[LB205 LB228 LB523]

The Committee on Banking, Commerce and Insurance met at 1:30 p.m. on Tuesday, March 5, 2013, in Room 1507 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB205, LB228, and LB523. Senators present: Mike Gloor, Chairperson; Mark Christensen, Vice Chairperson; Kathy Campbell; Tom Carlson; Sue Crawford; Sara Howard; Pete Pirsch; and Paul Schumacher. Senators absent: None.

SENATOR GLOOR: Good afternoon. We're going to get started. Welcome to the Banking, Commerce and Insurance Committee. I'm Mike Gloor, I'm the Chairman and senator from District 35, which is Grand Island. We'll take the bills up today in the manner listed, as the agenda lists them. That agenda was posted on the door outside. I'm going to ask for you to bear with me for a few minutes, we have to run through a few rules. You'll see some committee procedures up there, but I'll walk through those briefly. First of all, please check your cell phones to make sure they're either off or silent. We appreciate that so that it doesn't catch anybody by surprise. The order of the testimony will be the introducer, then we'll ask for proponents, then opponents, then people who want to speak in a neutral capacity, and then the introducer will have a chance to close. We'd ask all testifiers to sign in, fill out one of the testifier sheets, hand it to the clerk as you come up here and sit at this table. And then, please, be sure when you first sit down to give us your name and spell it for us so that the transcribers who aren't here with us have a chance--and don't necessarily have access to the sheet you just handed in--make sure that they get the transcript so that correctly. We ask that you be concise. We have a light system, but I'm not going to use that today. But we ask folks to try and be concise and keep your comments, if at all possible, to about five minutes. If you'll not be testifying, but would like to leave your mark on this hearing in some way, there are sign-in sheets on either side and you're welcome to sign in there and let us know what your stand is. If you've got written material, we need ten copies of that written material. And if you don't have ten copies right now, signal one of the pages and they can get those ten copies for you. Hand that material in along with your testifier sheet when you first come up here. To my immediate right is Bill Marienau who's counsel for this committee. Jan Foster is the clerk on the end of the table. And I will ask the other senators to introduce themselves starting with Senator Crawford.

SENATOR CRAWFORD: Thank you, Senator Gloor. My name is Senator Sue Crawford and I represent Legislative District 45, which is Bellevue, Offutt, and eastern Sarpy County.

SENATOR SCHUMACHER: I'm Paul Schumacher. I represent District 22, which is Platte, parts of Colfax and Stanton County.

SENATOR PIRSCH: Pete Pirsch. I represent Legislative District 4, which is Boys Town,

areas of Douglas County and west Omaha.

SENATOR CAMPBELL: I'm Kathy Campbell. I represent District 25, which is east Lincoln and eastern Lancaster County.

SENATOR CHRISTENSEN: Senator Mark Christensen from Imperial, basically represent from Johnson Lake to the Colorado line and Harlan County Lake to the Colorado line.

SENATOR HOWARD: I'm Sara Howard. I represent District 9 in midtown Omaha.

SENATOR GLOOR: And our pages today are William and Nathan who are over there and will help us as is necessary, and help you as is necessary. Senator Carlson is also a member of the committee, but he has several bills to introduce today and so will show up as soon as he is finished with his bill introduction. And with that, we'll move to our first bill, LB205. Senator Schumacher, you're up.

SENATOR SCHUMACHER: Thank you. [LB205]

SENATOR GLOOR: Welcome to your very own Banking, Commerce and Insurance Committee. [LB205]

SENATOR SCHUMACHER: (Exhibits 1 and 2) Thank you, Chairman Gloor, members of the Banking, Commerce and Insurance Committee. My name is Paul Schumacher, P-a-u-l S-c-h-u-m-a-c-h-e-r, and I represent District 22 in the Legislature. Today I am introducing LB205. LB205 deals with entrepreneurs and how you make things happen in the business world. Let's posit a situation where you have somebody in their early 30s, really on the ball, have this great idea. And by that time if they've been behaving properly they probably have a couple kids, maybe a house with a little bit paid down in equity. And they're really convinced they have an idea. Even though they got a full-time job, they wouldn't mind taking a shot at this particular idea. Well, how do you go about it? Well, in the corporate world there's basically two ways to go about it. One is, you hit up your relatives for the money that you need. And let's say you need $50,000 to make this thing click in the beginning or at least you think you do if you're willing to work for free. And most people who are entrepreneurs are willing to work for free for one, two, or usually the three years that it takes in order to make something happen. Well, your relatives may be tapped out or they may only have $5,000. All right, what do you do? Well, you can go down to the local bank. But the local bank, they have the nasty tendency to want a thing called security or cosigners, and all you have is a little equity in your house and two kids. And so it's kind of hard to get a loan on that basis. Besides that, if the idea fizzles, you've just got to pay back a $50,000 note, and you begin to get cold feet. You know, it'd just be better to sit at that job and not pursue this idea than risk losing your car and the equity in your house and all kinds of stress in your marriage and,

gee whiz, it kind of looks like it wasn't such a good idea after all. You could go down to the SBA or the VA or those kind of places, but you know what? Most of them want that signature, they want that security. And if your idea flops, you're out, and you've lost what little you've scraped together to make it work. Debt is a bad thing sometimes when starting a business. It really deters that very necessary risk taking that we depend upon in order to make things pop. All right, do we just give up there? No, there's another way. You see, there's probably a lot of people in your community--maybe even some relatives, but probably not--who are in their 50s, 60s, 70s, who have accumulated a little cash--and by "a little" I don't mean just a little, I mean, you know, hundreds of thousands, maybe a few million--who wouldn't mind trying to see new things happen, and would probably be willing to invest in your idea. And if it'd fizzle, they'd write it off. Now, they're not going to do that for free, they're not exactly angels. I don't think any...no matter what we'd call angel investing, I don't think they're really angels. But those folks will want a piece of the action. And you need $50,000, you maybe go find 5 of them, each at ten grand. Okay? And you'd give them each...say you want to keep back 20 percent of your company and the five of them take 16 percent of your company each; sounds like a fair deal. Things go well--they own you, a little bit of you--but at least you didn't put anything at risk and you got 20 percent of the company left over. And maybe over time they'll die off and you'll be able to buy them out and end up with your company. Now it could be that you haven't researched the heck out of everything and there's a big unknown alligator out in those waters that as soon as you power up and begin spending that $50,000 that you're starting up with, you find out it was just an insurmountable thing that maybe you could have known about if you'd have studied in that particular angle or thought about it, but you really didn't. Well, are they just out their money? No. And this is what I think the scariest provision in Nebraska law when it comes to entrepreneurship. It is provisions in the Nebraska Securities Act that then step into play and really increase the risk even more than if you went and borrowed the money and flopped. Now let me say at this point, I want to thank the Department of Banking for reviewing this bill after I introduced it and suggesting some ways that it could better be integrated into the Securities Act. And you have been handed out what is labeled AM431 which, in substance, follows the notion in the original bill but does so in a way that is...integrates better into the system of code that we have. This is the provision we have in law now. And as I read through it...ask yourself, would you go out and sell stock in your idea facing this? Would, if you were an attorney or an accountant, you encourage somebody to sell stock in their idea? Says: Any person who offers or sells a security in violation of (section 8-)1104 or offers or sells a security by means of any untrue statement of a material fact or omission to state a material fact necessary in order to make the statements made in light of the circumstances under which they are made not misleading, and the buyer not knowing of the untruth or omission and who does not sustain the burden of proof that he or she did not know and in the exercise of reasonable care could not have known of the untruth or omission shall be liable to the person buying the security from him or her, who may sue either at law or in equity to recover the consideration paid for the security, together with six percent interest, costs,

and reasonable attorney fees. Well, gee whiz. You face that language and you say, you know, I'm not going to risk that. How do I know for sure that I could prove that I didn't know something for good cause? I mean, it really puts the burden of proof on the entrepreneur, on the person seeking to sell the stock, that, you know, to just be an absolute guarantor if there was any information that turns out to be untrue or omitted to be stated. It makes it really, really scary. And if you're an attorney or an accountant and somebody wants to try to sell shares in their business, unless it's to really close friends or relatives, you just run the other way. And sometimes you'd run the other way anyway, because your malpractice insurance if you help people raise money for businesses, goes sky-high because the insurance companies don't want to take on the risk of things like this. It's really, really hard, and that language puts you in a position where you become guarantor of your offering. And if not an absolute guarantor, you're put in a plea-bargaining position when trying to--if you're sued--of having to cough up a big chunk of money. So we've eliminated the ability to access capital in the normal way for lots of small businesses. Now the bill that I've introduced today tries to address that and succeeds somewhat, not completely in doing it, but it's better than nothing. And that says that: For offerings of less than $250,000 if somebody complains that they lost their money buying stock in your deal, they have got to prove that you intended to cheat them; it puts the element of intent back in. There is an element of intent required by the federal law and this, in those limited, small offering situations, says that they have got to prove intent to cheat before they can successfully make a claim against you. It also makes it a little easier to register or to place the Department of Banking on notice that you are engaging in the business of trying to sell some stock in your little business, and it exempts that particular sale from the kind of regulations and paperwork that would otherwise be required of you to conform with the Nebraska Securities Act. I think that this goes at least part of the way to allowing people to access money for good ideas. And I think also it is...comes into play a little bit when, let's just say you were a community that had one of these old kind of opera houses that used to be on main street and used to be viable. And you wanted to raise money and set up a corporation, sell some stock in that old opera house to fix it up, and make it into a viable business that might make a profit and might lose some money. But whatever, you'd buy stock into it rather than just make a donation to some foundation you set up to buy the opera house and fix it up, try to make a viable business out of something like that on a community project. Well, this would also enable that kind of fund raising to take place without having to worry about somebody complaining after the fact that it was a bad investment and that they were unintentionally shorted or something was unintentionally omitted. So it is a rather simple way, I think, to enable folks to organize money at a very low level. After they get over a quarter of a million, at that particular point the regular rules kick in. I'm not so convinced that the Nebraska rules for over a quarter of a million are the best thing because they require still this negligent standard that the federal government doesn't require. But this bill tried to at least address the critical thing of a new business trying to organize money and encouraging entrepreneurs to go make those associations with people who have money, who have made money, and who,

quite frankly, behind the scenes will work for the success of the business. There is nothing like a little skin in the game to get the old boys who may have some money ready to pull the kind of strings they need in order for contracts to happen, for contacts to be made, for the business to become successful. And so that's why I introduced this today. It...in 30 years of practicing law, it's one thing that I've personally seen stop a lot of deals because bright, young people with an idea don't want to risk their house and a car and their financial security with debt. And they...if they went down the road to try to sell shares to folks, they don't want...you'd have to advise them that this is hanging over their head. And, quite frankly, if they have anything or any common sense, they'd be nuts in order to try to take on that kind of risk and also sell shares in their business. I'd be happy to take any questions. [LB205]

SENATOR GLOOR: Senator Schumacher, we're really talking about a provision of the Securities Act that relates to small securities, aren't we? [LB205]

SENATOR SCHUMACHER: Yes. [LB205]

SENATOR GLOOR: You and I may be coming at this from different ends of the issue. You're looking at ways that people can take advantage of opportunities to be entrepreneurs. And a couple of years ago I had constituents coming to me feeling that they'd been taken advantage of in small securities, and so I carried a bill for the department that tried to tighten up the small Securities Act so that people couldn't fly under the radar screen. The company, and there were eventually convictions, was called First Americans. And they were just offering small securities to friends and individuals in the community, but eventually, it proved to be a Ponzi scheme of sorts. I mean, it wasn't working. I'll be listening to make sure that we're not doing anything in this that ignores the lessons we learned from that. That being that, yeah, we want to be able to provide opportunities for people to finance their entrepreneurial spirit, but at the same time, we don't want to make it easier for somebody to repeat what happened in the central Nebraska community. Can you give me some kind of reassurance along those lines that you also went into this with your eyes open knowing sometimes people get into it for the wrong reasons rather than the right reasons? [LB205]

SENATOR SCHUMACHER: Well, first of all, this does not eliminate an offeror's liability for intentionally defrauding people. If it was a Ponzi scheme, if they knew they were...there was no way this thing could work and they were just basically bilking people out of their money, this does not protect them. This...provisions of this, if there is an intent to defraud, an intent to take somebody's money away and it's just a scheme, this does not stand in the way. In fact, the provisions in here basically call for the fact that they are still liable. You have to prove it, that it's a Ponzi scheme, but they are still liable. Also, this provides that the person who's making the offer has got to let the banking department know that they're making the offer and that they're active. And if the banking department...if there's any prior mischief by the offeror, the banking department

can require at that point a cease-and-desist order. So the banking folks really get--in order to qualify for this program--get advance notice that somebody's out there doing something and if anything appears out of order, probably would get an earlier notice than they would otherwise. And so it...I...it's not intended to enable anybody to cheat anybody out of any money, but what it is intended to do is take the risk away on the part of the offeror that you've just got to know everything in every way and then you've got to prove yourself innocent. [LB205]

SENATOR GLOOR: Okay. Senator Pirsch. [LB205]

SENATOR PIRSCH: Just in terms of background, can you kind of give the delineation? Certainly there's federal security law and state security--what they call blue sky law--and you have the, you know, on the federal side, the Securities Act of '33 and '34 and three other federal acts. But can you delineate just for the understanding of the committee, where the line is currently drawn in terms of that which is within our province to regulate? [LB205]

SENATOR SCHUMACHER: Okay. First of all, the states have got the right to regulate securities transactions within their border, but let's back up to your initial part of your question. Back in the Roaring Twenties and '30s, there was a problem with stock fraud. I mean, you'd sell snake oil and stock in the snake oil company and you'd try to get rich. So there was a 1933 Securities Act and 1934 Exchange Act, both of which had provisions that said it shall be unlawful to offer a security by use of any untrue statement, okay, or failure to state a material statement. And then evolution happened on the federal level. Over time, and probably peaking around--if my memory serves me correctly--in the 1970s, about the time I was in law school listening to the chief counsel for the Securities and Exchange Commission try to teach us securities law, there came to be a negligence standard put into the securities laws that it didn't require an intention to cheat, but the courts began to interpret a "you should have known before you sold these stocks" standards. And it got carried pretty much to the extremes. If I can remember a case right, there was an accounting firm that worked for a company that was issuing stock and there...the company that was doing it, had a policy that certain mail could not be opened in the regular course of opening the mail. It had to go to certain people before it was opened. Well, that mail had no nose in it as part of the stock operations. And the accountant firm was sued because everybody else was broke. And basically the case was, you were participating in this offering because you were the accounting firm involved, you were giving the advice out. You should have known something was up because this was a very abnormal procedure. You neglected to inform the people that something was up. And I think they were held liable. And so it got to a point where law firms, accounting firms, people who were not cheating anybody, were having real, real trouble doing what they do in the issuance of the organization of capital. About that same time I think, these kind of acts began to crop up on the state level; a little bit of monkey see, monkey do and mimicking the federal level.

And the federal government has since backed off, requiring actual intent to short people; the state acts have not. They've stayed at that high point of the negligence standard. And, quite honestly, I doubt very much if there's a whole lot of prosecution under the state act. But it's on the books, and if you're counseling entrepreneurs or people and you know it's on the books, you advise them to stay away from it. Accountants advise people to stay away from it. It's just too much--too much. And they don't have the money in a young operation, an entrepreneurial-kind of operation, to be able to take on the overhead to absolutely paper themselves silly so that, you know, they can come in when the time comes and say, look at all the research we did, write up the long prospectuses which on every other page warn you, you could lose your behind if you got involved with the deal. And nobody reads them anyway, but it's a function of the paper. And so, it deters the organization of capital. [LB205]

SENATOR PIRSCH: Yes. Under Dodd-Frank with the rise of the CFPB and it seems like there's pretty sweeping powers that may be not even...parts of it may be undergoing enactment and planning even now. Is there anything that would be implicated in this that would, you know, affect what we're doing here, proposed? [LB205]

SENATOR SCHUMACHER: I don't...I mean, Dodd-Frank, if it does anything with regard to the 10b-5 and 10b of the Securities or the Exchange Act, I don't know. But I do know that this is our act and if we're trumped by something in Dodd-Frank--which I do not pretend to know much about--if we're trumped by that, we're trumped by it. But I don't think we are. This is our act, and this is what I think is a problem that we can address and at least create a little exception to. [LB205]

SENATOR PIRSCH: Okay. [LB205]

SENATOR GLOOR: Senator Crawford. [LB205]

SENATOR CRAWFORD: Thank you, Senator Gloor. Thank you, Senator Schumacher. Is this...is there a similar kind of provision at some other state or was there any model that you based this on? [LB205]

SENATOR SCHUMACHER: This particular exemption I didn't...first of all, I think our state...originally, this particular Securities Act probably mimics a model act somewhere. [LB205]

SENATOR CRAWFORD: Uh-huh. [LB205]

SENATOR SCHUMACHER: It's written like it does, and I would suspect that it is. This particular exemption, the model for it really becomes the federal law that requires a dirty mind scienter, I think they call it. A dirty mind, in order to be liable. [LB205]

SENATOR CRAWFORD: Dirty mind. You should call it the dirty mind act. [LB205]

SENATOR SCHUMACHER: Dirty mind act. A little scienter never hurt anyone. [LB205]

SENATOR CRAWFORD: So the placement of blame or burden of proof, then, is modeled on federal, if I understand you correctly. I thought it was interesting, the provision about the written disclosure statement. Is that modeled off of something else or was that your idea? [LB205]

SENATOR SCHUMACHER: Well, it started out and then the banking department suggested little revisions in the language and something that they figured would work a little bit better procedurally than what I had and what I dreamt up. [LB205]

SENATOR CRAWFORD: Uh-huh. Uh-huh. Okay. Have you talked to any investors about this idea? [LB205]

SENATOR SCHUMACHER: No, I haven't talked to any investors... [LB205]

SENATOR CRAWFORD: Okay. [LB205]

SENATOR SCHUMACHER: ...other than I know the way it is now... [LB205]

SENATOR CRAWFORD: Okay. Right, sure. [LB205]

SENATOR SCHUMACHER: ...that you're very, very cautious, and that you only offer to either family or people that really are so loaded they probably wouldn't care. [LB205]

SENATOR CRAWFORD: And I appreciate you bringing that experience into the testimony. Thank you. [LB205]

SENATOR GLOOR: Senator Christensen. [LB205]

SENATOR CHRISTENSEN: Thank you, Chair. Senator, if these are like...I know in the green copy, one area where it says, very likely high risk, and where you stated--and I agree with you--that very few people read the prospectus, I guess it's called. Are we now leading people down a more dangerous road of losing money because one, they don't read, and two, we're encouraging people to try higher-risk investments again? [LB205]

SENATOR SCHUMACHER: Well, I don't know if this is encouraging people to try high-risk investments. In the prospectuses--is it prospectuses or are they prospecti--but, you know, what you...that are published in connection with registered offerings, those are incredibly complicated things all of which are embedded in there, this is a high risk,

you might lose your investment, this kind of thing. Which people...I mean, the professional investment advisors read through those things. I'm not sure that a common person ever reads through those things. But in this particular thing, I mean, any entrepreneurial kind of thing is a high-risk thing; lots of things can go wrong. And, I mean, after proper disclosure a person can decide if they want to participate in the offering or not. [LB205]

SENATOR CHRISTENSEN: Because I know if you start a business, and I've started a couple before, you've probably got less than a 30 percent chance of making it work because most people are underfunded or...and I know this is trying to reach out to help those that are underfunded and work on, but I guess I just get concerned that we're leading people down a road of jumping in on something that they shouldn't. I know your explanation at the beginning said that, you know, people that have money that can afford to write it off and lose it are the ones that should be doing this. But you always got those that don't have much that want to take that chance and bet against things they shouldn't have, and I guess I just hate opening that door for people if we shouldn't be. And I guess that's why I was asking. [LB205]

SENATOR SCHUMACHER: And the balance is between mobilizing capital or deterring entrepreneurial activity, and that's a balance. And what this tries to do is at $250,000, it strikes a balance. And up to that point, unless the person is out to cheat somebody, the Securities Act aren't going to come into play that much. [LB205]

SENATOR CHRISTENSEN: Okay. Thank you. [LB205]

SENATOR GLOOR: Senator Pirsch. [LB205]

SENATOR PIRSCH: Do you know, is somebody going to testify after you or is... [LB205]

SENATOR SCHUMACHER: I have no idea. [LB205]

SENATOR PIRSCH: Okay, so maybe I better ask you then. But so...and I'm just trying to get the extent of this. Does this purport for that amount, $250,000...offerings below $250,000? Is the standard then you get rid of what you called the negligence standard, right? [LB205]

SENATOR SCHUMACHER: Right. [LB205]

SENATOR PIRSCH: Is that right? So in (section) 8-1118, it...you wouldn't have the exercise of reasonable care requirement, right? [LB205]

SENATOR SCHUMACHER: You wouldn't have to...right. Basically, that's...I mean, it

isn't reasonable care. You'd have to...in the existing language, you'd have to prove that... [LB205]

SENATOR PIRSCH: Actual... [LB205]

SENATOR SCHUMACHER: ...the buyer not knowing of the untruth or omission, you'd have to...and on existing law, that he or she did not know and under the exercise of reasonable care could not have known of the untruth or omission. And this basically just shifts it back to the buyer has to prove that they were being cheated. [LB205]

SENATOR PIRSCH: That you did know, right? Essentially. [LB205]

SENATOR SCHUMACHER: Yeah, that you did know and you figured, I'm going to cheat you. [LB205]

SENATOR PIRSCH: Okay. And so that's one way in which it operates. Would it also require less, I mean...so if something met a criteria, less than $250,000 you properly...I mean, is there in terms of how you register these, are there less registration requirements than there would be exempt... [LB205]

SENATOR SCHUMACHER: It's an...there's an exemption from registration. [LB205]

SENATOR PIRSCH: Total exemption. Okay. [LB205]

SENATOR SCHUMACHER: But in that exemption, in order for it to stick as an exemption, it does submit filings to the Department of Banking and if you've ever pulled the wool over anybody's eyes in the process before, it sets you up to be stopped early on in the game. [LB205]

SENATOR PIRSCH: Okay. Do you know what year Nebraska implemented the negligence standard? You said in the 1970s, you thought. You don't know? [LB205]

SENATOR SCHUMACHER: In the thing that I printed out here in the statutes I've handed out, it looks like the first year is 1965, which would square pretty much with memory as to when the things were beginning to get negligence standard implemented in the federal law for a while. [LB205]

SENATOR PIRSCH: Yeah. And under the federal law, they don't have a negligence standard, right? [LB205]

SENATOR SCHUMACHER: The courts have backed off on it. The federal law, the wording never was changed, but the interpretation by the courts was changed. [LB205]

SENATOR PIRSCH: Right. And what are other states doing in this respect? Are they pretty much like what Nebraska is now? [LB205]

SENATOR SCHUMACHER: I think a lot of them have something similar to what Nebraska has. [LB205]

SENATOR PIRSCH: Okay, thank you. [LB205]

SENATOR SCHUMACHER: I don't think Delaware does, but I think... [LB205]

SENATOR PIRSCH: Are you...and then just one final...are you familiar with the bill Senator Gloor had introduced a number of years ago in response to the situation he described? [LB205]

SENATOR SCHUMACHER: No, I'm not. [LB205]

SENATOR PIRSCH: Okay, thank you. [LB205]

SENATOR GLOOR: Other questions? Seeing none, thank you, Senator Schumacher. [LB205]

SENATOR SCHUMACHER: Thank you. [LB205]

SENATOR GLOOR: We know that you're going to stay around to close or at least stay around. [LB205]

SENATOR SCHUMACHER: I can't get out of it. [LB205]

SENATOR GLOOR: Can I see a show of hands of those who would like to speak either as proponents, opponents, or in a neutral capacity on this bill? This will be short then. We'll start with proponents. Good afternoon, Mr. Director. [LB205]

JOHN MUNN: (Exhibit 3) Chairman Gloor. [LB205]

SENATOR GLOOR: I bet you remembered my bill. [LB205]

JOHN MUNN: And appreciated your help, as did the residents of Nebraska. [LB205]

SENATOR GLOOR: Go ahead. [LB205]

JOHN MUNN: Chairman Gloor, members of the Banking, Commerce and Insurance Committee, my name is John Munn, M-u-n-n, I'm the director of the Nebraska Department of Banking and Finance. I'm appearing today on behalf of the department in

support of Senator Schumacher's AM431 to LB205 which replaces the original language of the bill. The department would not have been able to support LB205 as introduced, and I'm appreciative of Senator Schumacher's willingness to work with the department to address the concerns we raised. The Securities Act of Nebraska is under the jurisdiction of the department. The purpose of the act is the protection of the investing public while, at the same time, facilitating the raising of capital, especially by small businesses. Protection of the public is accomplished by providing for the registration of securities, broker-dealers and their agents, and investment advisers and their representatives by prohibiting the use of fraudulent, deceptive, or manipulative practices in the sale of securities, and by providing for private civil actions and administrative and criminal penalties in the event of a violation of the act. Most importantly, the Securities Act of Nebraska requires full disclosure of all material facts relating to an offering of securities so that a potential investor may make an informed decision on whether or not to invest. The act exempts certain securities and transactions from registration. AM431 provides for a new transactional exemption from registration for securities offerings which do not exceed $250,000 over a two-year period, which use a minimum of 80 percent of the proceeds in Nebraska and which do not pay sales commissions except to registered agents of registered broker-dealers. Based on our experience, the department believes this exemption will be used by residents of a community raising capital to keep or reopen a business deemed essential to the community, such as a grocery or a cafe. Other important elements of the proposed exemption include a 15-day prefiling notice from the issuer to the department containing basic information about the offering and the delivery to potential purchasers of a written disclosure statement describing the proposed use of proceeds, the names of the insiders, and the financial condition of the issuer. Each purchaser must acknowledge in writing his or her receipt of the disclosure statement, the high level of risk associated with the investment, and his or her financial ability to withstand the loss of the entire investment. Finally, the issuer must file a post-offering statement with the department. There will be minimal regulatory compliance cost for the issuer under this exemption. AM431 would also amend two existing provisions in the Securities Act specifically in regard to these small offerings by limiting liability in civil actions and department administrative actions for these offerings to liability for misstatements or omissions of material fact made with the intent to defraud or mislead. Limiting liability is always of concern to any regulator. The changes proposed in sections 1 and 3 of AM431 are the result of much drafting and redrafting. We believe the proposed language is workable and appropriate within the confines of this new transactional exemption. It is the department's opinion that the proposed revisions to LB205 will facilitate the capital raising for small Nebraska startup businesses while protecting the Nebraska investor. I'll be happy to answer any questions. Thank you. [LB205]

SENATOR GLOOR: Thank you, Mr. Director. And so my assumption on this is that we've really maintained the integrity of the small offerings provisions of the Securities Act, disclosure reporting requirements and whatnot, but have made a few other little

changes. Have we changed the dollar amounts associated with... [LB205]

JOHN MUNN: This is good for offerings in total of less than $250,000. If an entrepreneur or a community wanted to go above that, there are other exemptions they could seek, but there are more restrictions as to the number of nonaccredited investors that could participate. One other difference in this exemption would be the issuer could advertise this opportunity to investors, where in (section 8-)1108, the one where you can sell to accredited investors and 15 or fewer nonaccredited, you can't advertise yet. [LB205]

SENATOR GLOOR: Okay. [LB205]

JOHN MUNN: And I think there's a presumption, too, in the bill, maybe in response to a question Senator Christensen raised, I think that investors are going to be closer to the principal activity of the entrepreneur rather maybe like in the case that you saw where there were investors not only across Nebraska, but outside of Nebraska. [LB205]

SENATOR GLOOR: Correct. Yeah, I would agree with that. Senator Pirsch. [LB205]

SENATOR PIRSCH: Thanks. With respect to your jurisdictional limits and as you bump up with federal oversight, so to speak, it's not so much a dollar level delineated, but just type of activity, right? Can you just briefly give...speak to that--to the limitations of state law to reach your domain, what you regulate as opposed to federal jurisdiction? [LB205]

JOHN MUNN: Well, of course, federal jurisdiction comes into play when you're talking generally interstate, you know, offerings. This does, as drafted, would allow up to 20 percent of the proceeds of one of these small offerings to be spent outside of Nebraska; the thinking being if it's a project in McCook or in South Sioux City where it may lap over into another state, you could seek support. And as Senator Schumacher said, sometimes those are your best disciples, investors in that type of thing. But when the activity is conducted within Nebraska, generally state securities laws. [LB205]

SENATOR PIRSCH: Yeah. Would it be...then would you work with other states then with respect to...or how would that work if 20 percent were in South Sioux...I'm sorry. Sioux City or something? [LB205]

JOHN MUNN: That's for use of the proceeds. [LB205]

SENATOR PIRSCH: Right. Okay. But there would...okay. And in terms of what's proposed here under the amendment that you're in favor of, there's no accredited investor type of requirement, right? [LB205]

JOHN MUNN: They may be, they may not be. [LB205]

SENATOR PIRSCH: Okay. And you'd still continue to, I mean, to the extent that it would be...there'd be related projects, you'd look at the totality of the circumstances in determining whether it was one...you know, in other words, you said a cafe or restaurant that you used. Well, if one project was to build a parking lot adjacent to the cafe or whatever for...and then one was parking, you know, I'm talking about a large parking lot of say a garage or something for $150,000 and then a restaurant next door to it for $200,000, that would be...you'd have the ability to say those are actually part and parcel one project, right? And, therefore, not within the $250,000...would you have regulatory... [LB205]

JOHN MUNN: Well, I suppose that's possible, but we aren't going to be giving the underlying enterprise, you know, a lot of scrutiny. [LB205]

SENATOR PIRSCH: Sure. [LB205]

JOHN MUNN: You know, that's why just the 15-day notice so we know this is happening, where it's going on, the substance of their disclosure statement and so forth. [LB205]

SENATOR PIRSCH: Yeah. Do you know, is this happening in these type of--I don't want to call it--de minimis but, you know, smaller scale security offerings. Are there...is this type of a thing available in other states that surround us or... [LB205]

JOHN MUNN: Not that I'm aware of. [LB205]

SENATOR PIRSCH: Okay. [LB205]

JOHN MUNN: And as to the type of activity that Senator Schumacher talks about, primarily the entrepreneurs because of our existing statute, I don't think there's a lot of that happening in Nebraska. The place where we see a bit of it is in the community-based types of things. [LB205]

SENATOR PIRSCH: Okay. [LB205]

JOHN MUNN: Unfortunately, we read sometimes in the Sunday paper how some community is very excited about they're able to keep their cafe, and five people put money into it. Well, they just tripped the securities statute, and we try and be as gentle as we can, but we have to go out and say, you know, you missed doing some things. [LB205]

SENATOR PIRSCH: Yeah. I see. That does happen. [LB205]

JOHN MUNN: And there is a cost. [LB205]

JOHN MUNN: And you'll have very well-meaning citizens, you'll have very meaning attorneys who are probably working for free, in a lot of situations, on community projects, but yet, they tripped our statute. As far as up to $250,000 it won't be as burdensome. If they should happen to miss the notice, the amendment does provide for a notice to cure of a late-filed notice. [LB205]

SENATOR PIRSCH: Okay, wonderful. [LB205]

JOHN MUNN: But our intent is...there's one in Senator Christensen's district in Cambridge, a clothing store was going out. Very well-meaning people, but they tripped the securities statute. [LB205]

SENATOR PIRSCH: Yeah. And just two other quick questions. To your knowledge, under Dodd-Frank, we're not running up against any kind of federal movement that would limit our jurisdiction in this? [LB205]

JOHN MUNN: No. About the only thing Dodd-Frank did in our securities supervision was raise the level of managed assets for investment advisor firms that fall under our jurisdiction to $100,000,000; used to be $25,000,000. [LB205]

SENATOR PIRSCH: Okay. And just briefly, the...since you played a major role with respect to Senator Gloor's legislation a couple of three years, can you just briefly reflect...refresh my recollection as to what we did in our security law? [LB205]

JOHN MUNN: It went mainly as to the penalties, the underlying penalties... [LB205]

SENATOR PIRSCH: Penalties. Okay, thank you. [LB205]

JOHN MUNN: ...for the activity that was standing. In that case it was the sale of notes. [LB205]

SENATOR PIRSCH: Yeah. Yeah, thank you very much. I appreciate it. [LB205]

JOHN MUNN: Uh-huh. [LB205]

SENATOR GLOOR: Senator Crawford. [LB205]

SENATOR CRAWFORD: Thank you, Senator Gloor. Is...when you talk about the limiting liability in civil action, is that just the change in terms of proof of burden that we talked about earlier or is there some other... [LB205]

JOHN MUNN: No. Primarily, the burden is on the purchaser. [LB205]

SENATOR CRAWFORD: Okay, that's just a shift in burden of proof. Okay, okay, okay, okay. And is 15 days enough, do you think, for your department to when the report comes in to check the person's record and make sure this is clear? [LB205]

JOHN MUNN: We think so. I think initially, Senator Schumacher proposed 30, and we felt that 15 would be sufficient. [LB205]

SENATOR CRAWFORD: Uh-huh. It was sufficient. Okay, excellent. And could you clarify, when you say a small community decides to get their clothing store back up and running and they trip security law, so what's the consequence for that community or people in the community when that happens? [LB205]

JOHN MUNN: Well, they didn't...they probably didn't disclose adequately, they probably advertised for investment... [LB205]

SENATOR CRAWFORD: Okay. [LB205]

JOHN MUNN: ...which is not allowed under the current statute. There have been, I think in the Cambridge situation, there were some rescissions where they had to go back and offer people their money back. [LB205]

SENATOR CRAWFORD: Their money back, right. [LB205]

JOHN MUNN: I think in that situation one of them didn't take it and said, no, I'm in anyway, even though I didn't get the sufficiency of the disclosure I should have had. [LB205]

SENATOR CRAWFORD: Right, right, right. Well, it's an interesting case, it's an interesting application of this... [LB205]

JOHN MUNN: It is. [LB205]

SENATOR CRAWFORD: ...for entrepreneurs and for communities, so thank you for that example. [LB205]

SENATOR GLOOR: Seeing no other questions, thank you very much, Director Munn. [LB205]

JOHN MUNN: Thank you. [LB205]

SENATOR GLOOR: Any other proponents? Any opponents? Anyone testifying in a

neutral capacity? Senator Schumacher, you're recognized to close. [LB205]

SENATOR SCHUMACHER: Just briefly, this is a bill that I think does quite a lot with changing not so much of anything that is...involves big money, and it enables us to I think try to stir the local equity market, try to...for entrepreneurship. It's very much along the theme that we've had on the floor several times about trying to get entrepreneur activity started. I think it also will make it possible for folks who may have a little money and earned a little money to engage in helping young people get started. And also a big part of this and I can't stress it enough, when you have somebody who has gotten some money, who is established in the community, put skin into your game, you have got a major ally in making your business successful. And they may not even be doing it for money, they may be doing it for fun, but it is important that you have that kind of undercurrent of community support from folks who made it when you're trying to start a business. And I think that's a big part of making things successful, and I think also this enables at least another avenue for people who may have ideas who may be properly cautious in not wanting to put too much of their young skin and their young family's skin in the game and, hopefully, it helps a little. So that...I'd take any other questions, but... [LB205]

SENATOR GLOOR: Are there any other questions for Senator Schumacher? Seeing none, thank you, Senator Schumacher. [LB205]

SENATOR SCHUMACHER: Thank you. [LB205]

SENATOR GLOOR: And with that, we'll close the hearing on LB205. We'll now move to LB228. And just a comment for those interested in testifying for either LB228 or (LB)523. I know Senator Nordquist, Senator Christensen have talked about these bills. There are people who are supporters of both bills or one bill more so than the other bill. We're not holding these together. We are running and feel the need to run separate hearings, but if you want to give us your pound of knowledge on one bill, you can grace us with an ounce of that knowledge on the next bill, just in the interest of time. And don't feel, for those of you who are new to this process, you can show up here and show that you are a supporter of both bills, but give us most of your testimony on one bill or the other. So with that, we'll start with LB228. Welcome, Senator Nordquist, nice to have you back. [LB205]

SENATOR NORDQUIST: Thank you, Mr. Chairman, members of the committee. I'll see if I can muster up an ounce of knowledge here with my opening. But, yes. [LB228]

SENATOR GLOOR: Oh, you're in charge of the pound of knowledge. [LB228]

SENATOR NORDQUIST: (Exhibit 1) Just to let you know, and as Chairman you recognize, I have been...spoken several times with Senator Christensen,

representatives of the chiropractors. And I'm offering an amendment to the committee that incorporates the intent of Senator Christensen's bill, (LB)523, into my bill. So with this amendment, LB228 would expand the cost-sharing parity to also include chiropractors as is in Senator Christensen's bill. The intent of LB228, as amended, is to provide parity in cost-sharing requirements between care sought from a medical doctor acting as a primary care physician and services rendered by physical therapists, occupational therapists, audiologists, speech-language pathologists, or chiropractors or chiropractic physicians. Essentially it would allow patients to pay the same for these therapies as when they go to see their family doctor. Currently in many health insurance plans, these medical professionals are classified under the specialist designation. Where the specialist designation is utilized, the classification is often accompanied by higher copayments for the consumer. Most other healthcare specialists are seen at significantly less frequent intervals than required in physical therapy, occupational, audiology, speech, or chiropractic care. This results in the patient paying higher copays for each specialist visit. These higher cost-sharing requirements multiplied by the number of treatments during one episode of care can act as a significant deterrent to finishing the full course of treatment and realizing the best outcome for the patient. Nationally, the copayment for primary care office visits average about $22 while specialty visits is about $32, according to an employer survey by the Kaiser Foundation. In the state's Wellness Plan for our employees, primary care office visits have a $20 copay, as do outpatient rehabilitation. So in our state Wellness Plan they are the same. I believe this is a recognition that in our state Wellness Plan, we understand the preventative benefits of these types of therapies in preventing more costly services...the need for more costly services down the road. However, in our regular plan, in our Choice Plan for state employees, they charge a 20 percent copay...20 percent after the deductible for these therapies, while they charge $20 and $30, respectively, for primary care visits. I think there's a real public policy question here as to whether a physical therapy session should cost as much as a visit to a neurosurgeon, for example. Visits to a neurosurgeon or other specialists of these sorts often are much less frequent than the kinds of therapies identified in the bill. It is not likely that a patient would need to see a neurosurgeon multiple times a week for several weeks. It's important to think of the long-term costs and incentives we are creating through this higher cost sharing that we currently have. Increased patient responsibility is often used to dissuade utilization of certain health services. For example, ER utilization has a high patient responsibility cost to dissuade people from utilizing it. Out-of-network providers is another example. But when we're talking about therapy, if patients don't get the ultimate course of treatment that they need and are dissuaded from that because of these high copayments, that very well could lead to them not regaining their full capacity, maybe facing surgery down the road, or additional costs through prescription drug treatment to treat that system. So as we move through a reform of our healthcare system, I think this is one area we need to talk about, about how to remove disincentives for preventative care, how to incentivize preventative care, and having smart cost-sharing structures that incentivize preventative behavior rather than leading to more expensive care down the road. So

that's the intent of LB228. I think that's the intent of Senator Christensen's bill. And I hope this committee will give it favorable consideration. Thank you. [LB228]

SENATOR GLOOR: Any questions of Senator Nordquist? Seeing none at this time, are you... [LB228]

SENATOR NORDQUIST: All right. I think I'm going to probably waive closing and head back to committee with Senator Christensen's bill. He can close for me, so whatever he says, act like it's right out of my mouth. All right? Thank you. [LB228]

SENATOR GLOOR: Can I see a show of hands of those who want to speak in any capacity on this bill, pro, con? Okay. We'll start with proponents. If you would, please come on up, proponents, and we'll get started. Good afternoon. [LB228]

JULIE PETERSON: (Exhibit 2) Good afternoon, Senator Gloor and members of the Banking, Commerce and Insurance Committee. I want to thank you for allowing me to testify today in support of LB228. My name is Julie Peterson, J-u-l-i-e P-e-t-e-r-s-o-n. I have been a physical therapist for 12 years and owner of Peterson Physical Therapy in Omaha, Nebraska. I also serve as a treasurer of the Nebraska Physical Therapy Association as well as the chair of the Practice Management and Reimbursement Committee. I am speaking on behalf of the Nebraska Physical Therapy Association in support of LB228. We also are in agreement with the amendment that was introduced by Senator Nordquist. The association represents 53 percent of all licensed physical therapists and physical therapist assistants in the state of Nebraska. It has been brought to our attention by patients as well as members that there has been an increasingly significant financial burden assumed by many patients in Nebraska when seeking physical therapy, occupational therapy, and speech therapy services, which ultimately limits access to care. Patients are encountering copays that range from $45 to $75 per visit and this often occurs after a calendar year deductible has been met. Some insurance companies are putting rehabilitation services under a category of specialist care rather than primary care visits as a cost-shifting strategy. Rehabilitative services are often provided two to three times per week for a period of several weeks so in the cases of stroke or traumatic brain injury, these services may carry on for months. It is therefore easy to calculate the high expense of receiving rehabilitative services when multiple visits are needed to fully recover from an injury. When patients cannot afford to pay high copays, the necessary rehabilitative services are not received. Take for example a patient who has undergone a total knee arthroplasty. It is imperative that these patients achieve functional range of motion following their surgery. Critical pathways are moving patients through inpatient stays quicker, relying on subacute, transitional care facilities, and outpatient facilities to complete postsurgical care. However, if a patient is faced with a $45 copay and is to receive physical therapy three times per week, the patient may choose not to receive skilled services. Oftentimes without skilled rehabilitative services a patient may need additional costly medical or

surgical interventions. In a 2011 research article published in the journal of Clinical Orthopaedics and Related Research, the authors reported that the most common indication for reoperation, not related to a joint revision, was due to joint stiffness in the knee. In fact, 58 percent of reoperations were due to stiffness. In a healthcare environment driven by outcomes and cost efficient services, patients would fare better with the appropriate treatment up front. Specialist copays are intended for specialized medical services or medical specialties such as seeing an oncologist or a cardiologist. Patients generally do not visit these practitioners on multiple occasions, unlike a provider of rehabilitation such as a PT, OT, or speech pathologist who often require several visits to achieve functional goals. Finally, on a personal note as a private owner of a physical therapy clinic, we are always trying to be one step ahead in providing services that exceed our patients' and our competitors' expectations. As a sole physical therapy clinic, I am continuously faced with the challenges of large hospital based or outpatient systems that have more money and more clout than one individual trying to make a difference in the community. My staff and I are focused and driven on outcomes and cost efficiency. We take a very personal interest in patient advocacy, especially when every visit counts. In the last year, I had a patient personally committed to her wellness and did everything she could for specialty services for urinary incontinence. She had a $50 copay and the reimbursement rate from the insurance company was $65. Therefore, my check from the insurer was for $15. I believe that my patient had absolutely no idea about her insurance benefits that were chosen by her employer. In conclusion, LB228 would protect patients against exceedingly high copays and coinsurances which limit their access to care. Therefore, I urge you to support LB228 in recognition that it is a bill to support patient advocacy and fairness in receiving quality rehabilitation services in Nebraska. We had one other comment on the fiscal note that we received. It had an indication for the state employee health insurance plan that we were asking...or in the bill that it wanted to convert rehabilitation services from a coinsurance to a copay. The bill does not say that. We just are asking that the copay, the coinsurance, or the deductible would be compliant with what you would be charged by going to your primary care physician. At this time, I'm finished, and I'd be happy to answer any questions. [LB228]

SENATOR GLOOR: Ms. Peterson, thank you for testimony. Can patients self-refer to therapists? [LB228]

JULIE PETERSON: Yes, in the state of Nebraska they can. [LB228]

SENATOR GLOOR: They can... [LB228]

JULIE PETERSON: Yes. [LB228]

SENATOR GLOOR: ...self-refer patients. Who determines the number of...I mean, how do you determine the number of treatments per week and the number of weeks

necessary, as a physical therapist? [LB228]

JULIE PETERSON: As a physical therapist you make that clinical judgment as to, you know, standard protocols. You know, for total knees and total joints there are some pathways that we can follow through the American Physical Therapy Association. Generally, it's just clinical judgment as to how often the patient is able to come, and financially, what the burden is to the patient. Insurance companies, though, often are restricting our number of visits, so there are many insurance companies that ultimately we run out of visits because of that visit limitation. [LB228]

SENATOR GLOOR: Is a number of visits or is a yearly, annual amount usually? [LB228]

JULIE PETERSON: It's usually a number of visits. [LB228]

SENATOR GLOOR: And is that per episode? In other words, if you're treating my knee or is that usually yearly maximum? [LB228]

JULIE PETERSON: It's usually yearly. And, again, some insurance carriers vary as to if it is per episode. But most of them are a yearly, calendar year number of visits. [LB228]

SENATOR GLOOR: Okay. Other questions? Senator Crawford. [LB228]

SENATOR CRAWFORD: Thank you, Senator Gloor. So just to clarify, I mean, the bill is calling for parity. So if an insurance company treats primary care physician payments with a copay, but...then you would be saying that they would need to treat services by physical therapists, occupational therapists also with a copay. Is that correct? I mean, I think that's what...I was trying to figure out the fiscal note, too. I think that was what they were trying to get at. [LB228]

JULIE PETERSON: Right. [LB228]

SENATOR CRAWFORD: If they...if a plan right now has those services under coinsurance, instead...that in order for it to be parity, it would need to...you would probably need to switch to a copay? Or am I misunderstanding that? [LB228]

JULIE PETERSON: Right. The intent of the bill is that if the coinsurance is a 20 percent coinsurance to your family care physician for a visit, then we would just request that the PT, OT, or speech visit would be the same coinsurance. [LB228]

SENATOR CRAWFORD: Right. [LB228]

JULIE PETERSON: If it's a copay of $15 to your primary care physician, we're just asking that if you go see a PT, OT or speech, that it's the same. [LB228]

SENATOR CRAWFORD: Right. So you're asking for the same type of payment at the same level, correct? [LB228]

JULIE PETERSON: That's correct. Exactly. Yes. [LB228]

SENATOR GLOOR: Seeing no further questions, thank you. [LB228]

JULIE PETERSON: Okay. [LB228]

SENATOR GLOOR: Good afternoon. [LB228]

NATALIE HARMS: (Exhibit 3) Thank you for being patient. [LB228]

SENATOR GLOOR: Not a problem. I was there two months ago, so I'm very empathetic. [LB228]

NATALIE HARMS: Senator Gloor and members of the Banking, Commerce and Insurance Committee, thank you for your time in hearing my testimony today in support of LB228. My name is Natalie Harms, I am a licensed physical therapist and have been a physical therapy professional for over 30 years. I know, I look really young. [LB228]

SENATOR GLOOR: We need you to spell your name for us, if that's all right. [LB228]

NATALIE HARMS: I'm sorry. Natalie is N-a-t-a-l-i-e, Harms, H-a-r-m-s. Thank you. [LB228]

SENATOR GLOOR: Perfect. [LB228]

NATALIE HARMS: I am the...a past president of the Nebraska Physical Therapy Association and I'm currently in my sixth year on the state licensure board and I am treasurer on the board of directors for the Federation of State Boards of Physical Therapy, which is a member organization representing licensing jurisdictions in the United States. I strongly ask for your support for this important legislation. Most of my career has been spent in education and patient advocacy. When one speaks of the access to healthcare services, the financial burden that healthcare creates is an important part of access and is important to consider. I am currently a co-owner of a private practice physical therapy corporation, and one of my tasks is to function as the CFO and work with patients on billing and insurance questions and concerns, of which there are many. I could share many stories of how insurance policies dictate to patients, through shared risk, a patient's ability to participate or not in their care. However, what I would like to do is to share with you my own personal story as a patient. The name at the top of the bill, pardon me, is now mine and has, more than any time in my career,

pressed me to educate and protect patients' rights and educate patients. It was one year ago that I received a diagnosis of psoriatic arthritis. This is a form of inflammatory arthritis which is probably most well known by the advertisements from a professional golfer in regard to medication. I didn't expect it, I didn't ask for it, I don't want it, and I don't want it to continue, but it's there and so I have to deal with it. Fortunately, I'm able to take medications that, for the most part, have stopped the progression of the disease with the exception of my left knee. On January 8, I underwent a total knee replacement. I have had surgical procedures in the past so knew what was going to happen, but nothing to this extent and certainly nothing requiring this much care. And currently, I am a patient in physical therapy. So I've been able to see this issue from both sides. My healthcare is a dance between my primary care physician, my orthopedic surgeon, my rheumatologist, and my physical therapist. Each one of these people play a role, whether it be medication management, postoperative care, how much care I need, and how long it needs to continue. I have to be the first to tell you that I deal in the world of physical therapy, so I don't often look at hospital bills, but it was rather shocking to see those bills with, again, my name on the top. The hospital bill arrived within two weeks of my discharge and was $60,457. I have been going to physical therapy since January and will continue through April. My current out-of-pocket costs for physical therapy--and certainly by the grace of God and being married to my husband, I have good insurance--is $827.01. And what I provided you is just a very simple graphic to look at the comparison if I were insured by other entities that we deal with on a daily basis. If I had Medicare, my out-of-pocket cost would be about $648 for the same amount of care, again, about half way to two-thirds through my rehabilitation at this point. But if I chose Medicare that was under a managed-care policy through either Humana or through UnitedHealthcare, as advertised and supported by AARP, my out-of-pocket cost for the same care would be $1,080. And lastly, if I had a policy with a $60 copay--which we do see several copay amounts at that point, currently, my out-of-pocket would be $1,620 for the same level and the same amount of care. And this is double what I currently pay, and I'm only part way through with my therapy. Patients are stunned when they find out what their out-of-pocket costs are. They have no idea what the policies are when they are choosing them. They choose to save money, but the policy sometimes that they choose only saves money if they don't access care. When I taught business management to doctoral physical therapy students at Creighton for many, many years, I would ask the students if they knew what their healthcare policy regulations were, if they even knew their deductible, or even who the company was, and certainly if they knew what their physical therapy benefits were. Over the 12 years I taught this course, only one student actually knew what their physical therapy limits were both in the terms of dollars as well as number of visits. And I would challenge all of us in this room the same question. Do we know what our policy states? And we're expecting people that are lay people that don't understand health insurance to understand, if I choose this policy, I'm choosing a $60 copay. They don't know. They could wake up tomorrow and have a stroke. They could break a hip today and break their shoulder in September and not have money to pay for the types of care that they need. I will continue my therapy

because if I don't, I will become a statistic. If I don't, I will need surgery again. And if I don't, there's no doubt that I could become disabled. And that is not the path that I choose, but I have a choice. I choose to do what my physicians and my physical therapist tell me to do. Many patients do not make that choice and cannot choose their own healthcare over putting food on their table. We write off about 7 percent of all of the care that we provide because people simply can't meet those copays. I certainly thank you for listening to my story and thank you for your time. And please speak on behalf of those patients who are not knowledgeable about how to maneuver through the complex system of insurance by voting in support of LB228. I would be happy to answer any questions. [LB228]

SENATOR GLOOR: Natalie, one of the things that I...initially comes to mind when I look at this sheet with the difference in out-of-pocket is, to me this represents the purchasing power of the payor because the lowest out-of-pocket is for Medicare--which I think brings most payors a majority of their patients--and then Blue Cross, and then you drop to the Humanas, Uniteds and I would imagine the number of lives that they cover. So I'm trying to decide whether this is a purchasing power graph or just an example of how much people have to pay out-of-pocket, because I'm not sure what we're talking about in this bill would dramatically change the differences between each of those. [LB228]

NATALIE HARMS: It is probably, to answer your question, a little bit of both certainly... [LB228]

SENATOR GLOOR: Okay. [LB228]

NATALIE HARMS: ...because as you see lower priced healthcare insurance you see increased risk on behalf of the patient. The unfortunate piece of that is the patient doesn't always understand that. So when you look at a health insurance with a $60 copay because of the way we're classified, it's just an example of the difference of what I would have to have paid if I were in a policy that classified physical therapy as specialty. [LB228]

SENATOR GLOOR: Well, and allow me to use this as an educational opportunity for us as legislators and the audience. We are having conversations about healthcare exchanges and navigators and the whole dialogue about being wise shoppers when you take a look at policies and knowing what you're buying for. This is a good example, I think, of some of the nuances when people go onto the market buying insurance. I would think you're correct. Most people don't look at their therapy coverages and what's covered, what isn't, limits on the number of visits, and so on and so forth. So thank you for that educational opportunity. [LB228]

NATALIE HARMS: Absolutely. [LB228]

SENATOR GLOOR: Are there other questions for Ms. Harms? Senator Crawford. [LB228]

SENATOR CRAWFORD: Thank you, Senator Gloor. What I want to clarify about the illustration as well, if I understand its relation to the bill, it's not just about purchasing power, but it's about the fact that some companies right now charge the specialist copay. And so that $60 is what they could get if they went to a cardiologist or some other specialist, right? And so the lower end, maybe the Blue Cross/Blue Shield, that amount might be...I don't know if it's the same as a primary care physician or if it's just a lower specialist copay when you hit this bottom end, the lower end. [LB228]

NATALIE HARMS: In my case--and those were statistics for me--in my case, it's actually a little bit higher than what my copay is for my physician because as you pointed out earlier, for my physician--and even in Blue Cross/Blue Shield--they don't classify my orthopedic surgeon as a specialist so it's a $25 copay. So my copay for physical therapy is slightly more than that because it's a percentage versus a copay. [LB228]

SENATOR CRAWFORD: So if this bill were to pass, it would be less than this? [LB228]

NATALIE HARMS: You know what? [LB228]

SENATOR CRAWFORD: What? Well, you... [LB228]

NATALIE HARMS: Well, when I read the bill, I don't believe that our intent was to say that if an insurance company has a copay that everybody should be under a copay or if an insurance company has a coinsurance that everybody should be under a coinsurance. That was not the way I interpreted the bill when I first read it. The nuance of the bill is to say that the reimbursement should be commensurate. So there shouldn't be, for instance, a 20 percent coinsurance if you went to your primary care physician versus a 30 percent coinsurance if you went to PT, or an extraordinarily high copay if you went to PT because of that classification versus a coinsurance with a physician. And, again, I provide that just as an example of if I had that insurance, this is what it would cost. [LB228]

SENATOR CRAWFORD: Thank you. [LB228]

SENATOR GLOOR: Any other questions? Seeing none, thank you. [LB228]

NATALIE HARMS: Thank you. [LB228]

SENATOR GLOOR: And we'll give you all the time you need to get back to your chair. [LB228]

NATALIE HARMS: Thank you. [LB228]

SENATOR GLOOR: (Exhibit 4) In fact, that gives me time to say I'm going to ask the pages to hand out a letter of written testimony from Justin Young who currently represents the Nebraska Occupational Therapy Association. Good afternoon. [LB228]

MEGHAN SCHLATTMANN: Good afternoon. [LB228]

SENATOR GLOOR: Whenever you're ready. [LB228]

MEGHAN SCHLATTMANN: (Exhibit 5) Okay. Good afternoon, Senator Gloor and the members of the Banking, Commerce, and Insurance Committee. I want to thank you for allowing me to testify today in support of LB228. My name is Meghan Schlattmann, M-e-g-h-a-n S-c-h-l-a-t-t-m-a-n-n. I have been a physical therapist for close to eight years and co-own Dundee Orthopedic Physical Therapy in Omaha, Nebraska, with my husband. I'm here today in support of LB228 on behalf of my profession and each individual who would greatly benefit from the services provided by all of the professions denoted in the bill. Over the past several years, healthcare consumers have endured rising out-of-pocket costs. Higher healthcare insurance premiums, deductibles, and copays are unfortunately the norm. For healthcare consumers who choose a plan that assigns copays for healthcare services, the amount of their copay depends largely on the type of care they are accessing; primary care, specialists, or an emergency room visit. Physical therapists often follow under the specialist category which brings with it a higher copay than a primary care visit. I find this deferral of healthcare cost to the patient unfair due to the frequency with which patients must access physical therapists versus a medical or an M.D. specialist. A typical physical therapy episode of care consists of multiple visits. For post orthopedic surgical patients, this can exceed 15 to 20 visits over a few months. Consultations with M.D. specialists usually only occur two to four times a year. All the disciplines denoted in this bill have contact with their patients multiple times over their episode of care, and the financial burden of higher copayments is often a deterrent to accessing their services. For many diagnoses, especially following an orthopedic surgery or a significant incident of back pain, if patients cannot afford to see their physical therapist with the regularity their diagnosis requires, they will experience significant functional limitations and possibly need further expensive medical procedures including surgery. The increased functional limitations can also limit an individual's ability to be a productive member of society. A patient may not be able to return to work, thus losing their income and needing to access unemployment assistance and/or be placed on disability. Research also shows that the mental burden of not being able to return to the previous professional and personal functional levels can lead to chronic pain and depression, both of which bring their own increased health costs and burden on society. As a private practice owner, I have a deeply vested interest in my profession, my patients, and my community. I truly believe

it is my duty to be an advocate for my patients. My husband and I operate a single-location private practice. Our livelihood hinges on the ability to provide the best, most effective care and achieve our patients' goals in a cost-effective and timely manner. If we don't do this, our patients will not return to our facility and will not refer family and friends. In supporting this bill, I am not seeking increased payment for my services. I am seeking to decrease the financial burden placed on patients by their insurance companies for care of healthcare professions that must be accessed frequently. Individuals should be in control of their own health, not their insurance company. In the state of Nebraska, physical therapy is a direct-access healthcare profession, meaning an individual legally does not need a referral from a physician to seek our care, which is another example of why we should be assigned the same copay level as a primary care physician. I am currently treating a woman in her late 80s that has a Medicare policy through AARP, which is a managed...is managed by UnitedHealthcare. She is responsible for a $40 copay for each visit because I'm listed as a specialist in her policy. In contrast, her primary care physician copay is $15. She had a total hip replacement, and the decision of whether or not she can stay in her home where she was living independently prior to surgery, depends on her attending physical therapy to improve her strength, balance, and overall function. Like many of her contemporaries, she lives on a fixed income and is currently trying to figure out how she will afford my services. She has told me that she can only afford one $40 copay a week. Typically a patient her age with her diagnosis attends physical therapy two to three times a week to achieve sustained functional independence. She is also frustrated because she knows if she isn't able to come regularly and improve her functional capacity she will have to move into an assisted living facility, which will deplete all of her funds. She should not be in this situation. If physical therapists were assigned the same copay level as a primary care physician, she would be able to afford the necessary amount of physical therapy. To conclude, LB228 will help to decrease the financial burden of increasing copays and coinsurances that are limiting patients' access to the healthcare they need and deserve. Support LB228 and you will be advocating for patients' rights and their ability to access quality rehabilitative services in Nebraska at a reasonable cost. Thank you. [LB228]

SENATOR GLOOR: Senator Christensen. [LB228]

SENATOR CHRISTENSEN: Thank you, Chairman. Thank you for sharing. I'm not picking on you. I'm going to make a couple of statements as an introducer of similar language. I've got to be careful not to talk the committee out of this. But, you know, if we're...as you said, if we're trading physical therapy for...instead of doing surgery or something, great; it's a great cost saver. But when we talk about decreasing the copays to make sure they're getting physical therapists to make sure we avoid that surgery, the consequence of that is driving insurance costs. And if we drive up insurance costs, then we end up with problems with either people going uninsured or employers drop insurance. It's a very delicate balance for this committee. And then you give another

great example--and again, not picking on you, but want to show you how we have to weight this--you do the example if they don't get their physical therapy, they won't be able to stay in their home so they're going to end up probably in some type of managed care rest home, something this direction. But the problem we run into, that's a different insurance. So if we run the cost up on the medical insurance to make sure they stay in their home, it's a different insurance they probably have for their cost to be in a rest home. And so we get into the situation of we're weighing multiple different baskets and multiple different ways of handling the whole situation because I even put on here, you know, if we stabilize insurance costs, we're probably driving up copays. If we increase the...or decrease the copays, then you're driving up insurance costs and it's a very delicate balance in here. [LB228]

MEGHAN SCHLATTMANN: Oh, absolutely. [LB228]

SENATOR CHRISTENSEN: And then when you start comparing going to a rest home which...or managed care situation versus the additional physical therapy or whatever is needed, you almost are coming out of two different insurance premium pots of if we do do more, which I agree, do physical therapy and keep them out of the rest homes which is a better financial position for the family and, specifically, if they don't have the rest home insurance or the--there's...and I don't know how to handle it all. And, as I said, I am a cosponsor of same legislation and don't want to talk committee out, but there's the delicate balance of through this whole situation that we must weigh. And you're welcome to respond, but you don't have to. I just thought I'm going to share because you give two great examples. But the consequences that we got to weigh on this side, I just wanted to share. [LB228]

MEGHAN SCHLATTMANN: No, absolutely. And it is, I mean, I am the accounts receivable department of my clinic as well as being a physical therapist, and so I encounter this on a daily basis. And in speaking with patients and the types of insurances they have, whether it's Medicare or private insurance, it's...as Natalie spoke to earlier, 90 percent of them have no clue what their policy entails. And I would say probably 10 percent of my patients who are of Medicare age have insurance that would then possibly cover them in an assisted living situation or extended care type things, but 90 percent do not because they don't realize that it's not covered under that. [LB228]

SENATOR CHRISTENSEN: Right. [LB228]

MEGHAN SCHLATTMANN: So, again, where are we? How do we address it? But, I mean, the main point is just because with the regularity patients have to access our care, having the copay or coinsurance be the same as a primary care visit would make a significant difference in the ability of these patients to afford the care that they need and then decrease the burdens of other areas of their life. [LB228]

SENATOR CHRISTENSEN: And I don't disagree with you. If we look at the total cost if we can have more physical therapy, whatever, and keep them home rather than have a repeat, or the example we had up here of had the knee replacement. If we don't get that taken care of, there's going to be additional surgery. I agree with that, and so there lies the difficulty... [LB228]

MEGHAN SCHLATTMANN: Best of luck. Yeah. [LB228]

SENATOR CHRISTENSEN: ...and understand what you're after in getting it reduced copay, that could drive up my insurance costs also. [LB228]

MEGHAN SCHLATTMANN: Uh-huh. [LB228]

SENATOR CHRISTENSEN: So okay. Thank you. [LB228]

SENATOR GLOOR: Senator Crawford. [LB228]

SENATOR CRAWFORD: Thank you, Senator Gloor. Well, I wonder if there is a good example to talk about in terms of meeting that balance. And I...the example that I've often heard is back surgery versus therapy. And I don't know if you have figures or if you could get figures to us, but...because when I first, you know, when I see the fiscal note, it's looking just at insurance costs. [LB228]

MEGHAN SCHLATTMANN: Right. [LB228]

SENATOR CRAWFORD: But the insurance I would...the cost to an insurance company to pay for physical therapy for therapy for a back situation versus the insurer's insurance cost to pay for back surgery is much higher. So the underutilization of therapies has other implications for costs, as well, is my sense. And it seems to me that's one of the challenges we're facing in terms of changing healthcare use patterns. [LB228]

MEGHAN SCHLATTMANN: Absolutely. [LB228]

SENATOR CRAWFORD: And so I don't know if that's an example where you might know what those figures would be. [LB228]

MEGHAN SCHLATTMANN: Actually, I am a certified spinal manual therapist and I specialize in back pain. [LB228]

SENATOR CRAWFORD: Okay. And she didn't plant that question. [LB228]

MEGHAN SCHLATTMANN: No, promise. And so...and I also am a faculty member for the company. I'm certified through and teach continuing education to physical therapists

on spinal-related issues; chronic pain, neurological pain. Yes. It is a huge discrepancy between the back surgery, therapy for back pain. There is...and part of it, I find it...for our profession, we haven't educated well--medical professionals as well as the general public--as to what we can do to help people with back pain versus just going to get surgery. We do live in a day where people want it now. They want to feel better now. They don't want to put the work in to do it, and so surgery seems to be a way to do that. There is very little in the realm of research that shows in the last 15, 20 years any major accomplishments have been made as far as improving outcomes and/or techniques with back surgery. The only thing that has changed is the amount insurance companies pay for it which has gone through the roof and so, thus, the rate of back surgeries have skyrocketed. In my personal experience, probably 70 to 80 percent of patients who come in with back pain and/or related-like pain as a result of the back pain, the majority of their pain is neurologically based; irritated nerves due to whether it's a disk injury, joint injury in their back. But the nerve is what is creating most of the pain and most of the problem. Unless the nerve is completely compressed and you're losing function and sensation completely, surgery will not necessarily fix that. Therapy, on the other hand, has a very high rate of success with patients with those conditions. But, again, most people don't know that. And again, I..you know, it's our fault as a profession for not getting out there enough and educating on that, but it is much cheaper to come to a physical therapist for back pain than it is to go have a surgery. I mean, her knee surgery was $60,000. Back surgery is way more expensive than that, and so, yes, it is a prime example of how increasing access to our services for that specific group of patients would be an immense cost saver for the general public. [LB228]

SENATOR GLOOR: Let me...maybe this is springboarding off your comments. You're kind of my dream come true in terms of a foil for some of my issues. I would say you've made a very good argument for why what therapists do is more akin to primary care physicians than orthopedic back specialists. But I think I also heard you say that all these expensive surgical suites we've built to do very expensive orthopedic surgery aren't a very good investment compared to a couple of small gyms that we've built for therapists to do their things on backs. Am I hearing that correctly? [LB228]

MEGHAN SCHLATTMANN: Yes. [LB228]

SENATOR GLOOR: We ought to have a moratorium on new surgical rooms, I think, in the state. [LB228]

MEGHAN SCHLATTMANN: I would agree. [LB228]

SENATOR GLOOR: It's an idea I might continue to pursue. [LB228]

MEGHAN SCHLATTMANN: But from a PR aspect, they are wonderful for patients if they see these shiny new rooms and everything. [LB228]

SENATOR GLOOR: Well, in my personal experience--because I used to be a hospital CEO before--is that you'll never get me to have back surgery unless I have to be wheeled in. I mean, that's my personal experience. [LB228]

MEGHAN SCHLATTMANN: Uh-huh, as is mine. [LB228]

SENATOR GLOOR: Except I also know that the day may come when that has to happen, that most of the back patients that I know who worked and worked and worked and exercised and took care of themself, eventually got to the point where they were able to assume a pretty normal life. But ten years down the road, still find themselves gravitating to back surgeries. Not all... [LB228]

MEGHAN SCHLATTMANN: Uh-huh. [LB228]

SENATOR GLOOR: ...but quite a few of them. But you've made a very good argument for why you see yourself more attuned to what we pay for primary care... [LB228]

MEGHAN SCHLATTMANN: Uh-huh. [LB228]

SENATOR GLOOR: ...than what specialists get paid. So that was a good example that you used... [LB228]

MEGHAN SCHLATTMANN: Thank you. [LB228]

SENATOR GLOOR: ...because I was struggling with that myself thinking, therapists and primary care physicians. But that's a good argument. [LB228]

MEGHAN SCHLATTMANN: Thank you. [LB228]

SENATOR GLOOR: Senator Campbell. [LB228]

SENATOR CAMPBELL: Thank you, Senator Gloor. I just want to add to that. You know, I can sympathize with the previous testifier because I've had a total knee replacement also. But I think what's also sad is when you see someone go through that surgery and then they do not do the number of visits they should to get that range of motion back. I mean, you have almost lost the benefit of not only that replacement, but the functioning of that knee when they don't continue because of high copays. So it's not just an issue of whether it's a surgery or not, but how important those two are that come together and...I mean, I can remember sitting waiting for my physical therapist and this lady sitting next to me and saying, this is my last time coming because I just can't pay the...I just can't do the copays anymore. And I'm thinking, golly, all that money spent and then... [LB228]

MEGHAN SCHLATTMANN: Yeah. And then...uh-huh. [LB228]

SENATOR CAMPBELL: ...to lose that functionality. [LB228]

MEGHAN SCHLATTMANN: Uh-huh. And then, that's our main goal is returning people to the life they want and the function. The function is the thing, and it requires the regularity of visits and, you know, the duration to achieve those. Uh-huh. [LB228]

SENATOR CAMPBELL: Absolutely. Absolutely. [LB228]

SENATOR GLOOR: Other questions? Seeing none, thank you very much. Other proponents? Proponents for this bill? Opponents for this bill? We'll move to opponents. Good afternoon. [LB228]

RUSSELL COLLINS: (Exhibit 6) Good afternoon, Senator Gloor and committee members, my name is Russ Collins. I'm vice president and associate general counsel of Blue Cross Blue Shield of Nebraska. Blue Cross Blue Shield of Nebraska opposes LB228. This legislative bill, along with... [LB228]

SENATOR GLOOR: Russ, could I ask you to spell... [LB228]

RUSSELL COLLINS: Sorry. Russ, Russell, R-u-s-s-e-l-l, last name, Collins, C-o-l-l-i-n-s. [LB228]

SENATOR GLOOR: Thank you. [LB228]

RUSSELL COLLINS: And forgive me if I combine LB228 and LB523 in my discussions, we've analyzed them collectively. We've tried to separate that out, but apologize in advance. This legislative bill, along with LB523, will increase the cost of individual and group health insurance in Nebraska and narrow the availability of tools insurers can use to keep insurance products affordable as the cost of the delivery of healthcare continues to rise. Today, Blue Cross has insurance policies and group insurance products that include higher copayment amounts for office visits to specialist physicians and lower office visit copay amounts for office visits to primary care physicians, as other testifiers have mentioned. Physical therapists, occupational therapists, audiologists, and speech-language pathologists are generally not included in the copayment structure for products at Blue Cross. Generally, as referenced sort of broadly by a previous testifier, those providers are subject to coinsurance and deductible amounts under most of our products. Our analysis estimates that requiring office visit copayment amounts being the same or parity for those amounts would increase the cost broadly across these products of approximately $500,000 annually. Office visit copayments were developed initially to encourage the efficient use of the healthcare system and to lower the policyholder's

cost-share amounts for basic office services at internists, family physicians, and other primary care doctors who generally treat a broad range of services, potentially to all body systems. When compared with the deductible or coinsurance obligation, which are generally calculated as a percentage of the allowable charges for the services, the office visit copayment is a flat dollar amount, generally well understood by policyholders. Higher office visit copayment amounts for specialist physician visits or other healthcare providers' services are generally applied because the scope of services specialists may treat is narrower than those of a primary care provider. Patients may see specialists for specific reasons rather than use the specialist for general care or to manage a broad scope of care. It's not uncommon for specialists to refer patients to other providers for services that may be outside their scope. In addition, Blue Cross uses deductible and coinsurance in certain insurance policies and products and applies those obligations to certain services that could be billed independently or with an office visit. It's possible that the manner in which these cost-sharing obligations apply to certain patient accounts can result in higher amounts paid by patients when services are provided by certain providers compared to primary care physicians. However, the differences in codes billed by physicians compared with other providers, including those addressed in LB228, may account for some of these differences. By opposing LB228, Blue Cross does not imply or assert in any way that physical therapists, occupational therapists, audiologists, or speech and language pathologists are not able to deliver cost-efficient care for multiple conditions. In many cases, these providers may be the best choice of provider for patients in certain settings. However, this legislation will limit the use of certain cost-sharing tools and, accordingly, increase the cost of health insurance premiums. This proposed legislation comes when the industry and consumers are working hard to keep up with new regulations and the corresponding increase in costs and premiums that may arise from the federal Affordable Care Act. For all of these reasons, Blue Cross and Blue Shield of Nebraska opposes LB228, and I'm available for any questions. [LB228]

SENATOR GLOOR: Mr. Collins, let me ask you. As you reviewed the bill, what would happen if a payor reverted to a different delivery model like one of the old HMOs where there was a gatekeeper? Would that mean if the insurer decided...required all patients to go to a primary care physician before they...family practitioner, pediatrician...before they received care from anybody else, whether it was a therapist or an orthopod or a neurosurgeon, and as an enticement to do so, waived any copays for that visit as an enticement for them to do so, would then this bill be attached to the hip to that? Would that then mean that no therapist of any kind could also be charged a copay? [LB228]

RUSSELL COLLINS: If I'm understanding your question, I believe the parity language of the legislation would require zero copay to be applied to the categories of treatment by the categories of providers that are addressed in the bill. [LB228]

SENATOR GLOOR: In this bill. Okay. Thank you. Other questions? Senator

Christensen. [LB228]

SENATOR CHRISTENSEN: Thank you, Chairman. More of a statement, then I'll let you address it. I see this, looking down at the problem we have from the 60,000-foot area coming down to...I went through about three years of lower-back pain. And if I went to a general physician, I got pain killers; went to a chiropractor, I got adjusted in the sore areas; went to a massage therapist, got the muscles worked down in the sore areas, and never got the situation dealt with. Finally, I found a NUCCA doctor, which is a advanced chiropractor. And to give you an illustration, you know, if this is your spine and your head sits on here, if your head gets tilted off, your body does this to get the head straight and messes up your body. That's what was happening to me. You can literally say I had my head crooked, right? But...and in looking at x-rays, it was 6 percent off. And in getting that adjusted, I spent six months--almost six months now--totally pain free, other than I got took by a cow two days after Christmas and got knocked off again and got that adjusted back. Other than that spell there, I'm six months pain free that I haven't been in over two years. You know, it cost me $300 for all the x-rays to do the before, the afters, and everything. And the office visit the first time--and he didn't get it clear the first time--we finished it the second time. So $360 I'm sitting pain free, but yet I went through two years of severe pain spending all kinds of money; physical therapists, massage therapists, chiropractors. That's why I say at 60,000-foot level, how do we determine what people really need because I think every one of them, I don't care, physical therapist, chiropractor, the NUCCA doctor, physical...the general physician--all have their place and all are beneficial. But how do we figure out which one it is we need to go to? Took me over two years. I sat here just happy as a lark feeling so good. I can think this summer handling 80-pound gear boxes and in excruciating pain holding it up trying to bolt it on. Shoot, now I would think nothing of it. Sixty thousand-foot level, insurance or whatever could cover what it cost me to get to feeling great if I knew where to go. I'd never heard of a NUCCA doctor. NUCCA.info, anybody that doesn't know it. I mean, I'm not going to say they're the cure-all because I know better. PTs are needed. OTs are needed. I just wished I had the magic wand to say, well, you need to go here for this, here for this. We could solve the medical cost problem. I'd hate to tell you how many dollars I spent between the massage therapist, chiropractors, the PT, whatever, I spent trying to get taken care of, and I've had six months free. You can respond; I don't think there's really anything really to respond to, but that's the issue I see. They all have their spot, but I don't know...if somebody comes up to me, I can tell them my experience. That's how I got to where I did. That's the magic thing. We could cut costs if we knew where to send people. I don't know how you determine that. [LB228]

RUSSELL COLLINS: Yeah, I think we'd all want a magic wand at some point trying to solve these problems. But I think that one thing that--just to make clear--is in our products, particularly our small group products, the choice about how these copays are used are generally left to the employer groups that are making these choices. We offer products with copay differences between primary care and specialists and products

without it. And I think the example about the state's various plans shows that different products are right for different employer groups or different customers. And we offer a full range of products with and without these copay differentials. [LB228]

SENATOR CHRISTENSEN: Thank you. [LB228]

SENATOR GLOOR: And before the audience gets too sympathetic for Senator Christensen, he took me out in a pickup basketball game two years ago and I had to have my knee scoped. So...and I had physical therapy afterwards. Senator Howard. [LB228]

SENATOR HOWARD: Thank you, Senator Gloor. Thank you for your testimony. I am still learning about the insurance business models so bear with me. What's cheaper for you? Is it a patient going into surgery or is it a patient going into physical therapy? [LB228]

RUSSELL COLLINS: I think it depends. But surgeries are generally, as has been discussed, would be much more expensive than multiple therapy sessions. [LB228]

SENATOR HOWARD: Okay. And then we've heard from other types of insurance that what's cheaper for you, a patient who goes to PT or a patient who doesn't go to PT? It's cheaper for you if they don't go to PT, right? [LB228]

RUSSELL COLLINS: It would depend. It would depend. [LB228]

SENATOR HOWARD: So if they don't access the service, it costs you nothing. [LB228]

RUSSELL COLLINS: Correct. [LB228]

SENATOR HOWARD: Okay. So my concern in not having parity is that right now it's acting as a disincentive for preventive care, which is I think what the Affordable Care Act is trying to rectify. And it in the long term, should make it cheaper for you preventing folks from going into these more expensive surgeries. And so, I guess, could you explain your opposition in light of the utility of preventive services? [LB228]

RUSSELL COLLINS: Yes. I think one thing to keep in mind is, as I discussed, that we use a coinsurance and deductible to be applied to most PT, physical therapy services. So if we could stick to that example... [LB228]

SENATOR HOWARD: Sure. [LB228]

RUSSELL COLLINS: ...we use copays generally on office visits or chiropractors, which we can talk about on the other bill, but coinsurance and deductibles are applied to most

of the products that we sell for physical therapy visits, so it wouldn't be a copay. So there's a difference there that there would be a coinsurance and deductible that would be applied. But certainly, there the question about what care you are incentivizing and the capacity to pay is always an issue. Our focus is providing...is trying to make affordable products and bring those to the market. And the cost...the overall total cost of the product drives the premium. The cost of premiums is just made up of the cost of all the claims for all the individuals under that product divided by the number of individuals--that's plus some administrative costs--that's just the premium. So more claims equals higher premium. [LB228]

SENATOR HOWARD: Regardless of the type of claim? [LB228]

RUSSELL COLLINS: Regardless of the type of claim. [LB228]

SENATOR HOWARD: Okay. [LB228]

RUSSELL COLLINS: And so certainly the cost-sharing obligations that are present in many plans, copayments, coinsurance, and deductibles can create incentives to have care or to not have care. But the thought process behind the way that they are applied is to encourage the efficient use of care in most circumstances. Certainly there are facts where it can be turned on its head. I think like any situation, everybody's different and the care that they receive will be different, but the overall concept and the overall design is to manage the increase in the cost of care with these cost-sharing obligations and to create incentives. And certainly the preventive care, it really...with the new regulations going forward under the Affordable Care Act, we really need to be clear about what type of preventive care are we talking about. But the therapy preventive care here that we're talking about, there are generally cost share obligations. And, again, the focus on making them higher in certain specialties is because they cannot treat a broad spectrum of disorders. So should something else come up at the visit, they maybe have to go to another doctor to have that condition treated. A physical therapist is not going to treat an ear infection that might be noted during a therapy session. That's the concept behind them, but there are certainly fact situations where things can be turned around and the incentives can work in the other direction. [LB228]

SENATOR HOWARD: Sure. And so your business model incentivizes fewer claims as opposed to overall health outcomes. Would you say that's accurate? [LB228]

RUSSELL COLLINS: Our business model is to design products that are affordable for the marketplace. [LB228]

SENATOR HOWARD: Okay. Thank you. [LB228]

SENATOR GLOOR: Other questions? Senator Crawford. [LB228]

SENATOR CRAWFORD: All right. Thank you, Senator Gloor. So I heard you say the number of claims is the key that it would...I assume you would have--or maybe not. So when you're doing an analysis of different plans and you're looking at number of claims, you're looking at cost per claims that it's encouraging. But I guess I wonder if you do analysis or have comparative plans that you can compare where you would be encouraging lower cost visits. I mean, it seems like a claim that's going to...for some very specialized, high-cost care, that that is a much higher claim than a claim going to a physical therapist's office. So it seems a claim is not a claim. Like in the just number of claims wouldn't seem to be the most appropriate way to hold down costs. [LB228]

RUSSELL COLLINS: I'm not sure I totally understand your question. [LB228]

SENATOR CRAWFORD: Right. [LB228]

RUSSELL COLLINS: But the cost of services and the reimbursement in honor of the allowed amount is certainly relevant, too. [LB228]

SENATOR CRAWFORD: Uh-huh, right. [LB228]

RUSSELL COLLINS: And there are certain services, you know, brain surgery is much more expensive than the physical therapy visit so that's relevant, too. And I think we offer a broad range of products to the marketplace, and different groups make different choices on these issues about what kind of copay they wish to apply and certainly higher copays or higher deductibles, coinsurances amounts are not something that the variable that changes that much across products. But higher deductibles and higher copayments will decrease the cost of care which can decrease the premium. That's the intent of those cost sharing obligations so that the...by eliminating the choices that are available, you're eliminating the opportunity for businesses and customers to choose lower cost options and make that choice in their premium level. Certainly, it can have consequences for individuals that would require a significant amount of care. [LB228]

SENATOR HOWARD: Uh-huh. [LB228]

RUSSELL COLLINS: But by taking away that choice, I think you're limiting the products that are available for sale in the marketplace. And certainly, the limitations brought by this bill can negatively affect the choices available and increase the cost generally of those products that had those differences in copays or have them today. [LB228]

SENATOR CRAWFORD: I was just a little confused about the last paragraph and trying to figure out the key argument there. [LB228]

RUSSELL COLLINS: Well, let me say one thing there before you... [LB228]

SENATOR CRAWFORD: Yeah. [LB228]

RUSSELL COLLINS: ...I think the issue is really that primary care physicians rarely provide the types of services that chiropractors--I'm sorry, I'm mixing the two bills--physical therapists and speech pathologists. And so in many ways, they're different types of services with different codes that are used for those services. [LB228]

SENATOR CRAWFORD: Yeah. Okay. [LB228]

RUSSELL COLLINS: And so comparing the two, at least under our model where we have a coinsurance and the deductible applied to physical therapies and trying to apply that parity to services from a primary care physician, the...it may be difficult to apply exact parity because the codes used and the services delivered are frequently very different. [LB228]

SENATOR CRAWFORD: Okay. So it's kind of a coding, billing issue is what you're talking about there? [LB228]

RUSSELL COLLINS: Correct. There may be some differences in coding that are...that appear to be an absence of parity, but it may be that a physician has billed an office visit and performed some additional services within that 99213--would be the CPT code--and a physical therapist would have just billed for the actual therapy that they performed. [LB228]

SENATOR CRAWFORD: Okay. Thank you. [LB228]

SENATOR GLOOR: Senator Schumacher. [LB228]

SENATOR SCHUMACHER: Thank you, Senator Gloor. Thank you for your testimony today. Basically, if we pass either one of these particular bills, what percentage increase in policy or in premium? [LB228]

RUSSELL COLLINS: If...for specifically on the copay issue? [LB228]

SENATOR SCHUMACHER: Right. Yeah, let's just...I mean, world now, world after passage of either one of these bills on $1,000 in premium, how much is my bill going to go up? [LB228]

RUSSELL COLLINS: It would be less than 1 percent. [LB228]

SENATOR SCHUMACHER: So about $10. [LB228]

RUSSELL COLLINS: Potentially, around that. Now the one thing that I will caveat that with is it was very difficult for us to do the analysis on the coinsurance and deductible parity because the differences in services that are built in code to try to equate when physicians or other providers bill exactly the same codes that physical therapists or speech-language pathologists bill. That was an analysis that was difficult for us to do, so we did our analysis strictly on the copay differences. And for those products that have differences in copays, which there have been some examples thrown around about the differences in copays and we do have products in that range, that would be less than 1 percent. [LB228]

SENATOR SCHUMACHER: Thank you. [LB228]

SENATOR GLOOR: Seeing no further questions, thank you, Mr. Collins. [LB228]

RUSSELL COLLINS: Thank you. [LB228]

SENATOR GLOOR: Other opponents? [LB228]

JAN McKENZIE: (Exhibit 7) Senator Gloor, members of the Banking, Commerce and Insurance Committee, for the record my name is Jan McKenzie, spelled J-a-n M-c-K-e-n-z-i-e. I'm registered lobbyist and executive director for the Nebraska Insurance Federation, testifying in opposition to LB228. I am providing you with a document that the national trade association, AHIP, America's Health Insurance Plans, has put out, and I just thought it might be some additional information regarding this issue of creating parity in both this bill and the next bill. And I just wanted to add a couple other things. I am in opposition, by the way, to LB228 if I didn't state that. In particular, I wanted to note the two points on the second page. I think what was emphasized in the previous testifier's argument was the importance of the primary care provider as a sort of the gatekeeper into what is maybe a faster solution to Senator Christensen's problem in having a good dialogue and continuing to ask your provider to look again or to think again or to consider something else from what was the first path. And I think the more consumers have become informed--and I know they say you're never supposed to Google something on-line, but now that we have access to looking at all kinds of different alternatives to a situation it, I think in many cases is beginning to help a consumer understand better what they might ask for, how many times they might ask for it, and how to maybe be in better charge of a situation that affects their own health. I also want to make sure the committee understands that nothing in either of these bills will in any way affect Medicare or Medicare Advantage. That is federally preempted so there is nothing that would apply this parity to those programs. With that, I would answer any questions you might have. [LB228]

SENATOR GLOOR: And I might add, it also would not affect ERISA plans. [LB228]

JAN McKENZIE: I believe that's true, Senator. I asked before I came up, but I wasn't certain so I didn't want to put that on the record. [LB228]

SENATOR GLOOR: I've got to believe that's true. I see a lot of nodding heads in the audience. [LB228]

JAN McKENZIE: I still believe...correct. I still believe if you're in an ERISA plan, the employer has the right to create the plan... [LB228]

SENATOR GLOOR: Yeah. [LB228]

JAN McKENZIE: ...for their employees. [LB228]

SENATOR GLOOR: Thank you. Other questions for Ms. McKenzie? Seeing none, thank you. [LB228]

JAN McKENZIE: Thank you. [LB228]

SENATOR GLOOR: (Exhibit 8) Anyone else in opposition to LB228? Anyone in a neutral capacity? We have a letter I'll ask the pages to hand out from the Department of Insurance that is, we believe, neutral. That's our interpretation; that it's neutral. Seeing no one in a neutral capacity and Senator Nordquist waived his closing, that concludes LB228, and next up is LB523. Senator Christensen. [LB228]

SENATOR CHRISTENSEN: (Exhibit 1) Thank you, Mister Chairman, members of the Banking, Commerce and Insurance Committee. I'm Senator Mark Christensen, M-a-r-k C-h-r-i-s-t-e-n-s-e-n, I represent the 44th Legislative District. LB523 is intended to address the problem of phantom benefits. This situation occurs when an insured individual has coverage under a health benefit plan for certain services, but because of the providers chosen, the individual is charged a higher copay, coinsurance, or deductible that may approach or even exceed the cost of service. The result is even though the person has insurance that covers the service received, they end up paying most or all of the cost out of pocket. For example, a person may be charged a copayment or a payment of $60 for a visit to a physical therapist or a chiropractor for a office visit costing $60, while they could have gone to a medical doctor for the same service and paid only a $30 copay for a $75 visit. Under this bill, a covered individual may be...may not be charged a copay...copayment, coinsurance, or deductible for services rendered by physical therapists, occupational therapists, audiologists, speech-language pathologists, or chiropractor that is greater than that charged to the insured by a primary care doctor or a osteopath for services. This legislation does not change the fee received by the healthcare provider. Rather, it ensures Nebraska consumers are not burdened with the unfair additional costs just because of their choice of healthcare provider. The bill does not mandate any new coverage nor is it a improper

burden on private enterprise. In fact, LB523 is consistent with provisions already in our insurance code prohibiting discrimination against consumers based upon their choice of healthcare provider. It is also consistent with our deceptive trade practices statute. Consequently, I do not see this bill as a new insurance mandate. It only requires insurers to do what they should already be doing for their policyholders. I would encourage the committee to advance LB523. I'd be happy to answer any questions. And the amendment just strikes the word "physician," as Senator Nordquist did in his bill, and inserts "medical doctor acting in the capacity of a primary care physician or as an" that fits in there. [LB523]

SENATOR GLOOR: Okay. Are there questions for Senator Christensen? Senator Crawford. [LB523]

SENATOR CRAWFORD: Thank you, Senator Gloor. What's the difference between this bill and the Nordquist bill then after the amendment? [LB523]

SENATOR CHRISTENSEN: With the amendment, basically none. [LB523]

SENATOR CRAWFORD: Okay. [LB523]

SENATOR CHRISTENSEN: So pretty much the same. [LB523]

SENATOR GLOOR: Other questions? Seeing none... [LB523]

SENATOR CHRISTENSEN: Should make for a short hearing that way, huh? [LB523]

SENATOR GLOOR: Can I see a show of hands of those who would like to speak to LB523? Okay. First, we'll start with proponents, please. [LB523]

BRADLEY STAUFFER: (Exhibit 2) Good afternoon, Chairman Gloor and the members of the Banking, Commerce and Insurance Committee. My name is Bradley Stauffer, D.C., B-r-a-d-l-e-y S-t-a-u-f-f-e-r. I'm the chairman of the legislative committee of the Nebraska Chiropractic Physicians Association, as well as a practicing chiropractor with a family practice in Gretna, Nebraska. I'm here today to testify in support of LB523 from the prospective of a chiropractic physician. I'd like to thank Senator Christensen, who serves on this committee, for introducing this important proposal. I would also like to extend my remarks in support of the concepts found in LB228, which was also the subject of a hearing today, with the appropriate amendments to include chiropractic and address other issues. LB523 addresses two issues: split health coverage copayments and health coverage charges on copayments. The issue of split copayments arises in a situation where a patient is treated in my office, received more than one service, and is assessed more than one copayment or a copayment and a coinsurance when covered by a health insurer. Once rare, this issue is becoming more and more commonplace as

health insurance plans are being redesigned. I would like to share with the committee a couple of tangible examples. I may have a patient who on one office visit receives an adjustment and a physiotherapy modality, such as ultrasound. The patient is assessed one copayment for the adjustment and a second copayment or coinsurance for the therapy service. Another example might be when I perform an examination, order an x-ray, and provide an adjustment on a patient all on one visit. The health insurance carrier then assesses one copayment for the examination and the x-rays and a second copayment or coinsurance for the manipulation. When a second copayment is involved, it is commonly equal to or more than the cost of the services associated with it. The supposed health insurance benefit becomes nonexistent. It's essentially a phantom benefit. When coinsurance is used, those amounts commonly apply to the patient's deductible, which means that the patient may bear the responsibility for the entire cost of that service. In either case, the outcome is the same. The cost of the visit is shifted to the patient. It's becoming more and more common for a patient to present to our office having been told by their insurance carrier that they have coverage for chiropractic care. We find that, in reality, the patients are bearing more and more responsibility for the entire cost or the majority of the cost for the services. I have framed on my wall a check from an insurance company for one penny, a check from another company for two cents as their payments for a patient's treatment as a reminder to me of such practices. Such phantom benefits are simply not fair to the patient. I do not believe they are made clear to the patient or the employer who provides the coverage. Some health insurers are marketing plans that appear to provide chiropractic coverage to individuals and group plan participants, but we are frequently the ones to explain to the patients that they will be responsible for either all or a majority of the payment. In fact, I recently became aware of a situation where a split copay occurred and when the patient called the health insurer, the representatives blamed the doctor for billing the services separately. Let me be perfectly clear that there is only one way to bill these services and that's separate and distinct. To do anything else would be considered illegal and possibly insurance fraud on the part of the doctor. The only way to avoid this issue would be for the doctor to not bill for all the charges, which the insurance company seemed to imply they should do, and that would be wrong. Just like in any other profession, a doctor should bill fairly for what they do and be reimbursed for it. I'm not aware of any other situation where a provider's patients are subject to two or more copayments or additional coinsurance when performing more than one service within their scope of practice on the same office visit. It is unclear to me why we should be treated differently than any other provider. Imagine going to your MD and being assessed one copayment for your office visit and a second copayment or additional coinsurance for your x-ray or your lab work. This would not be acceptable in any other area of medicine. It should not be acceptable in physical medicine either. In fact, if a patient were to see a doctor of osteopathy and receive a manipulation and an examination or therapy, they would be subject to one copayment rather than being subject to two. Different specialties providing the same services should be reimbursed at the same rate and on the same fee schedule. It's simply a matter of fairness. The second issue that LB523 would address, if the suggested

amendments are adopted, is the practice of charging our patients specialist copayments. Specialist copayments are typically higher than the copay of a medical doctor acting in the role of a primary care physician because a specialist's office charge is much higher than that of a primary care physician. Some specialists I refer to may have office visits as much as $800 or $1,200 per visit. We are more and more frequently seeing health insurers placing chiropractic care under the specialist copayment rather than handling us as they would a medical doctor acting in the role of a primary care physician. A typical chiropractic office visit is frequently less expensive than a primary care physician office visit, yet our patients are subject to the higher specialist copay. This again unfairly shifts the cost of the visit to the patient as many of these copayments are as high as $50 or $60 and they frequently exceed the cost of the service provided, leaving the patient with no coverage despite marketing that chiropractic care is covered. The last point I'd like to make is that these issues make a significant difference in the care the patient chooses. In this day of economic hardship for many, as little as $4 can make a difference in the type of care a patient chooses. It's extremely frustrating for us to see patients refuse conservative care and move on to more aggressive and expensive options simply because it's covered better by their insurance. This frequently leads to much more expensive care because it carries a lower cost to the patient. While I am sure you will hear arguments today about mandates, plan design, and increases in cost, I would ask that the committee look at the fairness for the patient; it's simply a matter of doing what is right for them. The insurers have been given many years to correct these issues themselves and rather than phasing these practices out, we have seen them become more and more prevalent each year. In the end, I believe that the bill would save money for the insurers, employers, and patients. I ask that you speak out for our patients and make sure they get the benefits they were promised and give them true access to the conservative, cost-effective care that they were promised when their insurance was purchased. I would respectfully request that you advance LB523 to the floor for debate. And if I could, I'd also like to go back and address one other thing and the cost issue that we were discussing. This is how we see this--and I understand what the insurance companies are trying to say--but here's where we see this. I recently had a patient that was coming in to see me, could not come in on a regular basis because of a high specialist copayment. I know in my heart I could have gotten him better, but he could not come in on a regular basis. He could not afford the care because he was getting hit repeatedly by high specialist copays. He has now gone on and done three epidural injections and is about to see a surgeon. He's already probably racked up $15,000 in costs. And so we see the other side of it. The patients are shifting out of more conservative and more cost-effective care into more expensive care. And, ironically, this is turning out to be cheaper for him than it would have been for him to continue with me. Similar case, I have a patient who had actually undergone...we had discussed back surgeries early. He had actually undergone two back surgeries in a very short period of time, I'm sure exceeding $100,000 in cost. He did not get better with either surgery and, ironically, his surgeon referred him back to me. I saw him for eight visits. We cleared up his problem in $400. So we see the other side of it, that this does

not really raise costs. What it does, is it helps people to maintain a more conservative care, which we feel actually should drive costs down because as we've said, you know, the entire talk about insurance reform is to try to get people into the most affordable care for them. And we believe that these practices are driving people out of that. [LB523]

SENATOR GLOOR: Thank you, Doctor Stauffer. [LB523]

BRADLEY STAUFFER: Uh-huh. [LB523]

SENATOR GLOOR: Are there questions for Doctor Stauffer? Seeing none, thank you for your testimony. [LB523]

BRADLEY STAUFFER: Okay. Thank you. [LB523]

SENATOR GLOOR: Good afternoon. [LB523]

STEVE GRASZ: (Exhibits 3 and 4) Thank you, Chairman Gloor and members of the committee, my name is Steve Grasz, S-t-e-v-e G-r-a-s-z. I serve as legal counsel to the Nebraska Chiropractic Physicians Association, and I'm appearing in support of LB523, also in support of LB228 as amended. This bill addresses a problem that needs prompt attention from the Nebraska Legislature on behalf of consumers, healthcare providers, and taxpayers. Our neighboring states of Iowa and South Dakota have both recently enacted legislation to address this situation, and I would like to hand out copies of the legislation from those two states. The first one is South Dakota and the second is Iowa. In short, when patients go to their physical therapist, chiropractor, or certain other healthcare service providers, they are sometimes being charged insurance copayments that are simply unreasonable. The copayments are so high that they may equal the entire cost of the services provided even though the patient supposedly has insurance coverage. This is often accomplished by charging two separate copays for the same office visit. This practice is not accidental. Rather, it is the result of new actuarial and underwriting schemes designed to shift additional costs to consumers. Perhaps this is obvious, but I do want to note that passage of this legislation does not in any way change the amount of money that the healthcare provider receives for his or her services. Rather, this bill addresses a hardship being placed on patients who need healthcare. The practice of manipulating copays is unfair not only to consumers, but also to employers and taxpayers. The consumer is told their insurance policy covers the service, but the copayments make the coverage illusory resulting in what is known as phantom benefits. In other words, the patient is told they have insurance coverage, but when they show up for the service, it turns out they must pay the cost out of pocket. The patient frequently blames the healthcare provider for what is really an actuarial gimmick. This is more than just a deductible going up. This deceptive practice creates a disincentive for people to even seek care. It is a shortsighted and improper cost shifting

on the backs of patients. The practice is also harmful to employers who provide health benefits to their employees. That is because employees who could be treated by physical therapists or chiropractors at relatively low cost decide not to get treatment since they must pay for the service out of pocket. The result is a less healthy workforce and increased absenteeism. This can eventually result in visits to more expensive providers for things such as MRIs and even back surgery followed by disability claims and higher insurance premiums for the employers. That is why insurance companies normally try to encourage treatment by the lowest-cost provider rather than discourage it. For much the same reasons, this practice is also harmful to the taxpayers. When people don't go in for early low-cost treatment, they may end up in the emergency room for more serious complications where the hospitals and taxpayers may end up footing the bill for some patients. It's predictable that opponents of this bill will claim the Legislature should not be legislating in this area as it would set a bad precedent or constitute a new mandate. However, the committee should know that a similar law has already been on the books in Nebraska for decades. Under section 44-513, it is already unlawful for an insurer to discriminate in coverage provided to policyholders in terms of whether the service is provided by a medical doctor or an osteopathic physician, chiropractor, optometrist, or several other categories of providers. Some of the professions included in the current proposed legislation such as physical therapists, are not listed in the current statute, however, and some insurers seem not to be following the statute as to others. LB523 will shore up and clarify existing law. This bill is certainly not new or novel. In fact, Nebraska would just be catching up with the national trend and even our neighboring states. In sum, LB523 would help equalize the playing field for the benefit of consumers, businesses, taxpayers, and we believe ultimately, even insurance companies, as it will encourage patients to receive treatment in the most cost-effective care setting for lower overall cost, and it will eliminate any short-term underwriting disadvantages to those insurance companies that do not engage in this unfair practice. [LB523]

SENATOR GLOOR: Thank you, Mr. Grasz. Any questions? Seeing none, thank you for your testimony. [LB523]

STEVE GRASZ: Thank you. [LB523]

SENATOR GLOOR: Additional proponents? Opponents of this legislation, bill? [LB523]

RUSSELL COLLINS: (Exhibit 5) Again, Senator Gloor and committee, my name is Russell Collins, R-u-s-s-e-l-l C-o-l-l-i-n-s, from Blue Cross Blue Shield of Nebraska. As I mentioned earlier, Blue Cross Blue Shield of Nebraska opposes LB523 because it will increase the cost of insurance products and will limit the opportunity to use cost-sharing tools to lower the cost of care...cost of insurance products. I believe we've covered all the ground I wanted to cover and so, from what Senator Gloor said earlier, I'll make myself available for questions if you have any. [LB523]

SENATOR GLOOR: Questions for Mr. Collins? Senator Christensen. [LB523]

SENATOR CHRISTENSEN: Thank you, Chairman. Thanks, Russ. Are you familiar with the statute, the (section) 44-513 that... [LB523]

RUSSELL COLLINS: I am. [LB523]

SENATOR CHRISTENSEN: How does that apply in your...I don't have it in front of me so I haven't read it. I just heard him quote it. So how...do you know how that is worded and applies? Are we following the current law or not? [LB523]

RUSSELL COLLINS: I believe we are. I mean, are you asking if Blue Cross follows the law or are you asking... [LB523]

SENATOR CHRISTENSEN: Well, you know, sometimes there's statutes out there people don't realize, and he brought that up how they're supposed to be treated the same as general physicians. And we're not. So I guess I got to read the statute to understand and I assume you do, too. [LB523]

RUSSELL COLLINS: Correct. [LB523]

SENATOR CHRISTENSEN: But I just wanted to know if you knew it off the top of your head and could answer that or not. And if not, that's not a problem. I'll look it up and I'm sure you will, too. So... [LB523]

RUSSELL COLLINS: Yeah. It's my understanding that the statute focuses on the amount realized by the physician and the categories covered by that statute. So it would focus on the...what we would call the allowed amounts. And the copayment and the coinsurance don't actually affect the amount that the provider would be eligible to collect. It's just splitting the responsibility for paying that amount between the member or the customer and the insurer. So a LB...(section) 44-513 would not, I think, apply to a situation where there's a specialty copay because the amount that would be paid for the same services would be...or the amount that is collectable by the provider for the same services would be the same. It's just the source of collection that would be different. And so I don't believe that it would apply or prohibit the current practice of using specialty copays. And, to be clear as well, the...I think the examples that have been brought up about how certain procedures performed with an office visit--I think the example was an ultrasound--so a patient goes and sees a physician for an office visit and then has an additional procedure like an ultrasound or maybe a CAT scan--physicians have CT scan machines in their offices and so do other providers--or a scope, a sinus scope or, you know, a scope looking down the throat at vocal cords or something. Those separate procedures, certainly with regard to physicians as well as other providers, could result in

a situation where there is an office visit subject to a copay and the surgical procedure--most of those are surgical procedures--or the imaging procedure code would be subject to a coinsurance and deductible across all provider groups. So it's not unique that there would be situations where the services delivered in an office would result in an office visit and a coinsurance applying to two separate services. [LB523]

SENATOR CHRISTENSEN: (Exhibit 7) Thank you. [LB523]

SENATOR GLOOR: Let me put that in a different frame if I could, Mr. Collins. If my daughter went in for an OB visit, she would have an office visit. And if an ultrasound was done at the same time for that OB visit, both of those are billed separately? [LB523]

RUSSELL COLLINS: Unfortunately, pregnancy would be a difficult example because of the global reimbursement... [LB523]

SENATOR GLOOR: Okay. [LB523]

RUSSELL COLLINS: ...which you might be familiar with... [LB523]

SENATOR GLOOR: Yeah. [LB523]

RUSSELL COLLINS: ...which we could...it would take a while to explain. [LB523]

SENATOR GLOOR: Yeah. You're right. [LB523]

RUSSELL COLLINS: But OB is a little different because of...for pregnancy. [LB523]

SENATOR GLOOR: What if I went in for a kidney stone? [LB523]

RUSSELL COLLINS: And you had an ultrasound? [LB523]

SENATOR GLOOR: And I ended up having an ultrasound to try and find out if that was the case. [LB523]

RUSSELL COLLINS: Yeah, the office visit if you went in with general abdominal pain, would likely be subject to a copay under the products that we're discussing. And the ultrasound could be under--depending on the way it's coded--could be subject to the coinsurance and deductible. But other surgical procedures that are performed in the office--ultrasound I actually e-mailed to see...to get the specific answer on that question and didn't have it yet before I came up here--but certainly there are definitely situations where office visits and additional procedures are separately handled under products. And there are situations where they are bundled. And surgeries, high-end imaging, and more complex situations are definitely handled separately. [LB523]

SENATOR GLOOR: Okay. Any other questions? Thank you. [LB523]

RUSSELL COLLINS: Thank you. [LB523]

JAN McKENZIE: Senator Gloor, members of the Banking, Commerce and Insurance Committee, for the record my name is Jan McKenzie, J-a-n M-c-K-e-n-z-i-e, here testifying in opposition to LB523 on behalf of the Nebraska Insurance Federation. Ditto my earlier remarks. Was that a half an ounce, or... [LB523]

SENATOR GLOOR: An ounce of...a lot of wisdom. That's a full ounce. We appreciate it, Jan. Any questions for Ms. McKenzie? Thank you very much. [LB523]

JAN McKENZIE: Thank you. [LB523]

SENATOR GLOOR: (Exhibits 6 and 8) Anyone else in opposition? Anyone in a neutral capacity? We have a letter, again, from the Department of Insurance that we are classifying as a neutral capacity. And we'll have the pages hand that out. Seeing no one else in a neutral capacity, Senator Christensen waives closing. And that will conclude LB523 hearing and our hearings for the day. Thank you all for your attendance, and have a safe trip home wherever home may be. [LB523]