will be sold in Nebraska because if MedPay turns into a reimbursement or something that helps defray the cost of running Blue Cross Blue Shield or a health insurance carrier, then why have it? If it's just going to be taken from me and used to defray the cost of running Blue Shield, why would anybody buy it? That stuff will become extinct. And if it spreads into disability, and I think it could--the language in these reimbursement provisions is broad enough--if it spreads to disability, there would be no reason to buy disability coverage either if every time you got sick Blue Cross Blue Shield takes it from you and says, well, it lowers the cost of premiums for everybody so there's a good

policy reason for it. No, it isn't. You buy the product for a reason, you buy it because you need the protection. And with high-deductible health plans, that MedPay is more critical than ever. So I am very...one last thought. This is not a Trojan horse. I heard somebody from the insurance industry say if Lathrop gets this on the floor, he's going to rearrange subrogation or...no. This is what I'm talking about. I'm not going to put this on the floor to try to make any other changes than what you see here. So with that, I'd answer any questions. [LB479]

SENATOR GLOOR: Senator Pirsch. [LB479]

SENATOR PIRSCH: So...and let me just clarify something. So if in the hypothetical, every insurance carrier were to put these clauses, you know, with respect to MedPay--we'll just use that scenario that...so the question: would there be any value whatsoever for the individual in taking out MedPay? [LB479]

SENATOR LATHROP: None. None. [LB479]

SENATOR PIRSCH: None at all. [LB479]

SENATOR LATHROP: There would be no benefit in having MedPay if the insurance company just gets to take it from you. [LB479]

SENATOR PIRSCH: In no scenario? It would always... [LB479]

SENATOR LATHROP: No. It'll go away. And why the health insurance...the guys that write the policies, why they aren't up here lined up to testify is mystifying. [LB479]

SENATOR PIRSCH: And one more question. You know, we've been using the MedPay example. But this would, as you said, is broader and would apply to more types of policies, including uninsured, underinsured, etcetera, etcetera. Would that be...does your principle hold the same? There would be no reason for that? [LB479]

SENATOR LATHROP: It does. It does, Senator Pirsch. The only place it doesn't is if somebody makes...if you have a large claim and you don't have a large uninsured motorist policy, then the principle is exactly the same. I...you know, I should be...I should have my lost wages paid before the health insurance company is...takes my product, uninsured motorist benefits, and applies it to my health plan. [LB479]

SENATOR PIRSCH: Okay. [LB479]

SENATOR GLOOR: Other questions for Senator Lathrop? Senator Carlson. [LB479]

SENATOR CARLSON: Thank you, Senator Gloor. I don't quite know how to say this

because normally I stand up for insurance companies and I surely stand up for agents. But you're talking about Blue Cross and Blue Shield. I mean, you've mentioned them, so this is the guilty party in your view. [LB479]

SENATOR LATHROP: Well, I don't want to use the term "guilty," but that's where I've encountered the problem, yes. [LB479]

SENATOR CARLSON: Okay, and Senator Gay was substituting for Blue Cross Blue Shield today. And other companies that are in the audience, if you think you don't agree with Senator Lathrop you can't come forward now because we're about to close this. But if you can give me information as to...I don't want to debate Senator Lathrop if I don't know what I'm talking about. But if I know what I'm talking about, I'm not afraid of him. And I'd appreciate information where you may disagree with him and think that you can explain to me in the examples that I gave, why that MedPay shouldn't go to the insured. I don't understand it, and I would have thought there would be some other companies that would come forward and say, it's not the way we do it. But we haven't heard anything. [LB479]

SENATOR LATHROP: And my answer to that, Senator Carlson, to the extent you have a question in there that I can comment on--first, if they're not doing it, this won't touch them. Right? This bill is only going to touch the people that are. And the second point I'd make is, you are standing up for insurers. And it's the guy who's writing the auto policy who is on main street Holdrege who's going to be done writing MedPay because no one is going to buy it. There is going to be no point. And if this grows and expands and "subro" and MedPay..."subro" and reimbursement agreements are, you'll be into Aflac. And that guy will have no business writing the policy if Blue Cross takes it and their answer is, well, it lowers the cost of doing business and that benefits all my insureds. [LB479]

SENATOR CARLSON: So in that regard, I'm surprised that there weren't agents that sell special disease policies or automobile policies come forward and say I don't like this, because there is a premium for MedPay... [LB479]

SENATOR LATHROP: Absolutely. [LB479]

SENATOR CARLSON: And if I'm paid a commission that's a percentage of premium, the higher the premium the better off I am. [LB479]

SENATOR LATHROP: Yes. [LB479]

SENATOR CARLSON: So I don't want those things not covered. [LB479]

SENATOR LATHROP: They tell me they like this bill in the lobby, and I don't know...you

know, when I talk to folks that do represent the auto...the guys who are selling the auto policies, they all sound like they like it. I just don't know why they're not here or why they won't step forward. [LB479]

SENATOR CARLSON: Okay. Thank you. [LB479]

SENATOR GLOOR: Senator Campbell. [LB479]

SENATOR CAMPBELL: Just a comment. I, too, appreciated the letter from the Nebraska Hospital Association because a lot of people think that all the hospitals howl in terms of, you know, not getting reimbursed or charity care, when in actual reality the greatest increasing cost is the underinsured who cannot pay the deductible. So interesting example. [LB479]

SENATOR GLOOR: Senator Crawford. [LB479]

SENATOR CRAWFORD: Thank you, Senator Gloor. I wonder if you could answer the question about why exempt policies that provide coverage for specified disease or limited benefit coverage. [LB479]

SENATOR LATHROP: You know, I'm sure I had a reason for putting that in there before. And while I'm sitting here, I don't really know. But I'd be happy to track that down and give you an answer. Maybe committee counsel would know the answer to that. [LB479]

SENATOR CRAWFORD: Okay. Okay. Can I ask one other question then? Maybe you'll have this answer. We're talking about asserting contractual rights so we've talked a lot about subrogation. And so if I understand it, that's the main contractual right that you're concerned about. Is there other ones? [LB479]

SENATOR LATHROP: It's a reimbursement provision. It depends, it can be...it's language that can be found...policies now make a distinction between subrogation and reimbursement. [LB479]

SENATOR CRAWFORD: Okay. [LB479]

SENATOR LATHROP: The language is very similar to one another and they overlap. So the circumstances can be the same whether it's found in a subrogation provision or a reimbursement. In the case of MedPay, since you're not recovering from a tortfeasor it is a reimbursement issue, and that's why we find it in the reimbursement provision of the health plan. [LB479]

SENATOR CRAWFORD: So that language covers both reimbursement and subrogation

challenges that you're seeing now? [LB479]

SENATOR LATHROP: Yes. [LB479]

SENATOR CRAWFORD: Okay. Thank you. [LB479]

SENATOR GLOOR: And I think the answer to your question, Senator Crawford, is it's intended to cover only major medical expense. [LB479]

SENATOR CRAWFORD: Okay, thank you. [LB479]

SENATOR GLOOR: Any other questions? Anybody else want to call out Senator Lathrop? Thank you, Senator Lathrop. I appreciate it. [LB479]

SENATOR CRAWFORD: Thank you. [LB479]

SENATOR LATHROP: Thank you. I appreciate it. [LB479]

SENATOR GLOOR: And with that, we'll close the hearing on LB479 and move to LB239. My thanks to the testifiers and their patience on this. Senator Wightman. [LB239]

SENATOR WIGHTMAN: Good afternoon. [LB239]

SENATOR GLOOR: Good afternoon, Senator Wightman. [LB239]

SENATOR WIGHTMAN: Good afternoon, Senator Gloor and members of the Banking, Commerce and Insurance Committee. For the record, my name is John Wightman, spelled W-i-g-h-t-m-a-n. I represent District 36. The Plum Creek Medical Clinic of Lexington, Nebraska, in District 36, is one of the pilot sites for a patient-centered medical home program established under the Medicaid program. This discussion should begin with a definition. A patient-centered medical home is defined as a healthcare delivery model in which a patient establishes an ongoing relationship with a physician in a physician-directed team to provide comprehensive, accessible, and continuous, evidence-based primary and preventative care, and to coordinate the patient's healthcare needs across the healthcare system in order to improve quality, safety, access, and health outcomes in a cost-effective manner. My personal physician, Dr. Joe Miller, is sitting here to my right and will provide you with more detailed information about the success of the Medicaid pilot program that Dr. Miller was kind of impressed...well, there are some who will question the impressiveness of keeping me alive last summer when I suffered a stroke, so. (Laugh) He will provide you with more detailed information by far than what I have here. Dr. Miller's enthusiasm for this program is very persuasive. Last session, I was the primary introducer of LR513 to

conduct a study of the patent...patient-centered medical home program. Some of you will recall an interim study hearing that was held on September 28, 2012. It was fortunate that, during my illness, Senator Gloor and his staff were able to move LR513 study forward and meet numerous times with a working group of representatives from the three largest health insurers in Nebraska and experts in the medical community. I have introduced LB239 for the following reasons. One, provide information to the new members of the committee about the patient-centered medical home system of care and provide an update to prior members of the committee. The testifiers that will follow me are experts on this subject far more than I. The rising cost of healthcare is a critical issue. Policymakers must support programs that address the root cause of healthcare costs if healthcare costs are to be contained. As you will hear today, the healthcare system must change. The patient-centered medical home model has been proved to reduce costs and improve quality. It is time to move beyond pilot programs and implement this system of care for all patients. Two, if legislation is found to be needed over the interim, a bill will be in a position to be amended to take necessary action. LB239 is a first draft and was introduced for discussion purposes primarily. The bill is not in a form to advance this year. I would request that the committee hold LB239 in its current form. As introducer, I am committed to continue discussion of the issues and even the need for a bill this year. The draft builds on the discussions and initial decisions made by the working group concerning the key definition of what a patient-centered medical home. LB239 uses the definition used under the Medicaid pilot and the quality standards for patient-centered medical homes. The quality standards for adults and pediatrics are being finalized. The key issue of payments to sustain this system of care must be addressed for a transformation in care to occur. A question has been raised about the applicability of the federal antitrust laws that state legislation enaction can resolve. A state law to create a federal law exemption must clearly articulate and affirmatively express a state policy to regulate and commit the state to actively supervise any possible and competitive contract...conduct. LB239 is intended to be the framework for such a law if it is needed. The insurance department would be required to provide oversight and must be a part of the discussions if they are to effectively regulate, if regulation is required. An advisory committee of experts is established to bring the major interested parties together with the department to provide the essential medical and insurance expertise to design a system for large group insurance plans, and the model of care would be phased in over five years. Nebraska has received a grant from the National Academy for State Health Policy to provide technical assistance on how to proceed. LB239 is to be a vehicle for continuing the process of the working group or providing the structure for antitrust protections if needed in the future. I have promised that LB239 will not advance or pass this session and, as the bill's introducer, that is my commitment. Thank you. If you have questions I would try to answer them, but you'd probably be much better off getting those answers from somebody that will testify after me. [LB239]

SENATOR GLOOR: Thank you, Senator Wightman, and thank you for your

commitment to this and just your general toughness overall. Any questions for Senator Wightman? Senator Crawford. [LB239]

SENATOR CRAWFORD: Thank you, Senator Gloor. Was there a reason why the focus was on physicians exclusively as...in terms of head of the medical homes, as opposed to primary care providers more broadly? [LB239]

SENATOR WIGHTMAN: Well, I think the...it originally started with physicians, I guess. [LB239]

SENATOR CRAWFORD: Right. [LB239]

SENATOR WIGHTMAN: As far as medical home providers, you know, I don't know how many of those would be qualified under the act to be a part of it, so. It might be broadened to include that, possibly. [LB239]

SENATOR CRAWFORD: Right, right. I just think, you know, if it's a...especially if it's a working group study,... [LB239]

SENATOR WIGHTMAN: Right. [LB239]

SENATOR CRAWFORD: ...it may make sense to consider incorporating nurse practitioners or primary care providers and see how they would fit. [LB239]

SENATOR WIGHTMAN: You could probably get a better answer as to how that would work through some of the later testifiers, but... [LB239]

SENATOR CRAWFORD: Um-hum. [LB239]

SENATOR GLOOR: Other questions? Thank you, Senator Wightman. And I'm assuming you're planning to stay and close, or not? [LB239]

SENATOR WIGHTMAN: I may not. [LB239]

SENATOR GLOOR: Okay. [LB239]

SENATOR WIGHTMAN: I probably will listen to Dr. Miller testify and then may leave, so thank you. [LB239]

SENATOR GLOOR: (Exhibits 1, 2, and 3) All right, we will pay attention. Thank you. And we have three letters of support from Appleseed, Friends of Public Health in Nebraska, and the Nebraska Pharmacists Association for this bill that I'll ask the pages to hand out. We'll note that in the record. Could I see a show of hands of those people

who'd like to speak on this topic, please? Okay, we'll start with proponents. [LB239]

MARGARET KOHL: Chairman Gloor, members of the committee, I'm Margaret Kohl. I'm Senator Gloor's legislative aide. My name is spelled M-a-r-g-a-r-e-t K-o-h-l. My job today before you is just to give you a little history on the efforts of patient-centered medical home in Nebraska. In about 2008-2009, the medical association started bringing in national speakers to start this discussion in Nebraska, and in 2009 Senator Gloor successfully passed LB396, which started the Medicaid Medical Home Pilot Program. That program ran for two years, over 2011 and '12. There was an advisory council of six primary care doctors, a hospital representative, and Senator Gloor. Over 50 staffers in HHS did their magic work in IT and details of the pilot program. I was included in two of those subcommittees that drew up the standards and evaluation documents for that pilot program. Two clinics were selected, Plum Creek in Lexington and Kearney Clinic in Kearney. They had an average of 7,300 patients a month during the two years of the pilot program. To make the transformation, Medicaid agreed to pay for some up-front costs, and this is what they were. There was a fee, called a per member/per month fee, which means for every Medicaid patient these two clinics had they received a certain amount of money. And in the pilot program, as they started out, the fee was low; and then, as they started reaching goals and making the transformation, that amount was ramped up. Medicaid also paid for a care coordinator, which is usually a nurse in the clinic that helps do a lot of coordination, and Dr. Miller will tell you what their experience was with the care coordinator. They also paid for a contract with a company called TransforMED to help the doctors and offices make this transformation because they had to do and absolutely define of how they treat a patient from the minute they walk in the door until they're gone. They had to do all kinds of administrative procedures. They had to do population management they weren't used to, which is gathering a lot of data and identifying certain diseases and making sure that all those patients are treated the way they should be as far as in compliance with treatment. There were some electronic health records. The disease registry component was paid for by Medicaid. And now they're in the evaluation phase. We're still waiting on some claims to come in to do the formal evaluation. Those fees, or all those things that Medicaid paid for over that two-year program, came up to over $730,000, so that gives you an idea of how expensive it is for the physicians' offices to make this transformation. The results aren't officially in, but Nebraska Medicaid was impressed enough that they are moving ahead with patient-centered medical home through their managed care contracts. Each managed care company has to provide at least two patient-centered medical home pilots a year. So there's three companies, that's at least six pilots a year and, in fact, it looks like there's probably going to be more than that. The healthcare professionals across Nebraska have begun getting certified through the national organizations like the National Commission on Quality Assurance or the Joint Commission, so they're getting certified as patient-centered medical homes. At the national level, Medicare has a national pilot program that started out with 8 states, went to 16. Now they take any state that has a multipayer patient-centered medical home into their Medicaid contract.

Locally, we've continued the work through LR513, which was Senator Wightman's resolution. The doctors and insurance companies and hospitals, other people around the table, are agreeing on adult clinical measures, pediatric clinical measures. We're working on obstetrical. Then we get to the tougher pieces, which comes into antitrust issues, common reimbursement structure, and how do we implement all this statewide. It's sort of puzzle pieces that we're trying to fit together. I saw the grant opportunity through the National Academy of State Health Policy, and we have been granted that award. It's just getting started, so I don't have a lot of information on that yet. But we're hoping that will help guide us through some of these rough waters here. One comment on the fiscal note: After Senator Gloor talked to the Department of Insurance and Roger Keetle and I talked to the Department of Insurance, they found out that a lot of the work that our resolution study group has already been doing, they thought they were going to have to start from scratch and do all that work. Well, they agreed that if this bill moves forward in some fashion, amended, that we would take another look at that fiscal note because a lot of the work has already been done. In general, LB239 is moving in the right direction, which is service delivery reform and patient-centered medical home. Do you have any questions? [LB239]

SENATOR GLOOR: Are there any questions for Ms. Kohl? Senator Pirsch. [LB239]

SENATOR PIRSCH: Is there a way...you had mentioned, you know, Chairman Gloor had been, I guess, first involved legislatively with that Medicaid pilot, right, in Lexington and Kearney. Do we...have we analyzed? Do we have results back and crunched numbers to gage effectiveness now? I mean, I'm assuming we do, but... [LB239]

MARGARET KOHL: We're in that process. They took some data and made a baseline, and then each quarter they gathered that same information. [LB239]

SENATOR PIRSCH: Um-hum. [LB239]

MARGARET KOHL: And at the end of the pilot program they have to wait a certain amount of time to make sure all the claims are in, then they'll crunch all that data and give us a report. [LB239]

SENATOR PIRSCH: How long was the pilot program in existence for the Medicaid? [LB239]

MARGARET KOHL: Two years. [LB239]

SENATOR PIRSCH: Two years. And the way it was structured, I take it that was by design. The two year was...was that a federally type of design? [LB239]

MARGARET KOHL: No. The other pilot programs in other states that we had watched,

or the complete statewide programs,... [LB239]

SENATOR PIRSCH: Um-hum. [LB239]

MARGARET KOHL: ...it takes a while for the cost savings to show up, and a two-year stretch seemed like a minimum to start showing those cost savings. [LB239]

SENATOR PIRSCH: Right. [LB239]

MARGARET KOHL: So that's why we picked that time frame. [LB239]

SENATOR PIRSCH: Right, and that was my question. Is two years enough for you to start seeing, in the major trends, like, you know, the low-hanging fruit, maybe obesity and things like that? [LB239]

MARGARET KOHL: Exactly. It's... [LB239]

SENATOR PIRSCH: I wonder if two years was enough time to...I mean, is...has it ended formally now? [LB239]

MARGARET KOHL: It has formally ended. [LB239]

SENATOR PIRSCH: So we...and so those particular patients are not...they're not carrying forward...nobody is voluntarily carrying forward with that structure, are they? Or can we continue to glean? [LB239]

MARGARET KOHL: Actually, the two pilot programs are carrying forward with that at their own cost at this point. [LB239]

SENATOR PIRSCH: They are, okay, so we will be able to, even though we're not paying for it, reap the benefits of that...of the knowledge that that will give us in terms of... [LB239]

MARGARET KOHL: Yes, and... [LB239]

SENATOR PIRSCH: Okay, wonderful. That's wonderful, Ms... [LB239]

MARGARET KOHL: And may I elaborate a little bit more? [LB239]

SENATOR PIRSCH: Sure, you bet. [LB239]

MARGARET KOHL: Dr. Miller has put together some information. They've kind of recorded what it took for their practice to make this transformation. [LB239]

SENATOR PIRSCH: Um-hum. [LB239]

MARGARET KOHL: And they're helping other practices in the state through a learning collaborative effort. [LB239]

SENATOR PIRSCH: Um-hum. [LB239]

MARGARET KOHL: And when they transform the physician's office, it...they make the total transformation. They didn't just treat Medicaid patients through the patient-centered medical home model. [LB239]

SENATOR PIRSCH: Um-hum. [LB239]

MARGARET KOHL: They treat all patients through the patient-centered medical home model, so the Medicaid patients weren't the only ones who received the benefit from what they did. [LB239]

SENATOR PIRSCH: So we're going to be able to reap or harvest some good information as time goes on, hopefully, in the... [LB239]

MARGARET KOHL: Well, whether we can actually pinpoint it with data or not might be a trick yet, but we're hoping that the data certainly backs it up. It certainly does from other states. Many other states have something similar to a patient-centered medical home, or another acronym you'll hear is ACO, accountable care organization. [LB239]

SENATOR PIRSCH: Um-hum. [LB239]

MARGARET KOHL: They all work similar. [LB239]

SENATOR PIRSCH: And do we have a pretty good feeling from the ACO? Have there been long-term studies of ACOs in other states where we've garnered a long enough period of time where we said, there's clearly...not just is it a better outcome for patients, but clearly, in terms of cost savings for the state, that that's been experienced in other jurisdictions clearly in document? [LB239]

MARGARET KOHL: Yes. I could provide you with an entire notebook full of documentation in that way. [LB239]

SENATOR PIRSCH: Wonderful. [LB239]

MARGARET KOHL: About the longest time period, I think, that one of the states has done this on a statewide basis is ten years at this point. [LB239]

SENATOR PIRSCH: Okay, thank you. [LB239]

SENATOR GLOOR: Yes, Senator Crawford. [LB239]

SENATOR CRAWFORD: Thank you, Senator Gloor, and thank you. And thank you also for all your work on the committee and for your work in identifying the grant. I wonder if you would just clarify the purpose of the grant that you were discussing in relation to this bill? [LB239]

MARGARET KOHL: It's all technical assistance, basically. [LB239]

SENATOR CRAWFORD: Okay. [LB239]

MARGARET KOHL: So they're going to help us gather information from other states on how those states have handled this piece or that piece and see if we can make it fit in Nebraska. [LB239]

SENATOR CRAWFORD: Uh-huh. [LB239]

MARGARET KOHL: I'm hoping we can get some legal guidance through the antitrust issues. [LB239]

SENATOR CRAWFORD: Okay. [LB239]

MARGARET KOHL: There's just a lot of information sharing that can go on, and we can glean the pieces that we can fit in Nebraska from those other states. [LB239]

SENATOR CRAWFORD: Excellent. Thank you so much. [LB239]

MARGARET KOHL: You're welcome. [LB239]

SENATOR GLOOR: Senator Howard. [LB239]

SENATOR HOWARD: Thank you, Margaret, for your testimony. This is really helpful, actually, in understanding this issue. You mentioned Joint Commission and NCQA. Did our pilot follow their certification measures? [LB239]

MARGARET KOHL: No, actually, we created our own. But how we did that I can exactly tell you because I was really heavy in that subcommittee. We actually took the NCQA measures and some other measures from other states and meshed them to what we thought would work for Nebraska. So we set up a two-tiered system. The first tier has...was the lower threshold, and then there were higher tiers where you were doing

more quality improvement and more follow-up with your patients and bringing in public health or outside education for diabetes, or whatever the case may be, that your patients needed. Those are all in the higher tiers and would be reimbursed in the higher tier. [LB239]

SENATOR HOWARD: And then were both of these clinics...did they both use the EHR? [LB239]

AUDIENCE MEMBER: No. No. [LB239]

MARGARET KOHL: Plum Creek already had theirs in place. Kearney is just getting their EHR up and running, actually. That's why Medicaid had to help them with a disease registry, because they got an outside vendor to help them with the disease registry until they could get their medical records electronic. [LB239]

SENATOR HOWARD: And then they both implemented this, the PCMH model, for the entire clinic. So they didn't have a base or they didn't have, sort of, a control group of patients. They implemented it for all of their patients? [LB239]

MARGARET KOHL: Medicaid used...built that baseline. They took the patients that they attributed to those clinics and then looked back a year at the expenses for certain things and used that as a baseline. [LB239]

SENATOR HOWARD: Okay, that's great. Thank you. [LB239]

MARGARET KOHL: You're welcome. [LB239]

SENATOR GLOOR: Seeing no further questions, thank you, Margaret. [LB239]

MARGARET KOHL: Thank you. [LB239]

SENATOR GLOOR: Next proponent, please. Welcome, Dr. Miller. [LB239]

JOE MILLER: I'm Joe Miller, M-i-l-l-e-r, from Lexington. Senators, thank you for allowing me to give you some time here of what's happened over the last, actually longer than, two years. The pilot project just ended April...or February 1...or January 31, and that's why we don't have all those numbers yet. But this has been an ongoing passion of mine over the last several years. We have gone through a two-year transformation. That included taking a clinic and, as my care coordinator said, tearing down everything, "relooking" at all work flow and how...patient flow and trying to redesign that so that it was really patient centered, not physician centered, not front-desk centered, not nurse centered, but patient centered, and trying to go through those things that Senator Wightman talked about--access, coordination of care, comprehensive care--and

directing that in such a way to make sure that patients were getting the best care that they could in an evidence-based way and at the same time trying to control costs. Some of the things that we have instituted are looking at patient flow and rooming procedures so that...every morning I sit down and look at my patient list, go through what are the things that I want to accomplish with each of these patients as they come in, what are the things that need to be done. Whether they are coming in for those or not, what are their healthcare needs that maybe haven't been met? We have become involved with an ACO as of January 1, which has 33 quality measures, and we're looking at each of those. We're looking at fall risk assessments. We're looking at depression scales. Along with the simple things that we take for granted is mammograms and flu shots and pneumonia shots and looking at blood pressures and those things. We look at each of those patients and we have a...I have a meeting with my team, which includes a physician assistant and my nurses, and we figure out what everybody needs so that when that patient comes in, if they need lab, instead of waiting for me to see them, they go directly to the lab and get their lab drawn. And while the nurse is getting them ready, the lab is being done, and then I can go in. And by the time I'm to a point through the interview, I will have their lab back and can give that to them. It just saves them time and is more looking after what is good for the patient. We also have protocols as far as refills and things that are done in the office. If a patient comes in as a diabetic and has not had a urine for protein over the last year, we...the nurses know that they can do that right away and not have to even get that from me because that needs to be done. And so we work as a team to make sure that everything is covered, not just the things that I think of, but the things that they know are important. Care coordination is probably the biggest component to this that really has changed things. We had to look...that was a new position. We went out and hired a lady who had been part time in our office, but her triplets had gotten into school so now was a little bit more available for full time. And we have trained her. We've gone through...she helped develop her position. She's a go-getter. But we also sent her to an on-line course through Johns Hopkins that got her certified in care coordination. She is an LPN, but what she has been able to do has really made huge differences. Every patient that is discharged from our hospital she goes through the...and makes sure that they have an appointment coming up. She makes, for our practice, any of our patients, makes sure they have an appointment coming up, make sure that we reconcile all the meds that they had when they were discharged from the hospital, makes sure that any labs or other tests that needed to be done are scheduled and done, and follows up and makes sure that happens. Every emergency room patient that comes into our emergency room that's one of our patients she follows up with, again, making sure that they have a follow-up appointment, making sure that they have their meds reconciled. Med reconciliation is huge all the way across the gamut, whether it's dealing with other facilities--and I have a story later that I'll tell you about--but the med reconciliation is important so that when the patient comes in we know exactly what they should be taking, not necessarily what they are taking, but what they should be taking, and hopefully they can tell us what they are taking. She also has developed an asthma protocol, which has been that we've worked together with...she

and I to put together that...some of the asthma consultants, say, for a primary care office is the best protocol that they have across the state that they have seen, trying to keep people out of the emergency room, trying to keep hospitalizations down for asthma, which is one of the big things for our kids. It was brought up the transformation was not just for Medicaid patients. This was for our whole practice, from prenatal to...and I have two patients over 100 years of age, at least in my own practice. And so we look at that all the way across the gamut. In doing that, I'm going to tell you two stories. One is about a pediatric patient, and one is about an elderly, nursing-home patient in which the care coordination really has made a difference. Chrystal noted that there was a young girl in...about four years of age that kept showing up in the emergency room. And they'd try to contact mother and couldn't ever get ahold of mom and finally did, and we got mom to come in. Mom was a Somalian mother, a single mom, had a...worked out at the Tyson plant in B shift. And in order to get care, she didn't have anybody to help her, so she would...this little girl would go from place to place, friend to friend, and end up getting asthma. She'd get...when mom comes home would be coughing and wheezing some of the time, and she'd end up in the emergency room. So Chrystal worked with her to, first of all, get her in and get her on appropriate medications in the office and not just coming into the emergency room and tried to teach her why we didn't want to do that. By the way, she was illiterate and couldn't read or write. We...she worked with getting her back into the school system. We have a preschool system set up through the school district that she had had to drop out of because she had missed so many days and worked with Tyson to get her on A shift so that she could get into...then would be in school during her shift and not have to be...float from place to place. We went in with the Health Department and checked out the home, thinking that that may be where the triggers were, but found out later that the triggers were actually in a couple of the different houses that she would go to, to be baby-sat. And once we've gotten her out of those environments and got mom on A shift and got her...she's not been in the emergency room, she's not been in the hospital, and we've controlled this little girl's asthma. We've gotten her back into an education system and taken away a lot of cost, but really made a huge impact in both the mother and the little child. The second story just happened not too long ago. It was an elderly woman that one of my partners had found a renal mass. She's in the nursing home, diabetic. And he knows her very well, has taken care of her for many years, sent her to a specialist in Kearney for consultation. Nothing was sent back to him, and she ended up getting the renal mass removed, was in a hospitalization, and the physician, for some reason, never called him. She was sent back to the nursing home. During the hospitalization she had had all her diabetic medicines discontinued. And when she was sent back to the nursing home, she was sent back without them. Well, it just so happened that the hospital happened to send a med list across the fax, and all of those go to Chrystal, our care coordinator. She noticed on there that the patient was supposed to have staples out of the wound, but no appointment had been made. So she went and talked to Dr. Kloch, and they all of a sudden figured out...he looked at the med list and he knew her very well, and says, wait, we need to get her back on her

diabetic medicines, we need to do this. And all this was done because of care coordination was there as a piece. I...they mentioned that we looked at what this costs, and a very low estimate of what it costs within our office over the last year is well over $200,000. As of February 1 we're not going to get any reimbursement for that from any payer right now. We have started in the ACO, which is a Medicare-based ACO that is going to be based on some shared savings at the end if we can prove that we can share some savings. But what this bill is about is we need to...healthcare needs to change. Unfortunately in the United States we've been doing disease care for the last aeons, and we need to move to healthcare. And we are the most expensive healthcare system in the world, and at the same time we are second from the last in outcomes in First World countries. We need to change that and we need to get a better system of delivery, and I really feel in the next five years that's going to happen. It's happening across other parts of the country, and we need to move forward with that. But in order to do that, somehow we need to get that paid for. My partners are saying, why do we want to keep doing this, we're not going to get paid anything extra? Because it's the right thing to do, and they're willing to do that, but I don't know that they're going to be willing to do that forever, nor are we going to be able to get the rest of primary care physicians to look at doing this also. So that's why we need a multipayer system, and there are places that do that. I know that a friend of mine that I've met is the...in New Jersey is getting 90 percent of his patients are on a per patient/per month payment system, and they're coordinating care. I've talked well over my five minutes. I'm sorry. (Laugh) I'll take questions. [LB239]

SENATOR GLOOR: Thank you, Dr. Miller. Are there questions for Dr. Miller? Senator Campbell. [LB239]

SENATOR CAMPBELL: Thank you, Senator Gloor. Dr. Miller, your friend that's getting reimbursed for that, could you describe under what system they're...are they through insurance companies or...? [LB239]

JOE MILLER: He is in New Jersey, and New Jersey is one of the few states that does have multipayer pilots. They have Medicaid. The Innovation Center with Medicare and Medicaid, New Jersey was one of the pilots for that; that just started within the last year. They're reimbursing Medicare patients somewhere between $8.00 and $40 per patient/per month, at an average of $20 per patient/per month on all of their Medicare patients. That's what they're getting reimbursed. They also are dealing with...the major insurers in New Jersey are all part of that, so that is...and that way he can put this whole system together. [LB239]

SENATOR CAMPBELL: Okay, thank you, Dr. Miller. [LB239]

JOE MILLER: Um-hum. [LB239]

SENATOR GLOOR: And, just by way of clarification, in that $20 per patient/per month is in addition to the fee schedule that they would have negotiated? [LB239]

JOE MILLER: In addition to fee for service, yes. And that's all based...that $8.00 to $40 is based on what their acuity of care and what their diagnoses are, put out by Medicare and Medicaid. They...that's adjusted depending on what their diagnoses are. [LB239]

SENATOR CAMPBELL: Thank you. [LB239]

SENATOR GLOOR: Senator Howard. [LB239]

SENATOR HOWARD: Thank you, Senator Gloor. Thank you for your testimony, Dr. Miller. Can you talk about the background of your care coordinator? Was she a nurse or a social worker? [LB239]

JOE MILLER: She was an LPN,... [LB239]

SENATOR HOWARD: Okay. [LB239]

JOE MILLER: ...had worked with us on and off--I shouldn't say on and off--part time and on and off for probably the last 15-plus years, during which time she had a set of triplets which took her out of the office for a while. And they're all in school now, and she has one older child, so she has four children. And so now she's able to come back and work with us full time. [LB239]

SENATOR HOWARD: And then who were the members of your team? [LB239]

JOE MILLER: The team is actually made up of the whole clinic. [LB239]

SENATOR HOWARD: Okay. [LB239]

JOE MILLER: But my own, personal pod: I have two nurses and a PA that I work with. But, you know, we coordinate things with Chrystal; we coordinate things with the front desk. You know, access is important, and one of the things that we have done at our office, we are now open 8:00 in the morning until 6:30 at night, and no stop for lunch hours, which used to be. And we're open on Saturday from 8:30 until 11:30 so that we do provide better access for our patients, trying to...you know, and again, we're there with Tyson; we're having...we have shift work. There's always a run on everything about 3:30/4:00, and what we've found is we needed to be open later so that we could take over some of that volume. [LB239]

SENATOR GLOOR: Senator Pirsch. [LB239]

SENATOR PIRSCH: Just a question I have and kind of the overall environment, worldwide. [LB239]

JOE MILLER: Um-hum. [LB239]

SENATOR PIRSCH: You had mentioned we do have the most expensive medical healthcare system in the world. [LB239]

JOE MILLER: Um-hum. [LB239]

SENATOR PIRSCH: Is that driven...I mean, do most other countries have more along the lines of the approach your suggesting and that's why they're lower, or is it just we have medical devices and etcetera that makes it... [LB239]

JOE MILLER: The studies have shown that, in the United States, primary care versus specialty care is about 75 percent specialty care and 25 percent primary care. If you look at almost all of the other First World countries, it's about a 50-50 balance. Every time you increase primary care and increase a primary care delivery system, the quality of that system goes up and the cost of that system goes down, and that's been shown over and over again internationally. Probably one of the biggest experts on that is Paul Grundy, who is in charge of healthcare for IBM internationally. And he says he would much rather have his patients in the Danish system than in the United States system. He has done a study at IBM. And if...he asked all his people, who is your physician, if they could give the name of a physician they were put in one group, and if they could not give a name of a physician they were put in another group. The group that they could name a physician--this is a not a patient-centered medical home or anything like that--had 27 percent fewer healthcare costs just because they had a physician. [LB239]

SENATOR PIRSCH: Um-hum. [LB239]

JOE MILLER: What we're trying to do is take that one step further with registries, doing population control, working at looking at some of the population things that we've done. It's, to me, has been amazing that...how we can...when we can finally measure things and follow those numbers and make a difference and looking at who are our patients that are outside of those parameters, getting them in, trying to get those things changed so that we can make those improvements. [LB239]

SENATOR PIRSCH: Wonderful. Thank you. [LB239]

SENATOR GLOOR: Senator Schumacher. [LB239]

SENATOR SCHUMACHER: Thank you, Chairman Gloor. You mentioned the Danish system. What distinguishes the Danish system from our system? What can we learn

from that if we try to... [LB239]

JOE MILLER: One of the biggest things is primary care. It's the hallmark of the system. The other thing that...and one of my good friends is...was born in Denmark. He's a businessman in Lexington, moved here when he was in college, met his wife, and moved here after they got married. He said, all of the specialists in Denmark are on salary, so there's no incentive to do extra procedures that maybe don't need to be done. His cousin happens to be the main hand specialist in all of Denmark. So if you cut your hand off, Soren is the guy who--and I've met Soren--is the guy who puts it back on. And they have cut their costs dramatically and have improved their healthcare. They're one of the...I think they're rated about fourth when you look at the healthcare delivery system, so. Yes. [LB239]

SENATOR SCHUMACHER: As we struggle with the Medicaid expansion issue and filling in the hole in the ACA, how can we apply that lesson to reduce our costs in whatever we try to build in? [LB239]

JOE MILLER: I think that if we can take patient-centered medical home across the state, which is my dream, to all primary care and at the same time utilize all the evidence-based things that we know, we can make huge differences in cost. If we can improve access...and one way is to take away first-dollar coverage to the ER, which is a huge problem because if you have first-dollar coverage and you don't have to worry about going into the ER, patients, whether they're on Medicaid or insurance or whatever, ah, my insurance will pay for it or Medicaid or pay for it. First-dollar coverage to the ER, you walk into the ER, at least in our ER, it's $700 to just walk in. By the time...and I'm sure in Omaha and Lincoln it's probably even greater than that. So trying to limit some of those things can really decrease cost. As we decrease hospitalizations and decrease readmissions, those are the big things, trying to give good coordinated care for our patients. [LB239]

SENATOR SCHUMACHER: Thank you for your testimony. [LB239]

SENATOR GLOOR: Senator Crawford. [LB239]

SENATOR CRAWFORD: Thank you, Senator Gloor. Do you happen to...you said you were still gathering information, so I don't know if you have any initial findings on rehospitalization and readmission to share with us. [LB239]

JOE MILLER: And I didn't bring those statistics. But I can tell you asthma was something that we were following, and we definitely had a decrease in both ER--I can't give you the exact figures--ER and admissions for our asthma patients because that was one of the programs that we put together. And that's a very small group of people, to be real honest with you, when we're looking at it. [LB239]

SENATOR CRAWFORD: Um-hum. [LB239]

JOE MILLER: But we were already seeing some changes in numbers in that first year of doing that because of the education and things we were doing. [LB239]

SENATOR CRAWFORD: Excellent. Thank you. [LB239]

SENATOR GLOOR: And I would go back to a question that Senator Pirsch brought up with Margaret Kohl, and that is there will be a report that goes back to the Legislature that's a roll-up of all this information. It was built into the legislation that established the pilot, so the Legislature, I think, by the end of the year will get a report that will then be passed on also to the Governor on the specific, quantitative, evaluative criteria. Other questions for Dr. Miller? Thank you, Dr. Miller,... [LB239]

JOE MILLER: Thank you, Senators. [LB239]

SENATOR GLOOR: ...for your commitment to the pilot project and to your patients. [LB239]

JOE MILLER: Thank you. [LB239]

SENATOR GLOOR: Next proponent, please. [LB239]

BOB RAUNER: (Exhibits 4 and 5) I'm Dr. Bob Rauner, B-o-b R-a-u-n-e-r. I'm a physician here in Lincoln, Nebraska. Basically, I've handed out two things to you. The longer one I'm guessing you wouldn't want to read the whole thing. It's only...it's about seven pages. What it is, essentially, is seven pages of successful pilots. This has been reproduced across the country over and over again. It's...some of those pilots are in the Air Force, the VA, Medicaid, Blue Cross, Humana. It's been working in every environment. If you set the program up correctly, every single time it improves care, keeps people out of the hospital, keeps people out of the emergency room. Key is set up correctly. Some folks try to set it up incorrectly by focusing only on one disease or only running it for one year or where the care coordinator is not employed by the clinic, but is actually on a remote phone or something like that or employed by the insurer. If you do it that way, it's designed to fail. And that's why I emphasize correctly, because if you don't do it that way and it's designed to fail, they'll complain, well, this doesn't work, we don't want to do it. And so it has to be done correctly. The other thing--and this is something that Joe mentioned a little bit--is you really can't do it for just one group of your patients. I'm part of an accountable care organization. We have nine clinics. We have...everybody has agreed, essentially, even though Medicare is the only one footing the bill right now, we're going to do it for everybody. If it's the right thing to do, we're going to try and make it work. Maybe that's just good intentions, but that's our attitude.

We have been working at this for, actually, five years now in Nebraska, trying to get to the point of having multipayer pilots. The second thing I gave you, actually, is the NMA core principles document. That started in 2008 from the Nebraska Academy of Family Physicians. We got all the primary care doctors to agree on it in 2009, and getting doctors to agree on anything is tough at times, as you may guess. But that's been our working document since 2009. We've been trying to work collaboratively with insurance companies for the last...three years after that was made to try and get a multipayer pilot, and we were unsuccessful. Now there are very good reasons why it was not successful, and, actually, other multipayer pilots across the country will say the same problems. There are two limitations for why it is difficult to make it a multipayer pilot. Number one is antitrust. It's hard to talk in a room and agree on anything without getting into antitrust issues. And it only takes one person in the room to complain, and suddenly everybody is in hot water. The second problem with medical home is it's an up-front investment with a long-term return. I mean, I think you asked earlier. Most plans show about two years. So if your insurance contract only goes for two years, you have two years of up-front costs. And year three, they may be with another plan, and now they reap the benefits. It makes no sense if you have less-than-two-year insurance contracts, and so I...my view is the reason we can't make progress is those two reasons: We have antitrust problems, and we have kind of "tragedy of the commons" problems. If only one person does it, they pay for it. Everybody else benefits, and so there's an incentive to freeload, essentially. In Joe's practice, I am...have no doubts whatsoever that that helped not just the Medicaid pilots. It helped them all, and so what we have to do now, I think, is get to the point where we can do this. And I think it's going to require some input from you guys, whether we like it or not. And it's just going to be needed because we have to get around the antitrust issues, and we have to get that critical mass problem. It's like in the old days of the railroads. They used to have two different widths tracks. That didn't make a lot of sense. They had to decide, okay, here's the width, otherwise, you're going to have two sets of locomotives, two sets of coal cars, two sets of everything. It's really expensive. From Joe's standpoint, if he's trying to run this and he's got different criteria for Blue Cross and different criteria for UHC and different for Medicaid, it drives up the cost, and if there's no payment like there is right now, it just even makes it worse. And so I'm convinced that we will probably need some type of legislation, but even, like Senator Wightman mentions, what we have now, it's a first draft. It's probably not adequate right now. We, ourself, have some issues with it. For example, the committee representation, some of the merit milestones maybe need some clarification. Maybe the antitrust needs to be fleshed out further. I'm not going to go into that, and please don't ask me, because we have a lawyer who understands it who is going to testify after me because I'm not a lawyer. So that's really the why here, why legislation. We're going to have to get something to get us over that antitrust and two-year hump, essentially. When we've brought great experts across the country, actually, and Paul...we had Paul Grundy from IBM. We had him here in 2008 to give a talk. We had Al Dobson from Community Care North Carolina, who is one of those pilots in there. In 2009 we had Chris Koller, who is the Rhode Island health insurance

commissioner. They pushed it from the health insurance commissioner side in Rhode Island. One of the Rhode Island pilots is in there. It's going to take some expertise. We're going to have the grant and technical support, but I think we're going to, at some point, require your assistance in some way to get rid of antitrust. Senator Crawford, you mentioned, where does the other people fit in this. One of the biggest challenges to this is, honestly, dealing with physician psychology, and I'm saying that as a physician. I'm like a marriage counselor to physicians right now. We are very independent people, as you may have noticed. We don't always work well in teams, and we have been trained to not work well in teams, and part of medical home is getting everybody to work well in teams. You have to have everybody involved--the nurse, the nurse practitioner, the physician's assistant, the front office, the care coordinator, and, yes, the patient. So all of these clinics, all nine of our clinics, have PAs, nurse practitioners, nurses, care coordinators that we're hiring. Everybody has to be involved. There's even studies now showing that there probably is a sweet spot, meaning, you don't want too many physicians, you don't want too many midlevels. There's probably a middle road where it's going to be best, and so it is definitely a team approach. So why do you say, is it physician led? Well, because you have to have some physicians in there. If somebody comes in...up with angioedema and no one has training to deal with it, you need the physician to handle that and preferably on site. So that's the team approach, so. And I'll kind of end it there to keep it brief. [LB239]

SENATOR GLOOR: And for the committee's...for clarification for the committee so you can keep track of the players, Dr. Miller was part of...his clinic was one of the pilots. Dr. Rauner is part of the working group that's been working, as a result of the resolution, through the summer months specifically on the multipayer approach towards this, so...and he obviously has been an advocate for patient-centered home for quite some time with other agencies and organizations. Questions? Senator Campbell. [LB239]

SENATOR CAMPBELL: Thank you, Senator Gloor. Dr. Rauner, do you think, as we go forward in the future, it will be...help that we have managed care of Medicaid all across the state? [LB239]

BOB RAUNER: (Laugh) If it's done right, yes. I think managed care has been a misused term in the past. Some people say, what's the difference between managed care and medical home? Well, as managed care was originally intended to be, that probably would have been the medical home. But it got kind of diverted, and it was only the insurance side and only, you know, the care coordinator on the end of the telephone with no cooperation amongst the physicians. [LB239]

SENATOR CAMPBELL: Right. Got it. [LB239]

BOB RAUNER: What medical home does is it puts people on the same...it aligns the interests, essentially. The care coordination, they've actually done dozens of studies on

this, that when you do care coordination over the phone it does not work. But when the care coordinator is in the clinic--you know, Chrystal has to be down the hall from Joe and say, hey, Joe, I've got this patient--patients listen to people they know. They don't listen to a random nurse calling on the telephone from a call center in New Jersey, and that's one of the big things that has to change. And the problem with the HMO world is they just didn't cooperate with physicians. We used to get things. For the last 15 years I'd get this report from an insurance company, here's your quality metrics. And I'd pull out the report and I'd say, I don't even know who half these patients are. That wasn't very helpful, and that's part of our issue. Also, there was the short-term management of costs where they found if we cut, you know, asthma medicines we can save money this next six months. Great, our quarterly bonus went up. But then, a year later, now our ER went up, and I think that's part of why we've hit our spiral with healthcare costs in the United States. [LB239]

SENATOR CAMPBELL: Right. [LB239]

BOB RAUNER: We've taken short-term management of costs and that gave somebody a quarterly bonus, but now we've got all these other people in the ER. [LB239]

SENATOR CAMPBELL: Right. We just don't have that long-term investment. [LB239]

BOB RAUNER: Um-hum. [LB239]

SENATOR CAMPBELL: But I think it's something that we need to watch, at least we are watching it in the Health and Human Services Committee, obviously. Somehow I feel like I'm almost back in the Health and Human Services Committee today. (Laughter) [LB239]

BOB RAUNER: Um-hum. [LB239]

SENATOR CAMPBELL: The second is really kind of an unabashed commercial here. Senator Gloor and I have worked on a resolution that hopefully will get to the Legislature to look at. But it is to try to bring healthcare providers, and if you think you are one you can be at the table,... [LB239]

BOB RAUNER: Um-hum. [LB239]

SENATOR CAMPBELL: ...to really look at what do we need to do in the state of Nebraska to be innovative, creative? [LB239]

BOB RAUNER: Um-hum. [LB239]

SENATOR CAMPBELL: How can we come together to start looking at what we need in

three and five and ten years down the line? And a lot of people are excited about this possibility to bring people together because we're looking for innovative ideas. It would seem to me that we certainly have a classic example here with the medical home pilots and what you've achieved so far. [LB239]

BOB RAUNER: Yeah, yeah. [LB239]

SENATOR CAMPBELL: And so we certainly would hope to get you involved, I know, as Senator Gloor and I continue to talk about this. [LB239]

BOB RAUNER: Um-hum. Yeah, I mean, I would say we'd love to. I went back and got a master's in public health partially to study that issue because other countries, and actually even some other state pilots, have things figured out. [LB239]

SENATOR CAMPBELL: Right. [LB239]

BOB RAUNER: We can make it work for Nebraska, and it doesn't have to be government. There are private...like Switzerland has an almost all-private model. It works great, but it's done right. And I'm hoping we can use our Medicaid expansion as a bridge for a couple of years to get to that. [LB239]

SENATOR CAMPBELL: We absolutely have to have the private sector along with the public sector sitting down. [LB239]

BOB RAUNER: Um-hum. [LB239]

SENATOR CAMPBELL: And we have a lot of creative people in the state who are doing wonderful things, but sometimes we don't bring them all together and collectivize all of that energy and innovation. [LB239]

BOB RAUNER: Um-hum, yeah. [LB239]

SENATOR CAMPBELL: So thank you for your work. [LB239]

BOB RAUNER: Yes, okay. [LB239]

SENATOR GLOOR: Other questions? Senator Crawford. [LB239]

SENATOR CRAWFORD: Thank you, Senator Gloor. Would you just expand on that last comment that you made about using Medicaid expansion as a bridge for a period? [LB239]

BOB RAUNER: Um-hum. Well, I think something has to be done now. We've got a lot of

people who do not get care. You know, I...at my prior job--I used work at the residency program here--we took care of half the Medicaid in Lincoln. And I saw people all the time, and it just broke your heart. You'd have a young woman with three kids, going the nursing school, she's got no health insurance. She needs something, you know. There's people like, yeah, a lot of these people are on welfare. There's people that are working poor that need help. Something has to be done for them in the interim. It's going to take us three to five years to set this up. We can't just ignore them for three to five years, and so I think we need to use something. And since it's 100 percent, I guess, sort of, kind of free the first three years, let's at least use that to get a bridge to that point because right now there are people who do die from lack of care. We have...we can't keep them waiting for five more years. I do think there are huge issues with long-term sustainability with Medicaid expansion. Those have to be addressed, but it's going to take us a while. And I just hope we would do something for those people who are stuck right now, and I don't seen anything else other than that right now that would help those people, so. [LB239]

SENATOR CRAWFORD: And would you argue that the medical home model is a key strategy for addressing that long-term sustainability question? [LB239]

BOB RAUNER: Yes. I mean, the...why...I first got started in this because of Community Care of North Carolina's programs. And if you look in there, they started in 2000, and they've been saving money in Medicaid. And if you can squeeze blood out of that turnip, you've got something that works. And Al Dobson, who is a family physician, who is their Medicaid director, we brought him here to try and figure out--Al, you tell us how this works, let's try and do it. And we actually used some of those ideas for this 2009 bill. It can work, but you've got to do it right. And it can work even in Medicaid, and, you know,... [LB239]

SENATOR CRAWFORD: Thank you. [LB239]

SENATOR GLOOR: Seeing no further questions, thank you, Dr. Rauner. Again, thank you for your commitment to this and to your patients. Good afternoon. [LB239]

ANN FROHMAN: Good afternoon, Mr. Chairman, members of the Banking, Commerce and Insurance Committee. My name is Ann Frohman. For the record, that's spelled A-n-n F-r-o-h-m-a-n. I'm an attorney and a registered lobbyist for the Nebraska Medical Association. I'm here today to testify in support of LB239. In addition to the testimony that you've just heard from the physicians, I also want to speak to not simply the delivery reform measures, but also the payment reform aspects of this. There seem to be a couple of challenges in getting there, as I understand the project taking off a few years ago, and one area was dealing with the antitrust piece. And coming from the insurance department and working in the world of overseeing rates and rating issues, antitrust issues were not uncommon with respect to, you know, navigating through

those. And in this instance I think we have large issues because you're dealing with not just the insurance sector, but with the providers, the hospitals, the physician community, so you have a number of sectors that we're trying to merge to get to a new model. And in doing that, this bill, I think, goes a long way to advance the idea of providing for sufficient cover, if you will, to allow for the dialogue to move forward. It would have been grand had this been enacted four years ago. But knowing where we've been going with small steps, moving from Medicaid, now Medicare, it is the time for the private sector. This is going to happen, in my opinion, in the marketplace. It's just a matter of when. And to get there, the recognition in here of having a government official involved in the supervision, I would assume, looking at it, that it's...it meets the active supervision test. You know, these are some things I'm not all that familiar with and would recommend that, you know, the Attorney General's Office perhaps look at what it takes to be active. But knowing that, you have a government official in the executive branch engaged on the issues is a good thing. The challenge with that, though, is having a government official involved for the purposes of resolving antitrust issues can be challenging because you're overseeing both the integration on delivery as well as payment reform. And so when you pull in...and the bill recommends the Director of Insurance. You have, you know, expertise as well on the payment side, in terms of the insurance carrier involvement, but what you lack is the ability of really appreciating, perhaps, the challenges for the physicians in the change in the models and what they have in terms of trying to meet. So I recognize that what we don't have in Nebraska that I've seen in other states is you have a healthcare reform czar or somebody that initiates kind of a balanced approach, who can look at it from the perspective of both sectors and integration. Now I'm guessing that those folks that have both sides of that equation are hard to come by. But with that said, it does make sense to me that you would need someone in the executive branch somewhere, heavily engaged. I noted that administrative support provided by the insurance department, perhaps that is where, if you needed to beef up active supervision, maybe legal support or something or someone with a skill set of substance could participate. And there are issues, we recognize, on how you fine-tune your advisory committee, and you've been working on a lot of that. So with that said, we recognize that perhaps it's a start of a chassis to build something that I think would be fruitful in the long run, and the antitrust piece in it is one that we think is necessary to get going and get deeper into the discussions. Any questions? [LB239]

SENATOR GLOOR: Thank you, Ann. Any questions? Yes, Senator Schumacher. [LB239]

SENATOR SCHUMACHER: Thank you, Senator Gloor, and thank you for your testimony today. You mentioned, as did prior testifiers, antitrust issues. Are these federal or state antitrust issues? [LB239]

ANN FROHMAN: The feds will defer to the state as long as...I'm looking at federal,

overall arching, because they will defer, under the Sherman Act, to the states. And if the states are actively managing antitrust issues, they will stand down. So that's the perspective I'm coming from, not from separate specific state antitrust laws. [LB239]

SENATOR SCHUMACHER: So it's the Sherman Act that is the issue, not Clayton, not the Fair Trade Act, not those things. It's the Sherman Act. [LB239]

ANN FROHMAN: Right. [LB239]

SENATOR SCHUMACHER: And administratively, the Department of Justice will not use its authority under Sherman if the state is doing something? [LB239]

ANN FROHMAN: Correct. [LB239]

SENATOR SCHUMACHER: And what is it that we are doing or not doing that is creating your problem? [LB239]

ANN FROHMAN: We are moving to discussions of, I want to call it, in a generic sense, shared...a model of payment where we eventually move into a shared savings concept. There were discussions earlier whether that's per member/per month or a true ACO model, like under Medicare, so it's changing the pure fee-for-service model, in essence. [LB239]

SENATOR SCHUMACHER: Has DOJ issued any guidelines as to when it will stand down on Sherman or when it won't? I mean, are we... [LB239]

ANN FROHMAN: There are supposed to be, I believe, a bulletin issued by the DOJ dealing with issues arising under the Affordable Care Act. I haven't read those, per se. I think they will overlap and provide guidance in this instance, but I don't know if they've issued them. That's... [LB239]

SENATOR GLOOR: I don't think they have yet. [LB239]

ANN FROHMAN: I don't... [LB239]

SENATOR SCHUMACHER: Now Nebraska has its own flavor of antitrust law and fair trade legislation. Do we need to make any changes in that to accommodate this? [LB239]

ANN FROHMAN: I don't believe we do, but I would have to defer to others on that. [LB239]

SENATOR SCHUMACHER: I notice in the legislation, when they define "health insurer,"

it means an entity whose share of the market is in the top three health insurers. Does that strike you as being problematic to define it that way? [LB239]

ANN FROHMAN: Yes, it does. I would see constitutional issues with, perhaps, equal protection if there isn't a, you know, a basis that can be explained and justified to meet the threshold test there. I'm not sure. Knowing Nebraska's market, that captures, oh, maybe 80-some-higher percent. Maybe that's the rationale for it, and the smaller carriers aren't going to have an impact anyway. So I'm thinking that's where it comes from. [LB239]

SENATOR SCHUMACHER: Well, you know, our constitution, as is...if we defer to constitutions these days, has pretty stringent language about special classes and about special legislation. So it would seem to me that, at the very minimum, if this moves forward, that that's a critical definition in here and that we have some other way, other than saying the top three, that we have some criteria we can say, okay, you fall within this category of insurer that's covered by this and...or you don't. [LB239]

ANN FROHMAN: I think it could be drafted in a way that gets around the challenge, yes, but perhaps those carriers constituting 80 percent of the market, you're not...I don't think it is one that you couldn't work around. [LB239]

SENATOR SCHUMACHER: Would you agree that we probably, before advancing this bill, need to tackle that subject? [LB239]

ANN FROHMAN: I would think so, yeah, good idea. [LB239]

SENATOR SCHUMACHER: Thank you. [LB239]

SENATOR GLOOR: Other questions? Thank you. Appreciate it, Ann. Other proponents. Any opponents? Anyone in a neutral capacity? [LB239]

DAVE McBRIDE: Good afternoon, Senator Gloor and members of the committee. My name is Dave McBride, D-a-v-e M-c-B-r-i-d-e. I'm appearing on behalf of Nebraska Optometric Association and our member doctors of optometry across the state, many of whom are primary care providers, at least in terms of...as it relates to vision health. We appreciate Senator Wightman being a champion of this issue and, Senator Gloor, your leadership on this. We certainly are interested in the concept of medical homes, agree that it's a coming trend and the marketplace is definitely going in that direction. We obviously see the benefits of this, and so we see merits in the bill. The only reason that we're not here in direct support of the bill, of this specific bill, really has to do with the fact that there are too many questions for us at this point about how non-M.D. providers may plug into the medical home as the model moves forward, and that leads to, sort of, the point of this testimony. We want to make sure that, as the discussion of the medical

home and the advancement of medical homes throughout the state moves forward, that non-M.D. providers, like doctors of optometry, are part of the solution and part of the process here. There certainly have been concerns for our profession and some others in terms of PPOs, HMOs, other models that involve physician-directed care, having to do with the potential that non-M.D. provider groups could get excluded, whether intentionally or unintentionally. We're not anticipating that that's going to be the case, particularly with medical homes, but anything that references physician-directed care, that's where it's of real interest to us. And so our specific interest in LB239 really has to do with section 4, dealing with the composition of this advisory committee. Since the committee is charged in this bill with providing direction and advice on all matters relating to proposed rules and regulations, development of standards, development of payment mechanisms, we would suggest that perhaps having a representative, at least, on this committee of a non-M.D. provider group would be appropriate and helpful in order to make sure that the rules, the standards, the policies, etcetera, as they are advanced provide for the best possible interface for various other provider groups into the medical homes. So, as I say, that's really our interest in this as the bill is...as you continue to consider the bill. And, assuming it moves forward, we would certainly or simply ask for your consideration in trying to address, some way, the issue of making sure that there is other provider perspective included in the discussion of this so that we can all be part of the solution. And with that, I'll take any questions you might have. [LB239]

SENATOR GLOOR: Thank you. Any questions for Mr. McBride? Seeing none, thank you, Dave. [LB239]

DAVE McBRIDE: Um-hum. [LB239]

SENATOR GLOOR: Next neutral. Good afternoon. [LB239]

LaDONNA HART: (Exhibits 6 and 7) Okay. Good afternoon, Senator Gloor, members of the Banking, Commerce and Insurance Committee. My name is LaDonna Hart, spelled L-a-D-o-n-n-a H-a-r-t, and I'm a family nurse practitioner from Lincoln. I've been in practice for about 15 years. I am a licensed primary care provider. I'm here on behalf of the Nebraska Nurse Practitioner Association and on the behalf of its greater-than-500 members. I'm here to offer neutral testimony on LB239. It's NNP's position that we support the concept of patient-centered care, medical care, medical home, outlined in LB239, but would like to share our concerns that this bill narrowly defines the practitioners involved in leading the medical home. For this reason we request that the committee consider adding a provision to allow nurse practitioner-led medical home practices teams and that NPs are listed as primary care providers in this bill. We also request a position on the Medical Home Advisory Board and reimbursement consistent to that of our interdisciplinary colleagues. It is the position of the American Academy of Nurse Practitioners and the NNP that any proposed legislation, regulation, or

demonstration projects that addressed patient-centered medical homes and primary care be based on the Institute of Medicine's definition of primary care, which is a provision of integrated, accessible healthcare services by clinicians who are accountable for addressing a large majority of personal care needs, developing a sustained partnership with patients, and practicing in the context of family and community. One such provider is a nurse practitioner. This is the essence of nursing. This is what we have done, what we do. We have been doing this since Florence Nightingale. I won't go through the other provisions of the IOM's recommendations for a medical home, but I did list them there. Nurse practitioners provide high-quality care, and we have it documented over nearly 50 years of good research, evidence based, that we provide at least as good as care as our colleagues in medicine. The nurse practitioners meet the National Committee of Quality Assurance standards in medical homes, meeting personal providers, care that is coordinated by a provider that is whole-person oriented, coordinated, integrated, of high quality, and will enhance access. Care teams already do form, without regulation. The needs of the patient should determine the composition and the structure of the care team at the point of care. Team-based care is multidisciplinary. It is nonhierarchal. It is collaboration among various professionals, centered on the patient's needs, and should not be thought of as a physician-led collaborative. In the landmark report by, "The Future of Nursing: Leading Change, Advancing Health," the Institute of Medicine wrote that nurses, "are poised to help bridge the gap between coverage of access, to coordinate increasing complex care for a wide range of patients, to fulfill the potential of primary care providers to full extent of their education, training, and to enable the full economic value of their contributions across practice settings be realized." It is true that Nebraska is confronted, like most of the country dealing with our healthcare, as very nicely outlined by both Dr. Rauner and by Dr. Miller...we are part of that team, and we are part of the solution. We are going to have to think about healthcare in a very different way, and that includes the way that we think about primary care, that it encompass all of us, it will take all of us to make this better. And just...I did want to comment on Dr. Miller's...that he has a nurse coordinating his care. Nursing programs and advanced practice nursing programs across the country have didactic, and we are trained in the coordination of patient care. And we have been doing this throughout our practices as advanced-practice nurses. I am certainly willing to answer any questions that I might be able to. Thank you for allowing me to testify, and thank you for Dr. (sic--Senator) Wightman for introducing this legislation. [LB239]

SENATOR GLOOR: Thank you, Ms. Hart. Are there any questions of her? Thank you for your testimony. [LB239]

LaDONNA HART: Thank you. [LB239]

SENATOR GLOOR: Next person who would like to speak in a neutral capacity. Good afternoon, Mr. Director. [LB239]

BRUCE RAMGE: (Exhibit 8) Good afternoon. Good afternoon, Senator Gloor and members of the Banking, Commerce and Insurance Committee. My name is Bruce Ramge. For the record, that's spelled B-r-u-c-e R-a-m-g-e. I'm the Director of Insurance, and I'm here to testify in a neutral capacity regarding LB239. LB239, as introduced, assigns the department important responsibilities in coordinating the development of the patient-centered medical home concept for Nebraska. This concept would restructure the delivery of healthcare services to Nebraskans and potentially provide greater coordination of the efforts of healthcare providers for healthcare and healthcare costs. We do have some concerns with the time lines and the duties and responsibilities of the department in the legislation. As an example, while we have considerable experience with the regulation of insurer payments, we have little experience in regulating the practice of medicine. Our uncertainties on the responsibilities are reflected in the consulting fees expressed in the fiscal note. With that said, we have discussed the bill with the introducer's staff, and we continue to learn more about the scope and intent of the legislation. We look forward to working with Senator Wightman and the committee as discussions continue on this idea and legislation. So thank you for your time. [LB239]

SENATOR GLOOR: Thank you. Any questions for Mr. Ramge? Seeing none, thank you for taking the time to come over. [LB239]

BRUCE RAMGE: Thank you. [LB239]

GALEN ULLSTROM: Chairman Gloor, members of the Banking, Commerce and Insurance Committee, my name is Galen Ullstrom, that's G-a-l-e-n U-l-l-s-t-r-o-m. I'm senior vice president and a registered lobbyist for Mutual of Omaha Insurance Company, appearing today in a neutral capacity on LB239. The only section, frankly, that I have any interest in is section 9 on the bottom of page 6, and that's the section that mandates that any group sickness and accident insurance policy offered or renewed in this state must provide coverage for the patient-centered medical home care. The definition of sickness and accidents under Nebraska insurance law is very broad. Section 44-709 really applies that to any policy covering sickness or accident. There is an attempt to provide some exclusions for short-term medical, specified disease, or limited benefit coverages, and that's language, frankly, that has been used in Nebraska statutes in the past. But I think, because of the work that's been done more recently, it probably should be better defined as to what is excluded. There's a lot of work on the federal side, starting with the Health Insurance Portability and Accountability Act, HIPAA, and also with ACA that brings in more what they consider accepted benefits, which are more the term now. And so certainly I note that this committee is going to be doing more work on it. I would certainly be glad to work with staff on this committee and also Senator Wightman's office to try to maybe get a better definition that not only can be used here, but you'll have future...you'll have other legislation coming before you dealing with other mandated benefits that it probably could provide better, clearer definition of what policies should not be included, like

disability income, for example, which is not specifically referenced. We've probably, over the years, treated it as other limited benefit coverage, but I'm not sure it shouldn't be specifically excluded. So that's my comments. Thank you, Senator Gloor. [LB239]

SENATOR GLOOR: Good points. Any questions? Senator Carlson. [LB239]

SENATOR CARLSON: Thank you, Senator Gloor. Galen, this is an opportunity to go back to another bill. [LB239]

GALEN ULLSTROM: Okay. [LB239]

SENATOR CARLSON: How would your company handle the concern about overinsurance and midpay in an automobile policy? [LB239]

GALEN ULLSTROM: That's a...yeah, we don't write this coverage anymore, so it's a...and I have to admit I'm not sure what we...what our subrogation is. Clearly we would be opposed to someone profiting through insurance to give an incentive to collect under different coverages. But I certainly see Senator Lathrop's position about somebody not being penalized for having other coverage in any capacity. So I don't know what...I frankly can't tell you. I don't recall this happening. I mean, I recall subrogation involved between workers' comp and our plans, but I don't recall the specific example where someone might not have been made whole, not to profit, but made whole at least, to cover, if they had other coverages, "coveraging" their deductible. So I don't really know the answer to that. [LB239]

SENATOR CARLSON: Well, I think you're saying that, as you recall your experiences, that you allow an insurer to be made whole, but not to make a profit. [LB239]

GALEN ULLSTROM: I think that's...I think that was the general concept, that someone shouldn't be put in a position where they can collect, similar to the coordination of benefit provisions, I think, that Senator Schumacher or somebody raised, where you decide between the company who is going to pay what. The same issue with the workers' comp versus a major medical claim. You don't put the person waiting before you divide this out. You pay the expenses and let the carriers decide later who, you know, who gets stuck for what, so. [LB239]

SENATOR CARLSON: Okay, thank you. [LB239]

GALEN ULLSTROM: Sure. Thank you. [LB239]

SENATOR GLOOR: Thank you, Galen. Anyone else in a neutral capacity? Good afternoon, Dr. Esser. [LB239]

DEB ESSER: (Exhibit 9) Good afternoon. Good afternoon, Chairman Gloor and members of the Banking, Commerce and Insurance Committee. My name is Deb Esser, D-e-b E-s-s-e-r. On behalf of Coventry Health Care of Nebraska, Incorporated, which is an Omaha-based insurance carrier serving over 200,000 members in Nebraska, we would like to offer neutral testimony on LB239. Over the course of the past few months, Coventry has been meeting regularly with our two major healthcare insurance colleagues, as well as Senator Wightman and Gloor and members of the medical and hospital communities, as we discuss patient-centered medical homes. Currently, Coventry is engaged in operating medical homes for our commercial Medicare and Medicaid programs to improve health status, patient outcomes, and to reduce the cost of healthcare in Nebraska. We remain committed to increasing the health outcomes of our members and contend that a medical home that focuses on quality measurements can accomplish the end goal when modeled correctly. However, we do have concerns about LB239 and that it may not be the correct approach to addressing the patient-centered medical homes at this time. Although our working group has met multiple times and we continue to make progress, the work is far from over. LB239 outlines a number of eligibility requirements, time lines, and procedures that are not realistic or attainable currently. Coventry remains supportive of medical homes and quality improvement projects, but asserts that this bill does not adequately reflect the stage of development of our working group as is. We thank Senator Wightman for introducing this bill. And although we cannot support it in its current form, we do look forward to the continued dialogue with the current members of the working group, other interested stakeholders, and Senator Wightman and Gloor on this issue over the next few coming months and the legislative interim. Thank you. [LB239]

SENATOR GLOOR: Thank you, Dr. Esser. And the heat must be getting to me, but did you spell your name for the record? [LB239]

DEB ESSER: Yes, sir, but I can spell it again. [LB239]

SENATOR GLOOR: Thank you. I think once is enough. [LB239]

DEB ESSER: Okay. [LB239]

SENATOR GLOOR: Thank you. Any questions for Dr. Esser? Senator Campbell. [LB239]

SENATOR CAMPBELL: Thank you, Senator Gloor. Just one question: As you looked through the bill, what's the biggest heartburn to you, if there's one? (Laughter) [LB239]

DEB ESSER: Well, I...you know, I jotted down a few things, and I think that there are a number of issues. I guess my biggest concern is antitrust issues at this point. [LB239]

SENATOR CAMPBELL: Okay, thank you. That helps. [LB239]

SENATOR GLOOR: Yes, Senator Schumacher. [LB239]

SENATOR SCHUMACHER: Thank you, Senator Gloor. The antitrust issues, what are the facts that you see give rise to a claim under Sherman? [LB239]

DEB ESSER: I'm not sure who it's under, what bill. [LB239]

SENATOR SCHUMACHER: Well, an antitrust claim then. [LB239]

DEB ESSER: Yeah, and I do know that in the past we have been told, you know, you have to avoid collusion, you can't be talking about rate setting, you can't be doing this type of thing, which would be addressed in some of this legislation, and so I think that definitely does need to be addressed. And I don't look good in orange, so I'm not going there. (Laughter) [LB239]

SENATOR SCHUMACHER: How about stripes? [LB239]

DEB ESSER: Not that horizontal, huh-uh. [LB239]

SENATOR SCHUMACHER: Thank you. [LB239]

SENATOR GLOOR: Other questions? Thank you, and thank you again for your commitment to the working committee, Dr. Esser. [LB239]

DEB ESSER: Thank you. [LB239]

TIM GAY: (Exhibit 10) Senator Gloor and members of the committee, my name is Tim Gay, T-i-m G-a-y, with Husch Blackwell, representing Blue Cross Blue Shield. We're handing out a letter from Michaela Valentin. She is a member of the working group. We are neutral on this. I'm not going to be repetitive because you've heard many of the issues from the proponents, actually, as well. There is work to be done. I think the first testifier talked about puzzle pieces still needing to be put together. That's what the letter pretty much says. We're happy to work with Senator Wightman, and we appreciate him and his staff, you know, holding the bill and going to work on it. We'd also like to commend Senator Gloor and his staff, and we know Senator Campbell has worked on this issue as much. But, as we say, we are supportive...we support the medical-centered homes and the concepts. It's just there's a few issues and, like I say, I'd just be repetitive. So in the interest of time, I won't be. [LB239]

SENATOR GLOOR: Thank you, Senator Gay. Any questions? Seeing none, thank you for your testimony. [LB239]

TIM GAY: Thank you. [LB239]

SENATOR GLOOR: Next neutral. [LB239]

BRUCE RIEKER: (Exhibit 11) Senator Gloor and members of the committee, my name is Bruce Rieker. It's B-r-u-c-e R-i-e-k-e-r. I'm vice president of advocacy for the Nebraska Hospital Association, here on behalf of the 89 hospitals we represent, testifying in a neutral capacity. We appreciate the intent of this proposal. This is a sign of things to come as we move from fee-for-service payments to more of a population-health component. Appreciate the questions that I've heard about managed care, care management. Some of those things maybe we could talk about those if you have an interest in doing so. The reason that we're here in a neutral capacity, even though we support the intent, is we're probably not ready for prime time yet. And, Senator Schumacher, specifically, if we want to jump right into the legal hurdles and the Sherman Antitrust Act, things like that, I would go to the middle of the second page of my testimony. And these things aren't new to us in the hospital world or the healthcare world because of the patient-centered medical home. But they have also come screaming to the front of the line with regard to healthcare reform as we talk about bundled payments, accountable care organizations, things like that. But as where we're bringing together various providers through the continuum of care, and when we look at continuum of care, it's from the beginning to the end, as I would say. Some in Washington define it as 3 days before admission until 30 days after, but there's a lot more in a medical home. You know, we look at preventative care, end-of-life care, and there's a myriad of providers. But one of the unique wrinkles in what we're looking at here is we have multiple payers, and that's what starts to bring in the antitrust concerns. But in the healthcare world there are more concerns than just antitrust. When we look at these concerns that I've just touched on and those six bullets: hospital provided resources for care coordination and practice transformation invoke Stark, anti-kickback, and tax-exempt considerations--and I'll explain what those are in just a moment; shared savings payments cause concern for civil money penalties--just in case you think some industries are heavily regulated, by the time we get done with these, you know, there are several things that go into...there are actually obstacles for some efficiencies that we could achieve in healthcare; joint negotiations by unaffiliated providers that trigger antitrust issues; hospital and physician participating in bundled payments give rise to concern over the state corporate practice of medicine laws and fee splitting--and that would be where you have a state agency overseeing how payments are divided amongst payers from primary care physicians to hospitals to postacute care and along down the line; acceptance of full-risk contracts--we have managed care statewide for physical health in Medicaid, but...and then we're headed there for behavioral health; and then, if we didn't have enough, technology, electronic medical records, and HIPAA, the Health Insurance Portability and Accountability Act, also present some issues. Now what are all those things? Okay, Stark. The Stark law prohibits a physician from

referring certain services to an entity where payments are made under Medicare where that physician has an ownership interest. So when we had the issue about physician-owned hospitals a couple years ago, Stark was the biggest issue right there is that you cannot refer a patient to a facility you have an ownership interest in. The anti-kickback statutes prohibit any payment for referrals where payment for services is made under a federal healthcare program, Medicare again, and TRICARE, several other programs. There are also tax-exempt status concerns because almost all the hospitals we represent are tax exempt. But private inurement is a diversion...would be a diversion of charitable revenues to an insider, and that is illegal. So as we have hospitals playing a role in these medical homes, along with for-profit providers, we need to be very cognizant of the discussions we have, as well as how the money is divided up for the payment of...where we move from a fee-for-service payment to a payment for the care. The civil money penalties prohibit a hospital from knowingly making a payment to induce a physician to reduce or limit services. So if we're paying somebody to be a gatekeeper to keep them out of our hospital, then we would invoke civil money penalties. And they're a strict liability for every one of these that I've outlined so far, so that, in a nutshell, is some of the obstacles that we have to overcome. And when I roll all that out and it's...you people would have to think, why, you're crazy to try and get through all those hurdles. But just in the last two paragraphs, and I've just touched on this, why we are neutral and...but support aggressively pursuing this in the interim is because there are a couple states that have done some very unique things, and one of the...or, well, two of those states are Maryland and Pennsylvania. But, you know, under the antitrust provisions, the...those two states, pursuant to a ruling by the Supreme Court, have invoked the state action immunity doctrine which, by way of the state, says, you know what, we recognize that competition is really the way we want to go, but there are certain arenas where pure competition really doesn't work. And in some of those areas, it's healthcare or...and one of those areas would be healthcare, especially in the Medicaid arena, but also as we step outside the Medicaid arena, and each of these states did it a little bit differently. But they crafted, under the immunity doctrine, basically, an immunity clause for the providers saying, here's how you will put together your patient-centered medical homes, this is how it will be regulated by the Department of Insurance, these are the steps that you'll have to go through. And we're a long ways from being able to have that laid out, but I think that it is entirely doable. And we compliment the senators for bringing this forward, that there is an avenue that we could pursue, and there are some other states that have done some incredible things with patient-centered medical homes, as well as some care management that, you know, we need to look at. So...and then if I could put one plug in? Probably lobbying the wrong committee, but this goes off of a comment that Senator Campbell made about this is a partnership, a public-private partnership. And I know I'm going a little bit further here, but as our hospital association identifies what we need to do the most, the key element that's missing is a public-private partnership where the data is available. And we were very excited that the Department of Health and Human Services included in its budget request to build an MMIS system, which would be funded with a 90-10 federal-state

match. And so put $2.8 million in per year and get $25.6 million per year from the federal government to build a system that helps us manage this care and put more efficiency in the Medicaid system. Right now, we as providers cannot even track the information or the...HHS, by some of their own admission, can't track what's going on in the managed care organizations. But we can't track who...which patient has had four MRIs or five CAT scans or been to the...to how many different emergency rooms every week of the year. It's an incredibly critical investment that would help us, and then we would have to have the partnership. But that's one of the things that needs to be done, and that also plays a role when we deal with Medicaid patients in a medical home. So I know I've given you a lot, but it is doable. This is where we have to go, and we're to manage our healthcare costs. And so we look forward to working with the committee and the senators. And with that, I'll entertain any questions. [LB239]

SENATOR GLOOR: Any questions for Mr. Rieker? Senator Schumacher. [LB239]

SENATOR SCHUMACHER: Thank you, Senator Gloor. Thank you for your testimony, Mr. Rieker. I'm kind of concerned that we keep hearing the buck passed to Sherman and to the feds on antitrust. Has anyone, to your knowledge, approached the Department of Justice and asked them for forbearance in the enforcement of Sherman with regard to one of these projects? [LB239]

BRUCE RIEKER: With regard to the patient-centered medical home, I can't answer that one. But I can answer the fact that we, as well as many other hospital associations across the country and the American Hospital Association, have approached the Department of Justice with regard to how they're going to enforce this when it comes to bundled payments in accountable care organizations, and we have no definitive answer from the Department of Justice. So in one instance they hang the carrot out there and say, hey, you know what, you do this and it will all work out. But then, when we stare these sorts of things...I mean, hospitals could lose their licenses if we violate these things, so you have to be very careful. And other providers, you know, I appreciated the comment about not looking good in orange or stripes. But, you know, these are things that...healthcare reform was passed in March 2010, and we still don't have guidance from the Department of Justice with regard to the ACOs and bundled payments, and they're very similar to what we're talking about here. We're...these...in essence, a patient-centered medical home is a mini-ACO, accountable care organization, and we're bundling payments from multipayers. And I can understand the insurance companies' concern about how far do they want to go down the line and what conversations can they have before they would invoke a problem, but no guidance yet. [LB239]

SENATOR SCHUMACHER: Any discussions with the U.S. attorney for Nebraska? [LB239]

BRUCE RIEKER: We have not done that. [LB239]

SENATOR SCHUMACHER: Well, that would be the Department of Justice locally. [LB239]

BRUCE RIEKER: We went straight to Washington, but... [LB239]

SENATOR SCHUMACHER: Well, that might have been your mistake. (Laugh) [LB239]

BRUCE RIEKER: Yeah, well. (Laugh) [LB239]

SENATOR SCHUMACHER: The other route of enforcement, I think there's probably a cause of action under Sherman or Clayton, but I think under Sherman. What would be a patient's damages under a private cause of action? There's two ways to enforce Sherman. Either Department of Justice does it or a private cause of action. What conceivable damages could there be to a person? I mean, I don't...this concern seems to be a big concern, and I'm not so sure it's so material. [LB239]

BRUCE RIEKER: Well, let's take one of these where it says that...let's take the civil money penalty, and the penalties for that are treble damages. [LB239]

SENATOR SCHUMACHER: Yeah. [LB239]

BRUCE RIEKER: But if an individual patient made a claim and it was upheld against a medical home, the civil money penalty law prohibits a hospital from knowingly making a payment to limit someone's services. So if someone, let's say someone that's used to getting their care in the emergency room because they know we've got to give it to them, but then they come to the medical home and they're told that they are not...this isn't the appropriate place for their care or that they...or that there is a care regimen that they should adhere to and they simply don't want to do it, if they prove a case that they were denied care it's treble damages, and then we have to see how big of a mass of individuals they tackle in the medical home and then who's all liable and responsible to each other or to that person. But there would also be penalties paid to the federal government for that. So we're talking big money if we don't get this right, but we're also talking big money if we don't do this because healthcare costs continue to go up and we're not managing the entire care. We're having episodic care at the most costly time, and they're coming, most of the time, to our emergency rooms. So the penalties and the strict liability adheres to every one of those that I talked about, and the penalties are huge. [LB239]

SENATOR SCHUMACHER: Bottom line, though, if the Attorney General or the U.S. Attorney for Nebraska doesn't bring an enforcement action, and if a private party has zero damages, three times zero is zero. [LB239]

BRUCE RIEKER: Bingo, yeah. [LB239]

SENATOR SCHUMACHER: And, I mean,... [LB239]

BRUCE RIEKER: We want to... [LB239]

SENATOR SCHUMACHER: How much research has gone into actually whether or not this thing is as big a problem as it seems to be being articulated? I mean, do we have a legal opinion out of a ranking law firm that says, here's where you could get burned? [LB239]

BRUCE RIEKER: I'm aware of legal opinions in case-specific incidents where you may have physician ownership or some of the, like, civil money penalties. But as it applies to where we're bringing together a group of providers and payers collectively, and gain sharing, as it were, it's like...is a word that's used in this. The insurance companies want to lower their costs, no doubt about it. We've heard them talk about that--we want to lower our costs, but we still want to apply the appropriate care. With the laws in place, we want to have as much in place as we possible can, but then, you know, there is never an absolute protection from somebody leveling or waging a claim against us, things like that. I understand that. [LB239]

SENATOR SCHUMACHER: Is there any movement underway at the federal level just to preempt the field? If these things are such a good thing and we've just got all this...you know, hangovers from the past hanging around here, is there any effort at the federal level just to preempt the field and say, look, this works, regardless of Sherman and supersedes Sherman and Clayton and the Federal Trade Act and all of the state concerns, anything? [LB239]

BRUCE RIEKER: For healthcare specifically? [LB239]

SENATOR SCHUMACHER: Yeah. [LB239]

BRUCE RIEKER: I'm not aware of that. I'm...I would imagine somebody has had a conversation, but I don't think...I mean, that's something that we approached the Department of Justice with that said, do we get a waiver from all of these if we form an accountable care organization or a bundled payment situation? And we have no guidance on that whatsoever. But I'm not aware of any movement congressionally to say, you know what, when it comes to the things that were components of healthcare reform. I know I say the ACOs and the bundled payments, which are primarily the ones that bring these up to the front. I'm not aware of any effort in Washington to cut that off. [LB239]

SENATOR GLOOR: I would interject here. And I don't want this to be a panacea, but

one of the reasons that there is a grant to take a look at multipayer systems is to, in fact, explore in part that very issue: what are some...what's some of the guidance we see nationally, what we can learn from some of the other states about this? So, I mean, I think there is a lot of questions about this across the country. And the grant, which is a multipayer grant, I think that's one of the things we hope will come to light as a result of participating in that is finding out what are some of the things we need not worry about, what are some of the things that we ought to worry about when it comes to this issue--a lot of question marks right now. [LB239]

SENATOR CRAWFORD Hmm. That was my question. [LB239]

SENATOR SCHUMACHER: Thank you. [LB239]

SENATOR GLOOR: Any other questions? Thank you, Mr. Rieker. [LB239]

BRUCE RIEKER: You're welcome. [LB239]

ANDY POLLOCK: Senator Gloor, Mr. Chairman, and members of the committee, my name is Andy Pollock, that's A-n-d-y, Pollock, P-o-l-l-o-c-k. I'm a lawyer and registered lobbyist for UnitedHealthcare of Nebraska. I will keep my comments very brief. We want to thank Senator Gloor, Senator Wightman, and their staff for leading the charge in this effort which we, in concept and in general, support. Dr. Dan Clute from UnitedHealthcare has been a part of the working group, and we pledge to continue the efforts of participating in that valuable group. I agree with the sponsor of the legislation in his introduction and Dr. Rauner that this legislation in its current form really isn't ready to move forward, and we would ask the committee to hold the bill. In response to a question asked by Senator Campbell about what our biggest concern about...this might be another witnesses's biggest concern. Ours would be section 9 and the time lines in that section, Senator, and I think I share Dr. (sic--Director) Ramge's concerns about that particular section. With that, I would conclude by saying that I'm not an antitrust lawyer. I've never played one on TV or even the Internet, and I would try to pass along questions or answer them if I could. [LB239]

SENATOR GLOOR: Any questions for Mr. Pollock? Seeing none, thank you for your testimony. [LB239]

ANDY POLLOCK: Thank you. [LB239]

SENATOR GLOOR: Anyone else in a neutral capacity? I believe Senator Wightman, unless he snuck back into the room, has gone and waives closing, and that will end the hearing on LB239. We will take a very brief break and reconvene in just a little over five minutes. Thank you. [LB655]

SENATOR GLOOR: If I could ask those folks who are not involved in this bill to move quietly outside and those folks who are involved to have a seat and get ready, we'll move on the hearing on LB655. Senator Carlson, welcome to your committee. [LB655]

SENATOR CARLSON: Thank you and good afternoon, almost evening, Chairman Gloor and members of the committee. I am Tom Carlson, spelled C-a-r-l-s-o-n, the senator from District 38, here to introduce LB655. Now this bill clarifies certain rights that a large employer, one with 100 or more employees located in Nebraska, has when utilizing the services of an insurance consultant. Specifically, the bill makes it clear that a large employer may have the fees the employer has agreed to pay to an insurance consultant collected from the employer by a third party and remitted by that third party to the consultant. Further, the third party performing such fee administration services for a large employer may be an insurer that has issued a policy of insurance to the employer. The bill, with the emergency clause, would be beneficial to Nebraska employers, as it grants them maximum flexibility when determining the best consultant payment structure for their particular situation. And notice I've said it's an advantage to the employer. And so I have some questions that I think should...could be entertained as we have testifiers on this bill. As a former insurance agent, I'm concerned that there be no change in the licensing requirement for an insurance agent when we get into this situation. I would hope that a licensed insurance agent would also be accepted as a consultant. I'd be interested in what's the difference between a commission on a product and a consulting fee on the same product. And most of us, whether we are cognizant of this or not, know that insurance products don't sell themselves. A local agent sells and services a policy best, and a poor agent or a poor product isn't good for the public. But it's necessary to have a good product and an ethical agent to best serve the citizens. And hopefully this bill will accommodate both, and I would ask you to be aware of that as you listen to testimony. If you have any questions, I'd try to answer those. [LB655]

SENATOR GLOOR: Thank you, Senator Carlson. Are there any questions for Senator Carlson at this time? Seeing none, thank you, Senator Carlson. Can I see a show of hands of those who want to speak to this bill, please? I see two hands. We'll start with proponents. Good afternoon. [LB655]

CHAD BARTHEL: (Exhibit 1) Mr. Chairman and members of the committee, thank you for the opportunity to testify today in favor of LB655. And thank you, Senator Carlson, for introducing this legislation. My name is Chad Barthel, C-h-a-d B-a-r-t-h-e-l, and I'm the director of sales for UnitedHealthcare of Nebraska. The bill before you will add a provision to section 44-2629 of the Revised Statutes of Nebraska to clarify that employers with more than 100 employees utilizing the services of an insurance consultant may have an independent contract allowing for the administration of consultant fees by a third party. Under the bill, the third party performing the administration may be the insurer which has issued a policy of insurance to the employer. While this process would be entirely optional for both the employer and the

consultant, the legislation is intended to modernize our state statutes to reflect the changing marketplace and allow the consultants to leverage the administration capabilities of their insurance partners. I'd like to thank the Nebraska Association of Health Underwriters, the Nebraska Association of Insurance and Financial Advisors, and others within the health insurance industry in Nebraska in their efforts of cooperation regarding this issue. With that said, Mr. Chairman, I would describe this legislation to you as a work in progress. All of the parties have agreed to continue discussing ways to improve this legislation and it is our intent to continue our work together to ensure that all outstanding issues have been addressed and that all parties are treated fairly in this legislation. Our hope is that once all stakeholders have had a chance to work through the legislation, we will be able to come back to you with an amendment for the committee to consider. I'd be happy to address any questions you may have. [LB655]

SENATOR GLOOR: Thank you, Mr. Barthel. And I'll ask at least one of the questions that's out there and that is, what's the difference between a commission and a consulting fee? [LB655]

CHAD BARTHEL: I was hoping that was the one question you wouldn't ask me. In my capacity as director of sales, that's not an answer I'd be able to provide you at this time. But I'd be happy to have UnitedHealthcare get back to you with a very specific answer. [LB655]

SENATOR GLOOR: Would you, please? [LB655]

CHAD BARTHEL: Yes, sir. [LB655]

SENATOR GLOOR: Okay. Any other questions? Seeing none, thank you for your testimony. [LB655]

CHAD BARTHEL: Thank you. [LB655]

SENATOR GLOOR: Any other proponents? Any opponents? Anyone in a neutral capacity? [LB655]

KORBY GILBERTSON: Good afternoon, Chairman Gloor, members of the committee. For the record, my name is Korby Gilbertson, it's spelled K-o-r-b-y G-i-l-b-e-r-t-s-o-n, appearing today as a registered lobbyist on behalf of the Nebraska Association of Health Underwriters. I'm appearing today in a neutral capacity because Senator Gloor and Senator Carlson kind of alluded to the history behind this legislation. As you can tell from the number of this bill, it was the last one thrown in on the last day. This issue...this bill, on the surface, would seem to be a very good idea. There are around 250 licensed brokers or consultants in the state. There are ten times that many agents. When I was

originally hired by NAHU--just to give some of you a little background--it was to deal with issues having to do with the Affordable Care Act and the ongoing role of agents as navigators or inside the exchange and outside the exchange as we move forward with the ACA. When this bill was brought to us, we've had ongoing concerns and issues with health companies wanting to end the practice of paying commissions for sales of insurance products. I don't know how many of you have tried to buy health insurance on your own. I'm one of the unlucky people that has to buy insurance on my own, and I can tell you I wouldn't want to do it without a licensed agent or broker consultant because it is very difficult, and I'm an attorney. I can't imagine people that are less...have less schooling try to figure all of this out. But this is one of the issues that the agents feel very strongly about, is being compensated for the amount of work that they do to work with both large groups which are covered under the current form of (LB)655, but also small groups and individual policies. There are a number of people within NAHU that would support this bill as it is drafted. There are a number that have great concerns because they're concerned that this will take us further down the road of the ending of paying any commissions. And then the only way that an agent or consultant could get compensated would be by charging a fee for service...by them charging a fee for service to the buyer of insurance, which would be completely outside of the actual premium that the purchaser is paying. Did I explain that well enough, I hope? And with that, I'd be happy to try to answer any other questions. [LB655]

SENATOR GLOOR: Senator Schumacher. [LB655]

SENATOR SCHUMACHER: Thank you, Senator Gloor. In struggling with the new language, I'm trying to make sense of what it says. It says: nothing in this section or any other Nebraska law shall be construed as prohibiting or restricting the right of a client to request that a third party collect from the client. So restricting the right of a person to request that somebody collect from that same person and remit to the consultants the fee charged by the consultant. Why wouldn't the client just pay the consultant? [LB655]

KORBY GILBERTSON: I will give you, what I have heard is that in other states...in order for the ease of collection of these fees, in other states--Iowa, for example--has legislation like this in place so that the client can write one check, send it to the insurance company, and then the insurance company can then remit that fee to the agent or a consultant. [LB655]

SENATOR SCHUMACHER: Is there some deductibility or somebody that would want to do that in such an indirect way when you can do it directly? [LB655]

KORBY GILBERTSON: Well, right now, all of us who buy insurance in Nebraska or from certain companies, you pay your premium and the commission comes off of that and is paid to the agent or consultant. This would change that and allow there to be a consulting fee charged and collected. The concern is that the company right now cannot

legally collect that fee and then remit it back to you. The argument for the bill is to allow the company to collect it for you and then remit it back to you as the agent or consultant. [LB655]

SENATOR SCHUMACHER: But it says: nothing in this section shall be construed as prohibiting or restricting, so that's not an affirmative grant of any authority. And then if you just go up to the rest of the section, section (1): a consultant is obligated to serve objectively and render service in good faith that best serves the interest. Well, how does anything in there restrict the right of the client? And if we want to say they can do something they can't do now, shouldn't this be in the affirmative rather than saying nothing shall be construed as prohibiting something? [LB655]

KORBY GILBERTSON: First I will say, I did not draft this. Second I will say, it is my understanding that they cannot currently collect the fee for the agent or consultant; the company cannot. There is nothing prohibiting the consultant from charging a fee right now. Does that make sense? So nothing in your example would be affected by this. This would purely allow the company to collect a fee and then remit it to the consultant or agent. [LB655]

SENATOR SCHUMACHER: Thank you. [LB655]

KORBY GILBERTSON: Uh-huh. [LB655]

SENATOR GLOOR: Senator Crawford. [LB655]

SENATOR CRAWFORD: Thank you, Senator Gloor. So are we trying to make sure that you could pay agents or consultants? [LB655]

KORBY GILBERTSON: Actually, no. In this legislation, it's still limited to consultants. And that's why NAHU is not supporting the bill at this point. Obviously, there is some concern that all agents then in order to be paid under this type of scenario would then need to get a consultant's license. And right now there are only about 250 of those in the state. [LB655]

SENATOR GLOOR: Can I ask this question a different... [LB655]

KORBY GILBERTSON: Sure. [LB655]

SENATOR GLOOR: ...explain this issue another way that helps me? We have gigantic insurance company, we have employer with 100 employees, and somewhere in between we have somebody who is helping sell this product. [LB655]

KORBY GILBERTSON: Uh-huh. [LB655]

SENATOR GLOOR: Right now, how that individual gets paid comes off the payment made, the premiums paid to the gigantic insurance company. [LB655]

KORBY GILBERTSON: Right. [LB655]

SENATOR GLOOR: What this would allow is that a fee goes to the gigantic insurance company and the person selling it works with the gigantic insurance company on getting that piece of payment. [LB655]

KORBY GILBERTSON: Right. And it would not come, then, out of the proceeds from the giant insurance company but, rather, the fee that's paid by the client. [LB655]

SENATOR GLOOR: I understand. I understand some of the concern. [LB655]

KORBY GILBERTSON: Uh-huh. [LB655]

SENATOR GLOOR: Thank you. Any other questions? Senator Campbell. [LB655]

SENATOR CAMPBELL: I'm going to go back to Senator Schumacher's question. Is there a tax advantage somewhere for somebody that this...you have to pay? [LB655]

KORBY GILBERTSON: It's my understanding that it has more to do with the company...the minimum...is it the minimum loss ratio--left from the back row--the...okay. What happened I don't know how many years ago, insurance companies had to...I believe it's referred to as a minimum loss ratio, and they could not have so much of their income going towards certain things. And so what occurred last year--and this was done at the federal level--what happened the year before last--and I was not involved in this, did not represent them then. So I'm just based on what I knew from them. And Mr. Marienau can shake his head no at me if I'm going off track, but what happened at that time, a number of insurance companies then reduced or eliminated commissions from their programs with their agents. What has then happened since then--and this might be a completely separate issue--we have heard stories from Iowa where companies have ended the practice of paying commissions and have asked agents and consultants--and in Iowa they don't have a separate agent or consultant licensure structure--they have asked them to instead of accepting commissions, to then charge their clients fees. So then it does not go through the actual insurance company. It's a separate fee charged and then remitted back to the agent or a consultant. Our concern, obviously, is that...twofold. Number one, it can affect the agents that aren't licensed consultants. Number two, that this could create a slippery slope whereby other companies would join in the parade of ending the payment of commissions. [LB655]

SENATOR GLOOR: Other questions? Seeing none, thank you. [LB655]

KORBY GILBERTSON: Thank you. [LB655]

SENATOR GLOOR: Anyone else in a neutral capacity? [LB655]

ANDY POLLOCK: Mr. Chairman and members of the committee, my name is Andy Pollock, A-n-d-y P-o-l-l-o-c-k. And like I said before, I represent UnitedHealthcare Nebraska who Mr. Barthel also represents. I'm not here to rebut anything that Ms. Gilbertson said. I did ask Senator Carlson's permission to come up here just to address a couple of questions of the committee. And, in particular, one that he asked that I don't think that we answered and I think that we have a responsibility to answer. And that is, will this change the licensing requirements for agents who are not consultants? And I can tell you that that is not the intent of the legislation. Ms. Gilbertson raised issues about that, and she and I have talked a little bit in the lobby about that particular issue. That's one of those issues that I think we need to figure out. Is there an issue, and how do we best address it? And I don't think that that will be difficult based on my review of the law. And we just need a little bit of time to try to work that out to make sure that there's no trigger of any kind of dual-licensing requirement. I think it might be helpful to walk through just a brief history of how this bill came about. And like Korby said, Ms. Gilbertson said, it did come up late. It came up late in discussions between UnitedHealthcare, which is compensating brokers throughout the country through this type of mechanism, a fee-based arrangement rather than a commission-based arrangement, and they've been doing it, I think, to the success of both the company, the broker, and the employers as well. When they talked to the department--and this is all coming secondhand to me from discussions with my client so if I need to clarify afterwards, I'll be glad to do that--but as I understand it, they went to the department and said, here's what we're planning on doing, here's what we're doing in other states, do you have any concerns/issues about this? I think fundamentally--and, again, I don't pretend to speak for the department--the department said, we don't have any fundamental concerns, let us look at the law. They looked at the law and pulled up this section 44-2629 and said, we're concerned that you might be putting consultants in a place where they might be breaching their duty of loyalty, compromising their duty of loyalty to their clients, the employers. And we would recommend that you take a stab at trying to fix this provision of law. Again, this is December, late December, January. They said, we're not going to draft this for you. So UnitedHealthcare internally undertook to try to draft this so that the consultant wouldn't be in that position of compromising his or her duty of loyalty to his client or her client. That's the objective of the bill. We ran it by the department, they said they don't have any issues with the language at that point. And since then, we've been trying to socialize it with everybody else. The hearing came up a little bit earlier than we thought, and so we've committed to the other parties to make sure we have a chance to talk about this after the hearing. So insofar as Senator Schumacher's question is involved, Senator Schumacher, that's why it's in the negative. The department didn't suggest that we had to have authority to do this. They were

concerned that we put the consultant in a position of compromising their duty of loyalty to their client. And this would make clear that this kind of payment arrangement would not constitute a breach of that duty of loyalty under the first part of the law. That was the goal of what the language is. It does seem a little bit odd. I agree with your perspective on that. That's hopefully an explanation of why. [LB655]

SENATOR GLOOR: Thank you. Questions? Senator Crawford. [LB655]

SENATOR CRAWFORD: So the idea is that they're not violating their duty because they're collecting...they're supposed to be consulting on which kind of insurance to buy. And then they also get to collect a fee. [LB655]

ANDY POLLOCK: I think the concern--and you may have to ask the department this--but my guess is the concern is that because they were getting a fee through the insurance carrier, the question is, does that mean that they have a duty...that they're doing something in accepting that fee from the carrier that might interfere with their duty of loyalty to the employer? Like Ms. Gilbertson said, commissions are paid through the insurance company. So I'm not sure that I completely have my mind around that in terms of the concern, but that was the nature of the department's concern on that particular section. [LB655]

SENATOR CRAWFORD: Can a consultant earn a commission? Is that the difference between a... [LB655]

ANDY POLLOCK: They do right now. [LB655]

SENATOR CRAWFORD: They can? [LB655]

ANDY POLLOCK: Yes, uh-huh. [LB655]

SENATOR CRAWFORD: Okay. So they already do that. So I'm just going to follow-up on one other point made earlier. So is this structure partly to get around the minimum loss ratio concern? [LB655]

ANDY POLLOCK: I'm not in a position where I have any slightest bit of knowledge on that, Senator Crawford. I...as I understand it, this is a practice that United is undertaking throughout the country. And they approached the Department of Insurance to see if it was okay in here, and it led to that conversation. I can tell you that absolutely our intent is not to stiff brokers or consultants on their fees. And I think the timing of this legislation has led to some suspicions, and that's why I think we need some time to talk. I think those discussions would be fruitful. But I can assure you that United, when we approached Senator Carlson to introduce this legislation, that that had nothing to do with it. It's just a change in the way the system works. And frankly, as I read the law, I

don't know how this could make it any easier or harder for a company to either pay or choose not to pay its consultants. That's not the goal of the legislation. [LB655]

SENATOR CRAWFORD: Thank you. [LB655]

SENATOR GLOOR: Senator Schumacher. [LB655]

SENATOR SCHUMACHER: Senator Gloor, thank you. Thank you for your testimony today. Does this have anything to do with the issue of the Affordable Care Act and navigators and how they're getting paid? Is there any relationship there or is it a mere coincidence that it's coming up about the same time that issue is brewing? [LB655]

ANDY POLLOCK: I don't have an answer. I'll ask the company. [LB655]

SENATOR SCHUMACHER: Okay. In simple terms...I'm trying to get my head around what actually is going on here. Somebody wants to buy a car. They don't know anything about cars, so they hire a consultant to tell them what kind of car is the best car and which one they should buy. And they decide they want to buy a Buick. And so they go to the Buick dealership, and this thing permits the dealership to contract with the guy who wants to buy the car to charge him a fee to pay to the guy he hired to consult with him? [LB655]

ANDY POLLOCK: Correct. I think nationwide--and, again, I will...this is subject to check--this has saved, in terms of the administration costs of collecting those fees and remitting them--frankly, it takes the monkey off the back of the brokers if they would be collecting them. And I don't know that that's necessarily the case according to what Ms. Gilbertson said. But it's to try to consolidate the administration, the collection, and the remittance of those fees. [LB655]

SENATOR SCHUMACHER: Thank you. [LB655]

SENATOR GLOOR: Senator Howard. [LB655]

SENATOR HOWARD: What is the minimum medical loss ratio in the ACA? Can you remind me of that? [LB655]

ANDY POLLOCK: I can ask my client and have them give you an explanation. I have a rudimentary understanding of it, but not good enough to explain it to somebody else, Senator Howard. [LB655]

SENATOR HOWARD: And I'm sure Bill can remind me as well. I thought it was 80/20. But I wanted to make sure, are commissions included in the administrative 20 percent? [LB655]

ANDY POLLOCK: I'll have to check. [LB655]

SENATOR HOWARD: Okay. Thank you. [LB655]

ANDY POLLOCK: Sorry. [LB655]

SENATOR GLOOR: Any other questions? Thank you, Mr. Pollock. [LB655]

ANDY POLLOCK: Thank you. [LB655]

SENATOR GLOOR: Anyone else who would like to provide testimony in a neutral capacity? [LB655]

TIM GAY: Tim Gay with Husch, Blackwell, T-i-m G-a-y, representing Blue Cross Blue Shield. I wasn't going to testify on this and then I did hear...but I couldn't pass up the opportunity to just say Blue Cross and Blue Shield does pay commissions as well as consultant fees and want to continue that practice; we appreciate the professionals. Ms. Gilbertson talked about how confusing it is, and it is very confusing. Earlier you talked about the navigators, whether they'll be compensated or not. During the summer there was discussion should they or shouldn't be. I don't know where that's going to end up or how that will all end up yet. But that, again, is going to be a very difficult situation. The idea of a consultant--and this is maybe speculation--but the way I understand it, a consultant...if you pay a consultant fee, you could write that off as a taxpayer as a business expense. On the ratio, the medical loss ratio, I agree with Mr. Pollock. I'm not sure exactly, but I think that's probably the commissions would be under the administrative fee, whether it's 85 or 80/20. But everybody is looking at their administrative fees and what you can and can do without. I don't know, you know, how the whole bill got started, but we'd like to work in any way we can. But like I say, I wanted to get up and kind of...I know, sometimes insurance companies get a bad rap. But that is one thing we really do appreciate and I just couldn't pass up the opportunity to put that plug in. Thank you. [LB655]

SENATOR GLOOR: Thank you, Senator Gay. Senator Schumacher. [LB655]

SENATOR SCHUMACHER: Thank you, Senator Gloor. Thank you, Mr. Gay, for your testimony. So is that the method to this madness, that if they pay the commission or the fee to the explainer--for lack of a better word--it doesn't come under the ACA's 15/85 or 20/80 thing? And they get by, having more administrative expense using this mechanism than they would if they did it directly? [LB655]

TIM GAY: I don't know the motives behind the bill, but I think everyone is looking at their administrative expenses because...due to the ACA. So... [LB655]

SENATOR SCHUMACHER: Is that the way it functions, regardless the motive, that you end up this way having the ability to have more expenses and profits than you would...or resources not applied to medical care than you would the other way? [LB655]

TIM GAY: I think everybody's running their company somewhat the same, but somewhat different. It's a choice you make. And the point I wanted to get across was, we're proud of the commissions. We pay the commissions. It's one of those things--Steve Martin has been on record--we want to continue to pay because we value the consultants and the agents along the way. However it's worked out on this bill, we're going to monitor it and try to help in any way we can to make sure that exists in the future because it's an important role for the industry. [LB655]

SENATOR SCHUMACHER: So the fee paid in this roundabout way does not impact the 80/20 limitations under the ACA, but paid directly it would. Is that where we're ending up today? [LB655]

TIM GAY: I would check that out 100 percent because the ACA is a complicated bill and exactly what's in that. I could check it out and find out. I'd be happy to do that. [LB655]

SENATOR SCHUMACHER: Okay. Well, I'm trying to find...usually people want to do things in a straightforward, direct way. And this convoluted way, there's got to be a pony in this pile someplace. [LB655]

TIM GAY: There again, I mean, on the bill we're just going to monitor it and see if we can help. [LB655]

SENATOR GLOOR: Senator Campbell. [LB655]

SENATOR CAMPBELL: I just throw this out because it's an article I read. And I don't know whether the feds will change their mind, but the last I read, if you are opting for a federal exchange, the feds will hire the navigators or whatever. I mean, if they're volunteers, they're going to pay them, or whatever, but they will do it. And they have not yet set the criteria for what those folks...what they need or what they'll do. [LB655]

TIM GAY: Whether it's paid or not and who it will be and what you're... [LB655]

SENATOR CAMPBELL: Right. [LB655]

TIM GAY: And that will be a hard job, whoever they hire, I think. And what your qualifications would be. We don't know that yet. [LB655]

SENATOR CAMPBELL: Yeah. Arkansas, for instance, has gone ahead and invested

some money in getting people prepared as navigators even though it's a federal, hoping that the feds will utilize them because they want those people well trained and in place because you've really got to...it's kind of a chicken and an egg, because you've got to have those ready to go before January. And yet you don't get reimbursed for that out of the proceeds to the exchange until 2014. So there's a lot of questions about the whole navigator issue. But because we have opted to be a federal, we would need to watch what the federal government is going to do in relation to these all across the country. [LB655]

TIM GAY: And Senator Campbell, Senator Carlson brought up--and I agree with that, too, from some experience--insurance does not sell itself. And the exchange will not sell itself. It's going to be very complicated and, again, there will be an important role for whoever fits... [LB655]

SENATOR CAMPBELL: Somebody. [LB655]

TIM GAY: ...that method, whether it's a consultant or an insurance agent or broker or whatever. [LB655]

SENATOR GLOOR: And I'd just add, adding to the challenges when you consider the thousands of people who will call in, how many clients' calls... [LB655]

TIM GAY: Calling in...the line, yeah. [LB655]

SENATOR GLOOR: ...can a navigator handle in a day, a week, a month? And can we reasonably hire that many people and get them trained by that period of time? Can anybody? Anyway, thank you. [LB655]

TIM GAY: Thank you. [LB655]

SENATOR GLOOR: Anyone else in a neutral capacity? Seeing none, Senator Carlson, would you like to close? [LB655]

SENATOR CARLSON: I will, thank you. And actually I'm a little relieved after listening to the testimony. This bill is not ready for prime time. Mr. Barthel called it a work in progress. It needs an amendment. Korby Gilbertson also pretty much indicated that it needed some more work. Andy Pollock the same, and I believe Tim Gay would agree with that. Where Korby Gilbertson indicated there are 250 consultants in the state and about 2,500 agents, now I can't state this as a fact, but I have a concern that the smaller number of consultants consider themselves a level above the licensed agent and wouldn't mind making themselves rather unique and probably would not object for another procedure in there for a licensed agent to become a consultant. And I've got a real concern about that, so hopefully that kind of thing comes out more clearly before

we would act on this bill. An insurance company wants to have plans sold minimizing expenses and maximizing profits. That's okay. I think that's what they want to do. An agent...an ethical agent or an ethical consultant wants to sell a plan, service the plan, and be fairly compensated. Now in my experience in the insurance, and I don't think it's changed in the last several years, you had to be real careful. I could not as an agent sell a plan and negotiate with the employer who I'm trying to sell a plan to, the commission. That's called rebating. That's against the law. So if I were to receive a 4 percent commission from the company and I would tell the employer, well, go with me and I'll give you a percent of my commission, that's rebating. You can't do that. I don't see a whole lot of difference in negotiating a fee. If a normal fee is 4 percent, but I can negotiate down to 3 and Senator Howard is the agent and she's trying to sell it to somebody at 4...and she's going to get 4 percent and I go in and say, well, I'll negotiate that fee down to 3, and I knock her out. In straight commissions, you can't do that. It's against the law. So negotiating a consulting fee I think has some question marks with it. And hopefully that all is ironed out and we know where we are before this bill would go forward. And it may be a good bill, we'll have to see. Any questions? [LB655]

SENATOR GLOOR: (Exhibit 2) Seeing none, thank you, Senator Carlson. [LB655]

SENATOR CARLSON: Okay. [LB655]

SENATOR GLOOR: And that will end of the hearing on the last bill introduced this legislative session, LB655. [LB655]