[LB831 LB858 LB883 LB926 LB953]

The Committee on Banking, Commerce and Insurance met at 1:30 p.m. on Tuesday, February 18, 2014, in Room 1507 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB883, LB858, LB831, LB953, and LB926. Senators present: Mike Gloor, Chairperson; Mark Christensen, Vice Chairperson; Kathy Campbell; Tom Carlson; Tommy Garrett; Sara Howard; Pete Pirsch; and Paul Schumacher. Senators absent: None.

SENATOR GLOOR: Good afternoon and welcome to the Banking, Commerce and Insurance Committee. I'm Mike Gloor. I'm the State Senator from Grand Island and the Chair of the committee. I would ask you to, if you haven't already, either turn off those cell phones or put them on vibrate so that's not a disruptive thing for us. We're going to take the bills today in the order on the agenda posted outside. I know there are some people who are...have to leave at certain times and I'm sorry for that. This committee tries to move as quickly as it can, but it's also a committee that has a lot of questions and that's one of the reasons for hearings. So we'll keep things moving as best we're able. You can help us if you would by, if you're going to provide testimony on a bill, moving to the front so there's a little less back and forth time. The order of our testimony is the introducer, proponents, opponents, people in a neutral capacity, and then closing by the introducer. We would ask you to be sure and fill out one of the testifier sheets and when you come up, hand those sheets in to the clerk or to the pages. Be sure and spell your name for us. Give us your name and then spell it out. It's not for us so much as the transcribers who aren't here and need to be able to get your name correctly for the record. We do not use the lights here. Or I should say, on occasion, we use the lights, but my plan isn't to use the lights today. I still would ask you to be respectful and try and keep your testimony to five minutes. If you're not testifying, but would like to be on the record in support or opposition or neutral capacity, you're welcome to fill out and sign in by the forms that are near the back door. One of the new things we're relaying is, please make the microphone your friend. Get as close as you can to the microphone. We've had some cases, not just with testifiers, but also with senators being a little far away from the microphone and it becomes hard to pick up the conversation. So be...please, speak into the mike. To my immediate right is committee counsel, Bill Marienau. And down at the end of the table is committee clerk, Jan Foster. And I will have the committee members, as is the tradition in this committee, introduce themselves. Senator Garrett.

SENATOR GARRETT: Senator Garrett from District 3, which is Papillion and Bellevue.

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

SENATOR CHRISTENSEN: Mark Christensen, District 44, Imperial.

SENATOR CARLSON: Tom Carlson, District 38, Holdrege.

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

SENATOR GLOOR: We have two members who aren't with us right now. I know at least one is introducing a bill elsewhere and both Senator Pirsch and Senator Campbell will join us as soon as they are able. Our pages today are Emily Schiltz from Sioux Falls, South Dakota, and Steven Schubert, right here in Lincoln. And they are here to help you and help us. And with that, we'll start with Senator Nordquist. Welcome back, Senator Nordquist.

SENATOR NORDQUIST: Hi. Thank you. Chairman Gloor and members of the committee, State Senator Jeremy Nordquist, N-o-r-d-q-u-i-s-t. And I'm here today to introduce LB883. I'm sure each one of us in this room has been affected by cancer...a cancer diagnosis in some way. Just imagine that you or one of your loved ones receives that devastating diagnosis. Imagine that your family has health insurance that you pay into every month and you think it's good insurance with a reputable company. And then when your loved one receives that diagnosis, obviously, you're worried. You feel a little bit of comfort knowing that their cancer treatment is a benefit that your insurance policy covers. Your plan explicitly states that radiation and chemotherapy are covered services. Then imagine that your loved one's doctor...their doctor prescribes chemotherapy that comes in the form of a pill as opposed to an IV bag. That's because the pill is the only option for a specific cancer at this point in time. This lifesaving chemotherapy that your loved one needs requires a 50 percent out-of-pocket copay which equates to $3,000 per month. If the chemotherapy that was best for the specific cancer diagnosis is facing came in the form of a bag, you would have to pay the cost of an outpatient visit rather than $3,000 a month. Then imagine a few months down the line, your doctor says they need to change treatment and, unfortunately, this new oral form of chemotherapy isn't covered at all at a cost of $7,600 a month. This is the scenario that was in place and we would go back to if the current parity for oral chemotherapy and IV medications for cancer patients was allowed to expire. Some of you that were on this committee and in the Legislature at the time will remember, in 2012 I introduced LB882 that establishes parity between such medications between orally administered chemotherapy and IV-administered chemotherapy. Today, LB883...and I did not plan to have LB882 and LB883, it's just coincidence. The bill this year, LB883, would repeal the termination date, the 2015 termination date for parity and allow that parity to continue in our state statute. Currently, it is required that any health insurance policy that provides coverage for cancer treatment shall provide coverage for a prescribed, orally administered, anticancer medication on a basis no less favorable than IV-administered medication that are covered as medical benefits. Again, this was the language adopted in LB882 and has been mirrored in almost two dozen states, I think, around the country so far. I think we were the 16th state at the time, if I remember

right. Oral cancer medication typically fell under a different plan benefit. Rather than being a medical benefit like IV therapy, oral chemotherapy was often classified as a prescription drug benefit and required much larger copayments. The lack of parity between the two was a new problem that was growing in 2012 as more and more orally administered chemotherapies came onto the market. Research shows that when confronted with the reality of high out-of-pocket expenses, cancer patients forego expensive therapies or discontinue therapies and that, unfortunately, medical oncologists were prescribing other medications that they knew were not the best option because of the high cost of the oral chemotherapy. And we will have testifiers that will come behind me that can speak about their specific cases that happened prior to the passage of LB882, but I just want to make a couple points that this is not a mandate. It does not mandate coverage of oral chemo or require health plans to have a pharmacy benefit. It simply continues to establish parity in out-of-pocket costs and ensure that patients have access. So it says that if you are providing IV...if you cover IV chemotherapy, that this has to be covered on a no less favorable benefit. It still allows insurers to have preauthorization. It allows requirements of copayments. It allows, still allows copayments or coinsurance as long as they don't exceed treatment in other cancer treatments. And I don't think that we have seen any reputable or any distinct premium impact from the adoption of this law as when we introduced the first time, the amount that we were talking about on plans was...most studies showed it less than 50 cents per member per month. And if it has had an impact, it has been in line with those initial amounts. So I would appreciate your support of this bill to continue the parity amount and ensure that patients and doctors are able to make the best treatment decisions when they do face a cancer diagnosis. Thank you. [LB883]

SENATOR GLOOR: Senator Nordquist, why did we put a sunset provision in this bill? [LB883]

SENATOR NORDQUIST: It was a compromise at the time to just take a step back and see if there were any impacts on it, negligible impacts on premiums or anything else. And that was just what it took. It passed on General File 44-0, but I was willing to, just to remove all opposition, continue to work on it and we did and adopted an amendment on Select File. And then it passed unanimously on the floor. [LB883]

SENATOR GLOOR: Good. And is this session the one where this bill would need to be passed in order for us to miss the 2015 date? [LB883]

SENATOR NORDQUIST: It's at the end of 2015 so, potentially, we could try to run something through next year. But I would be inclined to try to move it this year, if possible. [LB883]

SENATOR GLOOR: Sure. Sure, I understand. Other questions? Senator Christensen. [LB883]

SENATOR CHRISTENSEN: Senator, I know that was a difficult bill to get out of committee. [LB883]

SENATOR NORDQUIST: It was a tough vote in committee, I'll tell you that. Forty-four to nothing on the floor, but a tough vote in committee. [LB883]

SENATOR CHRISTENSEN: Well, I think it just narrowly got out, if I remember right. And there was concern that having them take it at home and stuff would cause not being watched and things like that when they take it intravenously in the hospital. Do you know of any concerns there has been since we changed this? [LB883]

SENATOR NORDQUIST: No. Not one bit. We haven't seen any effect like that. I think the oncologists that are prescribing it are doing it in the appropriate manner. And we haven't heard any concerns from the State Board of Health or anyone in that regard. [LB883]

SENATOR CHRISTENSEN: Okay, thank you. [LB883]

SENATOR GLOOR: Senator Carlson. [LB883]

SENATOR CARLSON: Thank you, Senator Gloor. Senator Nordquist, it's been...this went into effect October 1, 2012. So it's been, if I count right, 16 months that it's been. [LB883]

SENATOR NORDQUIST: Uh-huh. [LB883]

SENATOR CARLSON: And so we are a good year and a half ahead of the deadline. And I think, I wasn't on the committee two years ago so I don't remember the discussion, but I think the purpose of the sunset provision is to be able to prove that it, in fact, didn't cost any more or maybe cost less than what the estimate was in order to get the bill passed. [LB883]

SENATOR NORDQUIST: Right. [LB883]

SENATOR CARLSON: So why do you want to take it off a year early? [LB883]

SENATOR NORDQUIST: Why? I just think we need to give certainty to the patients that are being treated, to the doctors that are treating. I haven't heard any pushback from insurance directly, saying this is driving up premiums. We knew going in there would be some cost. We talked about that on the floor, that it would range from as low as 4 cents per member per month to maybe as high as 50 cents to 60 cents per member per month. And we moved the bill forward knowing that, and we have seen no evidence to

the contrary. So I think it's just providing certainty rather than getting into the mix next legislative session and not knowing how it could come out. [LB883]

SENATOR CARLSON: Do you know if there's anybody that's going to testify after you that would have...the 16 months is not a very long time... [LB883]

SENATOR NORDQUIST: Uh-huh. [LB883]

SENATOR CARLSON: ...who would have pretty accurate information on what the cost seems to, in fact, be? [LB883]

SENATOR NORDQUIST: I don't know that...if anyone from insurance will be testifying. If not, we will get that information to you after the hearing. Yeah. [LB883]

SENATOR CARLSON: That would be good. Thank you. [LB883]

SENATOR GLOOR: Senator Schumacher. [LB883]

SENATOR SCHUMACHER: Thank you, Senator Gloor. If there isn't enough data accumulated so far, any problems just changing 2015 to, say, a magic day of 2020? [LB883]

SENATOR NORDQUIST: That would be an option. We can always sunset things, Senator. [LB883]

SENATOR GLOOR: Seeing no further questions, thank you, Senator Nordquist. [LB883]

SENATOR NORDQUIST: Thank you. Thank you. [LB883]

SENATOR GLOOR: Are you staying around to close? [LB883]

SENATOR NORDQUIST: Yeah, I will be. [LB883]

SENATOR GLOOR: Okay. We'll now move to proponents. And as the testifier is getting situated, if it feels a little warm in here, it is. And they tell us that they are at work on trying to get the temperature a little better controlled. So feel free to try and unbutton your shirt collar or get as comfortable as you can for a while. And we'll hope it cools down faster rather than slower. Hi. [LB883]

SHELLY JACKSON: (Exhibit 1) Hi. My name is Shelly Jackson, J-a-c-k-s-o-n. I also was here for the testimony on the initial bill. I'm the mother of a leukemia patient from here in Lincoln. My son, Tyson, was entering his senior year of high school when he was

diagnosed with leukemia in 2007. And the seven and a half years since then have been fairly devastating on many levels. He's had a tough time medically. He's had periods of successful treatments. He's relapsed four times. He's received multiple chemotherapy drug treatments since his diagnosis, all of which have ultimately failed to control his leukemia after some amount of time. In August of 2012, he had testing that revealed his leukemia had undergone a genetic mutation that was potentially terminal and left him with no FDA-approved treatment options outside of a bone marrow transplant for which he does not have a matching donor. He's currently participating in a clinical trial for a drug that was approved during the course of his trial. And I tell you his medical history not because it matters, necessarily, to the course of this particular bill, but I'm telling you this to illustrate something. My son fought this disease very hard. The only person who fought harder during his treatment was our insurance company, to avoid paying for it. I had good insurance when he got sick. As hard as he fought to beat cancer, they fought just a little bit harder to avoid paying for it. And while we are extremely grateful for every day that he has survived this disease, we failed to understand during his diagnosis that picking the right chemotherapy was not going to be the most devastating thing for our family. We didn't realize that surviving the financial impact of this diagnosis was going to be more difficult. At the time when my son began receiving treatment, I had very good insurance with a low deductible, low out-of-pocket maximums, with a reputable insurance company that has a big name in Nebraska. We mistakenly assumed that funding his treatment was not something we would need to worry about. When we discovered the reality of treating cancer with oral chemotherapy drugs was much different than we had thought despite this coverage...despite a plan that specifically stated it covered chemotherapy and radiation, despite the fact that the only treatment available for his leukemia during the time he was receiving it was oral chemotherapy. We weren't picking an option that was easier for him to take at home. This was the standard of care. This is the standard of care for many treatments. His initial chemotherapy payments were around $36,000 a year. That was our copayment. That didn't apply to our out-of-pocket maximums because they put his chemotherapy in our prescription drug benefit instead of in his chemotherapy benefit. Because it came in the form of a pill that wasn't experimental, that wasn't being taken for convenience purposes, it landed at a place on a drug formula that meant our insurance company would only pay 50 percent. Several months into his treatment, they switched the place on the formula where this drug fell and our copayments fell to $35 a month. Then several months later when he needed a new drug, the new drug wasn't on the formula at all. And we had to pay for all of it and it was $7,600. I worked a second job, I used my savings, I cashed out my retirement, we liquidated our assets until it wasn't an option anymore. He was uninsured for a time because he maxed out the lifetime benefit on our insurance. And as soon as he was old enough, he went into the SSI disability system so he could receive coverage through Medicare and Medicaid. At the time, our objective was to keep him into treatment and that's the only option we could find, but in a sense, we built a cage for him. He is beholden to a system that he never should have belonged to. My son is 24 years old. He lives on disability and he doesn't really have any other

options now. And this shouldn't have happened. We had insurance, and this shouldn't have happened. The physical limitations that his disease and its treatment have placed on him may prevent him from being able to successfully work in some careers, to earn a living wage, to experience financial security. He has no real hope of finding employment with a high school education that will enable him to buy insurance through the health pool. And outside the expansion of Medicaid, he doesn't qualify in Nebraska. Our family finances have been decimated by the impact of our insurance situation to the point where we are not going to be able to provide meaningful financial support for him for the rest of his life. My son will spend his entire life beholden to a disability system that he never should have entered. And our family is not alone in this situation. I know there's a lot of competing interests in this legislation and I'm not a politician, so I can say this. I think why there is a sunset clause is because there is a couple of senators that were working with the insurance industry and that's what had to happen to get this to pass. I do know that there was an interim health study done in Missouri last year. They passed this bill this year; they're passing it now. But last year, they did a study...a cost impact study instead, rather than passing it in advance of that. And in Missouri, they found that it will cost 52 cents per subscriber per year to pass this law. That's the most recent study that I know of. To my knowledge, Nebraska has not conducted such a study at this time. But all of that being said, I don't see...this bill isn't really about how much it's going to cost per subscriber. This bill is about clarifying the definition of chemotherapy. I bought insurance coverage for chemotherapy. My insurance company should have been required to pay for it. This wouldn't fly if it was my auto insurance. If car insurance glass changed so when I wrecked my car they weren't going to pay for the glass, that wouldn't fly. It shouldn't fly for insurance...for health insurance. In addition, I think that from a taxpayers', as a whole, perspective, it's...you're doing a disservice to the taxpayer to not allow this bill to stand. You're pushing people who were previously in a private insurance policy into a public welfare system because they don't have any other alternatives to survive. And this is detrimental to the taxpayers, as a whole. I do understand that I'm very close to the situation and I see it in a very black-and-white manner that other people may see more shades of gray. There are a lot of industries and organizations that have a financial stake in this and the costs are high. There's a lot of lobbyists. Healthcare is very expensive. But I can't help but ask. I'm here because I didn't have anywhere else to go. What are people like us supposed to do? I was a college educated, middle-class Nebraskan. I bought the insurance that responsible parents buy. I did what I was supposed to do. I wasn't just expecting somebody else to foot the bill. And this shouldn't have happened. We shouldn't be here asking the Legislature to clarify the definition of chemotherapy for us, but where else are we supposed to go? If not for this law, more people are going to be in this situation we were in. Adults in the United States have a 1 in 3 chance of being diagnosed with cancer in their lifetime. And allowing this law to expire would be a travesty for them. [LB883]

SENATOR GLOOR: Thank you, Ms. Jackson. Do you know from a treatment standpoint, is leukemia likely to be one of the cancers where you're going to find more

oral treatments as opposed to IV treatments? [LB883]

SHELLY JACKSON: Seventy percent of cancers have an oral treatment option. [LB883]

SENATOR GLOOR: And is leukemia any greater than... [LB883]

SHELLY JACKSON: Certain forms of leukemia, essentially, have no IV treatment options anymore. That's true of some other forms of cancer as well. Multiple myeloma, which is actually bone cancer, is treated primarily through oral chemotherapy, I believe. A lot of prostate cancer. There's oral chemotherapy treatments given in 70 percent of cancers, though, and approximately 35 percent of oncology drugs in the pipeline are oral. [LB883]

SENATOR GLOOR: Yeah. I think I remember that from the first time around is that even if you wanted to get outpatient treatment, the drugs aren't manufactured for intravenous administration anymore. It's only oral. [LB883]

SHELLY JACKSON: And interim cost studies are great, but there's a larger picture. You may be able to say that it's going to cost 57 cents per subscriber per year to cover this oral chemotherapy. But it's going to take a very long time to say what the cost difference is because this person who didn't go to the infusion center and did not receive an IV infusion for chemotherapy and did not pay the nurse or the doctor and did not have the side effects and did not end up in the hospital, there's a cost savings on that side, too. I mean, that's a lot of...that's a long-term data study. But again, to me anyway, this is less about how much it's going to cost per person and more about, this is the right thing to do. If you're going to sell insurance that covers cancer treatment, then you should be required to cover cancer treatment with it. [LB883]

SENATOR GLOOR: Thank you. Any other questions? Senator Carlson. [LB883]

SENATOR CARLSON: Thank you, Senator Gloor. So you really feel like that that condition should have been covered in your original policy? [LB883]

SHELLY JACKSON: Absolutely. [LB883]

SENATOR CARLSON: And you feel like that was in the contract? [LB883]

SHELLY JACKSON: Absolutely. [LB883]

SENATOR CARLSON: Did you pursue anything, any legal procedure to try and get them to pay? [LB883]

SHELLY JACKSON: I pursued the appeals process through the Department of

Insurance for as long as I could. I was denied. I mean, as far as did I hire a private attorney? No, I was losing my residence. I was cashing out my retirement trying to keep my kid alive. I didn't...the funds to hire a private attorney to fight my insurance company weren't really there. I went to the Legislature. You know, I wrote 1,200 letters. I've testified in Washington twice for the federal version of this law, which I believe will pass. [LB883]

SENATOR CARLSON: How long ago was this, the onset of the disease? [LB883]

SHELLY JACKSON: Two thousand seven. [LB883]

SENATOR CARLSON: Seven, okay. All right, thank you. [LB883]

SHELLY JACKSON: Uh-huh. [LB883]

SENATOR GLOOR: Thank you, very much. Other proponents? Good afternoon. [LB883]

TESSA FOREMAN: (Exhibit 2) Hello. My name is Tessa Foreman. And just as I was here in February... [LB883]

SENATOR GLOOR: Tessa, could we get you to spell your name out for us? [LB883]

TESSA FOREMAN: Oh, T-e-s-s-a F-o-r-e-m-a-n. Just as I was here in 2012 to support the original chemo parity bill, LB882, I'm here today in support of LB883 to remove the sunset clause and make the chemo parity bill permanent. In April 2010 at the age of 47, I was diagnosed with Stage III rectal cancer. When I met with my oncologist for the first time, he explained that there were two chemotherapy options used to treat this type of cancer, an oral medication called Xeloda and an intravenous drug called 5-FU. He informed me that studies had shown the two drugs to be equally effective. We discussed the side effects of both drugs. All chemotherapy drugs can have devastating side effects, including both of these. However, Xeloda, the oral medication, is believed to be better tolerated than the IV drug. Also, oral chemotherapy drugs are easier to administer, less invasive, would require less visits to the oncology clinic, and be less disruptive to the patient's daily life. Because of these reasons, both my oncologist and I thought the oral chemotherapy drug would be the best option for me. That's when my insurance company stepped in, disregarding the wishes of both my oncologist and myself to select the treatment option they preferred. They refused to pay for the oral chemotherapy drug. Without any other viable options, I began the process of treatment with 5-FU by having surgery to install a PORT-A-CATH in my chest, needed to administer the drug into my bloodstream. I developed either an allergic reaction to the port or an infection that resulted in severe pain at the site of the port. A number of tests were run, but no cause was determined. I was treated with antibiotics and allergy

medications. Then I began the 5-FU treatments. I had horrible side effects from the drug. I developed mouth sores that covered the entire inside of my mouth and lips causing me to be unable to eat for days at a time. They became so bad I couldn't even drink water because my mouth was swollen shut. My husband had to take me to the cancer clinic several times for IV fluids so I wouldn't get dehydrated. I also suffered from severe diarrhea from the 5-FU. I had to go to the hospital daily for a period of time to get shots in my stomach. And I became so dehydrated from the diarrhea at one point that I was hospitalized for several days. These side effects caused me to make repeated trips to the oncology clinic, the urgent care clinic, and the emergency room. My husband and I both lost days and days of work time. Much, if not all of this, could have possibly been avoided had I been allowed to take the oral chemotherapy. According to my calculations, my insurance company paid out over $40,000 to cover the treatments I received just for the side effects that were caused by the IV drug. The decision as to what type of chemotherapy treatment I received should have been made by anyone other...should not have been made by anyone other than my oncologist. The doctor treating you for cancer, the doctor trying to save your life should get to decide which treatment is best for you. It wasn't fair to me that someone with no medical degree in a cubicle at an insurance company got to make a decision that had such an impact on my life. In passing LB882 two years ago, you put that decision-making process where it should be, in the hands of the doctor and the patient. Just last week I had the opportunity to ask my oncologist whether this law had made a difference. He said it had been much easier for him to treat his patients with oral chemo drugs and said, "I would hate to see that go away." Please don't let it go away. Please advance LB883 to the General File and allow cancer patients in Nebraska to continue to have access to oral chemotherapy medications. Thank you. [LB883]

SENATOR GLOOR: Ms. Foreman, I'm hopeful that your prognosis continues to still be positive. [LB883]

TESSA FOREMAN: Yes, it is. Thank you. [LB883]

SENATOR GLOOR: Good. Other...any other questions? Seeing none, thank you. Other proponents? [LB883]

DAVID HOLMQUIST: I'll try to be friendly to the mike, but not too friendly. I'm sorry. Chairman Gloor and members of the Banking, Commerce and Insurance Committee, my name is David Holmquist, D-a-v-i-d H-o-l-m-q-u-i-s-t. I am a registered lobbyist and I represent the American Cancer Society Cancer Action Network. We are the 501(c)(4) partnering organization with the American Cancer Society. I appear before you today to express our strong support of LB883. We are grateful to Senator Nordquist for bringing this issue before the Legislature in 2012 and for his efforts to pass the original bill, as well as grateful to the members of this committee who are still seated behind the desk and who worked hard to get this bill advanced out of committee at the eleventh hour,

frankly, on 11:00 a.m. and on the last day of priority. So that's how we got it to the floor. Well, it's now time for the Legislature, I believe, to remove the sunset provision that was included when LB882 passed in 2012. Oral chemotherapy drugs represent an exciting new development in frontline cancer treatment. And these drugs are showing remarkable promise at targeting the tumor with limited side effects. The drugs offer patients a convenient and noninvasive alternative to intravenous and injected therapies. And they are a critical treatment option for many cancer patients. The legislation passed in 2012 changed the way oral cancer therapies are covered in many insurance plans. Rather than require what can be an unaffordable copay when classified as a prescription, LB882 requires that oral chemotherapies that are equivalent to intravenous therapies be covered in the same way as an office visit is covered for traditional intravenous chemotherapy. The American Cancer Society Cancer Action Network is deeply concerned with cancer patients' quality of life and ensuring access to oral cancer drugs when appropriate, has the potential to improve patients' treatment experience. Some factors include: convenience of taking medication at home in a comfortable and familiar setting, transportation problems which are reduced for both rural and urban populations when daily or weekly travel for infusion can cause added stress as well as cost, and there are fewer complications with some oral therapies and often fewer side effects. Another important factor to consider is that roughly 30 percent of the new cancer treatment therapies in the development pipeline are oral products. It is essential that these new treatments be readily available to patients after approval by the Food and Drug Administration. One of the ways of making these therapies readily available will be keeping patient cost to a minimum by continuing to cover the drugs in the same way that the infused therapies are covered. When the original bill passed, it received the unanimous vote by the members of the Legislature present. And that included those who had initially opposed the bill on the floor. I want to repeat that. It was passed unanimously. I urge the committee to advance LB883 to General File and urge support of final passage of this bill, eliminating the sunset provision. Thank you for the opportunity to testify and I'd be happy to take any questions you might have. [LB883]

SENATOR GLOOR: Thank you. Are there any questions? Seeing none, thank you, Mr. Holmquist. [LB883]

DAVID HOLMQUIST: Thank you. [LB883]

SENATOR GLOOR: Other proponents? [LB883]

JULIA CANAS: Good afternoon, Mr. Chairman and members of the committee. My name is Julia Canas, J-u-l-i-a C-a-n-a-s, and I'm the patient access director for Nebraska chapter of the Leukemia and Lymphoma Society. Today I'd like to share with you why parity is critical for our patients and how not having parity discriminates against cancer patients. The Leukemia and Lymphoma Society is the world's largest voluntary health agency dedicated to curing leukemia, lymphoma, Hodgkin's disease, and

myeloma and ensuring access to quality, affordable, and coordinated care while improving the quality of life of patients and their families. LLS spends lifesaving blood cancer research around the world and provides free information and support services to patients. In 2013, the Nebraska chapter assisted over 300 patients and their families across the state overall and, specifically, 116 patients with copay assistance by distributing over $250,000. In addition, we've historically given over $1 million to the University of Nebraska Medical Center toward their research to find a cure. In recent years, innovative, targeted, patient-administered anticancer medicines have become the recognized standard of care for many types of cancers. Currently, at least 25 percent of all cancer drugs in development are patient-administered forms of treatment, including oral-administered therapies. We believe blood cancer patients should have access to the most clinically appropriate care for their condition. Without parity, the insurance industry can treat patients differently based upon where they receive their care. Patients that receive IV chemotherapy in a provider setting, such as a hospital or doctor's office, are charged under their health plan's medical benefit while patients who are prescribed an orally administered anticancer product are charged under their plan's prescription benefit. Patients taking oral anticancer treatments typically have much higher out-of-pocket costs than those receiving IV because they're not charged a flat copayment, but rather, a coinsurance which is a percentage of the cost of the drug and can be thousands of dollars each month. Without parity, these outdated benefit designs discriminate against patients based upon the site of service where they receive their treatment. Keep in mind, oftentimes the only option for patients is an oral anticancer therapy. And for those patients, outdated benefit designs will often require the patient to absorb a disproportionate share of their costs. For example, Gleevec, an oral treatment for chronic myeloid leukemia carries a retail price for an average monthly supply of 400 milligram tablets in the $6,000 to $7,500 range. Many CML patients are dependent upon this oral therapy to keep them alive. And without parity, a 20 percent coinsurance requirement generates an out-of-pocket expense of at least $1,200 a month. Oral parity means cancer treatment fairness for patients by equalizing their out-of-pocket costs and it means being able to have access to the treatment that is most clinically appropriate for them. Continuing parity simply eliminates discrimination caused by outdated health benefit designs. It does not require an insurance company to provide coverage of any kind or create new insurance benefits. Fair and equal coverage means if a health plan already covers cancer treatment, the plan must apply the same cost-sharing rules to drugs that are self-administered and drugs that are IV administered. In all of the 27 states and the District of Columbia that already have oral parity, there has been no evidence of statistically relevant increase to premiums. States like Texas, Indiana, Massachusetts, Maryland, Vermont, and California have completed studies which have shown negligible increases or none at all. Since 2008, states have been leveling the playing field for cancer patients ensuring that no matter how dispensed, they have access to the best treatment for them. To date, 27 states and the District of Columbia have passed legislation on parity for oral anticancer treatments ensuring cancer patients have fair and equal access to cancer treatment. You can see from the oral oncology

access legislative landscape that I've included in your handouts, Nebraska was ahead of many states in enacting legislation to ensure parity now falls in line with the majority of your bordering states, including Colorado, Kansas, and Iowa. And similar legislation is moving through your Midwestern neighbor states of Missouri, Wisconsin, Ohio, Michigan, as well as a few states on the East Coast. As you know, in 2012 you and your colleagues took an important step forward and joined the majority of states by passing legislation to ensure parity for its residents which has provided critical patient protections for those suffering from cancer. It's imperative to continue to provide access and not revert back to cancer patients being discriminated against based upon the site of service where they receive their treatment. In closing, cancer patients in Nebraska should continue to have fair and equal access to oral therapies which allows patients and their doctors to decide the most clinically appropriate treatment and continue parity to a patient's out-of-pocket expense no matter which setting they receive their care in. I want to bring to your attention that there was a patient that was going to provide testimony today and she has...and she was sick and so her testimony should be included in your information. And if you did not receive that, please let me know. And I thank you so much. Are there any questions? [LB883]

SENATOR GLOOR: (Exhibits 3, 4, 5, and 6) Are there any questions? I'm not sure that we got that letter. [LB883]

JULIA CANAS: Okay. Okay. [LB883]

SENATOR GLOOR: But it certainly can be e-mailed to committee members. [LB883]

JULIA CANAS: Yes. [LB883]

SENATOR GLOOR: We got your handouts and we've got some other supportive testimony from other organizations, but there isn't that letter. [LB883]

JULIA CANAS: Okay. Okay, I will follow up on that. All right. [LB883]

SENATOR GLOOR: Oh, I'll bet it...would it be Peg Ricketts? [LB883]

JULIA CANAS: Yes, it is. Yes, it is. Thank you very much. [LB883]

SENATOR GLOOR: I stand corrected. It is. Thank you. [LB883]

JULIA CANAS: All right. Thank you so much. [LB883]

SENATOR GLOOR: Thank you for your testimony. Other proponents? Good afternoon. [LB883]

ANN FROHMAN: Good afternoon, Senator Gloor, members of the Banking and Insurance Committee. My name is Ann Frohman, for the record, that's spelled A-n-n F-r-o-h-m-a-n. I'm here to testify on behalf of the Nebraska Medical Association in support of LB883. We applaud Senator Nordquist's efforts to recognize that oral anticancer medication should be on par with the injectables and that steps taken to remove the sunset provision are good for, really, for the patients of the Nebraska Medical Association membership. And with that, I'd like to keep my testimony short, but an aside on, I think, we heard a question earlier in state mandate. I was looking through some of the materials that came out of CCIIO on the health insurance exchange and noted that back last summer, I believe in June, that they had offered a Q&A on this topic and indicated that they viewed parity issues like this. And they specifically mentioned this one is one that should be considered in the dynamics of developing exchange products is not as a state mandate. [LB883]

SENATOR GLOOR: Important information. Are there questions for Ms. Frohman? Seeing none, thank you. [LB883]

ANN FROHMAN: Thank you. [LB883]

SENATOR GLOOR: (Exhibit 7) Other proponents? Seeing none, we now move to opposition to this bill. Anyone who would like to testify in a neutral capacity? Senator Nordquist, you're recognized to close. Senator Nordquist waives and that will end the hearing on LB883. We'll now move to LB858. Senator Howard. Good afternoon, Senator Howard. [LB883]

SENATOR HOWARD: (Exhibit 1) Good afternoon, Senator Gloor. [LB858]

SENATOR GLOOR: And welcome to your Banking, Commerce and Insurance Committee. [LB858]

SENATOR HOWARD: Good afternoon, Chairman Gloor and members of the committee. For the record, I am Senator Sara Howard, H-o-w-a-r-d, and I represent District 9. LB858 was introduced on behalf of the Nebraska Pharmacists Association to recognize the cognitive services and clinic role that pharmacists play as members of the health care team. LB858 does not expand the scope of practice for pharmacists so you can all be relieved of that. And it does not mandate additional benefits for insurance plans or policies. LB858 recognizes pharmacists as providers of health care services for benefits already included in insurance plans and policies which pharmacists are allowed per their license to provide. LB858 also allows insurers to contract with pharmacists for these clinical services and specifically states that the clinical services are not part of the prescription filling and dispensing process which occurs in pharmacies. That distinction is made because clinical cognitive services and dispensing are not the same. The shortage of primary care providers is something the Nebraska Legislature has

discussed frequently these past few years. What you may not know, though, is that there is not a shortage of pharmacists. As a public health policy, it makes sense to pay physicians, nurse practitioners, and physician assistants to care for acute medical needs such as fixing broken bones, surgery, and emergency traumas. But it also makes sense to pay pharmacists, the medication experts, to care for patients and educate them on medication adherence, management of chronic diseases through a medication, providing medication reconciliation, and care transition from the hospital to, for example, a long-term care facility or a home setting, and even at dismissal from the hospital. I would also like to point out that Nebraska Medicaid does credential and recognize pharmacists for tobacco cessation and recently added immunizations to the list of services that pharmacists can provide in Nebraska. My experience in clinical pharmacy is at OneWorld we have a pilot project around clinical pharmacy. We were having...we continue to have a challenge with a large number of hypertensives who have out of control blood pressure. And so we tasked a pharmacist to contact a pool of patients and try to address either barriers to their medication adherence, to check their blood pressure, and then work with a provider to titrate their medication when necessary. And what we found was that the clinical pharmacist, by reinforcing what the provider had done, actually improved those health outcomes for that pool of hypertensives. So they did better than our hypertensives who did not have time with a clinical pharmacist. While many of our patients are not insured by private insurers, at OneWorld the number of individuals with private insurance we expect to increase because of the Affordable Care Act. Clinical services that pharmacists provide to their patients not only improve patient health outcomes, but are cost savings for employers, insurers, and the health care system. As more of our patients become insured and there are more accountable care organizations and patient-centered medical homes and as managed-care plans continue to take shape, the number of primary care providers could, potentially, decrease. And as that shortage continues, pharmacists are uniquely qualified to provide chronic disease management, medication therapy management, and other health care services to allow primary care providers more time with acute patients. Thank you for your time and attention to LB858. I would be happy to try to answer any questions. [LB858]

SENATOR GLOOR: Senator Howard, you're going to have some folks testify after you who, I'm guessing, are pharmacists and can... [LB858]

SENATOR HOWARD: Yes, and they can explain more of the billing process, some of the challenges in the billing process as well as they can explain, in a more robust way, what clinical pharmacy looks like for patients. My experience is just with our clinical pharmacist. But it looks different in a hospital setting versus a clinical setting. [LB858]

SENATOR GLOOR: Okay. Questions? Seeing none, thank you. [LB858]

SENATOR HOWARD: Thank you. [LB858]

SENATOR GLOOR: We'll move now to proponents. Welcome. [LB858]

KEN KESTER: (Exhibit 2) Thank you. Senator Gloor, members of the Banking, Commerce and Insurance Committee, my name is Ken Kester, that's K-e-n K-e-s-t-e-r. I'm here today representing the Nebraska Pharmacists Association in support of LB858. I'm a pharmacist and I'm employed as the pharmacy team leader for Nebraska Heart Hospital in Lincoln. I also serve as a pharmacist member of the Nebraska Board of Health, though I need to be clear that my testimony today is on my behalf and NPA's behalf. It is unrelated to my role with the Board of Health. The pharmacists of Nebraska are grateful to Senator Howard for introducing this very important legislation to recognize pharmacists as health care providers in Nebraska. Let me give you an illustration of our current limitations and how this bill could help us; kind of where I live. Nebraska Heart Hospital is located right next door to Nebraska Heart Institute or NHI, which is a doctors' office for cardiologists and surgeons. There are several clinics within NHI Office, including an anticoagulation clinic, a congestive heart failure clinic, a lipid clinic, and others. We're in the midst of transitioning the anticoagulation clinic to one managed by pharmacists because pharmacists can get paid for that. These patients come to the clinic to have a lab level drawn and we can, then, speak to them about the drug that affects that lab level. We can bill incident to the physician visit just as nurses do for the same type of visit. Since we're going to be in the vicinity, that is, in the clinic, they would love to have our pharmacists provide medication therapy management for their other patients as well. But unfortunately, we cannot do that because we do not have a way to pay for the pharmacist's time. CMS actually set up billing codes for medication therapy management several years ago, but we can't bill for these services, in part, because pharmacists are not considered providers. Pharmacists can free up time for physicians, nurse practitioners, and physician assistants to see the most acute patients while working collaboratively with them to manage patients with chronic diseases such as CHF or congestive heart failure, diabetes, asthma, chronic obstructive pulmonary disease, to name a few. In fact, this is already happening in Nebraska. Some pharmacists have collaborative practice agreements with physicians, but there's no payment model in place to support the patient care. Through Medicare Part D program, pharmacists providing medication therapy can provide medication therapy management services, but the activity is reimbursed through a pharmacy. And many of these practice sites don't include a pharmacy. Pharmacists provide tobacco cessation counseling and immunize, but cannot bill for these services as they are not on the list of providers for these services. Study after study has shown that when pharmacists are involved in managing the medication therapy, providing medication reconciliation, or managing chronic diseases as part of the health care team, patients have better outcomes and costs are reduced for the patients, employer, and the insurer as a result of those better outcomes. These studies show that for every $1 spent on patient care involving a pharmacist in that care, saves $4. That's a return of investment, on average, of four to one. I'm providing...and where that data came from is what I'm going to speak about

next. I'm providing for you an executive summary of a recent report from the United States Surgeon General's office that is supported...and is supported by the U.S. Surgeon General that highlights the positive impact that pharmacists have on patient health care. This report is organized into four focus points of discussion which I'll briefly mention. Focus Point 1 discusses how pharmacists are already integrated into many practice settings. Focus Points 2 and 3 make the case that for pharmacists to continue to improve patient care and health care system outcomes, recognition as health care providers and compensation models are needed. Focus Point 3 outlines an impressive amount of evidence-based outcomes evidence from pharmacist delivered care aligned with demands on the health care system, such as access, prevention, quality, and cost effectiveness. So...and at the bottom of my testimony is a website that links...what you got was about a 10-page executive summary. That, in fact, is associated with a rather impressive 95-page report and one of the more exhaustive reports I've seen in this realm that goes through many, many studies that have shown the beneficial effect of pharmacists in providing this type of care for patients. So I appreciate the opportunity to comment. I'm happy to answer any questions I can. [LB858]

SENATOR GLOOR: Mr. Kester, I have some familiarity with this. By the way, on behalf of the committee, thank you for your service on the Board of Health. [LB858]

KEN KESTER: You're welcome. It's my pleasure. [LB858]

SENATOR GLOOR: And if you have extra time, we'd be glad to talk to you about the 407 process and how much fun that is. [LB858]

KEN KESTER: Okay. I...you know...well, we can talk about that. [LB858]

SENATOR GLOOR: We probably will wait for another day. [LB858]

KEN KESTER: I'm in the midst of the fun of one right now, so. Okay? [LB858]

SENATOR GLOOR: I'll bet. There's always one out there. In my past life, we used Pharm.D.s in an acute care setting... [LB858]

KEN KESTER: Uh-huh. Uh-huh, yeah. [LB858]

SENATOR GLOOR: ...to round with...to round at the same time physicians were rounding... [LB858]

KEN KESTER: Yeah. [LB858]

SENATOR GLOOR: ...because the opportunity for them to interact with those physicians could result in better therapies and improvement in quality... [LB858]

KEN KESTER: Yes. [LB858]

SENATOR GLOOR: ...as well as a better control of cost... [LB858]

KEN KESTER: Uh-huh. [LB858]

SENATOR GLOOR: ...if for no other reason than it gave us sort of equal footing with the drug reps and their ability to bend the ear of physicians... [LB858]

KEN KESTER: Uh-huh. [LB858]

SENATOR GLOOR: ...but would never have considered billing for those services because it was part of, you can say it's hypothetically, but it's part of the reimbursement that we would get... [LB858]

KEN KESTER: Right. [LB858]

SENATOR GLOOR: ...for the overall care of the patient just as the dietician's time or the therapist's time or whatnot. How is this different? Explain to me, if you would, how this is different. [LB858]

KEN KESTER: This is different because it's broader than just in hospitals. Frankly, I agree with what you're saying about hospitals. We're already there. I will say, in hospitals there's a push to having...you know, to have pharmacists round with doctors. You'd have to have a pretty good sized hospital to do that, to have enough staff to warrant that. Smaller hospitals have trouble with it. I can tell you that with the current push to prevent readmissions, hospitals are looking more and more into that, to having pharmacists more involved, even the smaller ones. And my hospital is one of them. What I'm talking about, I think would affect more clinic operations where, again, right now, there...I mean, for medication therapy management, for instance, what that entails is, is reviewing the patient's entire medication profile and have a sit-down face to face with that patient to discuss what's going on with their medications, how they're responding, making recommendations to the prescriber based on that. It goes beyond the counseling you'd get when you pick up a medication in a pharmacy. That...I mean, certainly that can happen in a hospital. But in a clinic setting, it's just ripe for it because that's where the patients are, and we tend to lose track of them a little bit when they go home versus when they're in a hospital. We simply, unless you're doing that through a pharmacy and that pharmacy has contracted with specific companies, there's not a way for us to bill for that. We think this would be one of the steps on the direction...on the way to doing that. [LB858]

SENATOR GLOOR: I have this visual imagine in the fall of driving down the street and

going by pharmacies... [LB858]

KEN KESTER: Uh-huh. [LB858]

SENATOR GLOOR: ...that say, come in and get your flu shot for X amount of money. [LB858]

KEN KESTER: Uh-huh. Uh-huh. [LB858]

SENATOR GLOOR: Is that charge for the vaccine itself? What are we paying for if we take advantage of that? And is that delivered usually by a pharmacist? [LB858]

KEN KESTER: First of all, yes, it is usually delivered by a pharmacist. Secondly and regrettably, I have absolutely no experience in the area you're talking about right now. I'm a hospital guy. So I...I'm sorry, not just to jest, but I've never been involved with immunizations so I can't really speak to that. Again, the setting...and frankly, what frustrates me is being next door to a clinic when they have patients in and out of there all the time, congestive heart failure patients, diabetics, lipid...patients with poor lipid control that can't afford a doctor visit every week or every two weeks. Pharmacists can step in there and help them revise their medications for the best outcomes. That's the role I see that this would help to provide. [LB858]

SENATOR GLOOR: But you couldn't...under this bill, you wouldn't be setting yourself up in, for want of a better term, private practice. [LB858]

KEN KESTER: No. [LB858]

SENATOR GLOOR: You'd still be getting referrals from physicians to serve in this capacity? [LB858]

KEN KESTER: Yes. Yes. This bill would not enlarge our scope of practice, than we get into 407 territory for, specifically, because when people first see the word "provider" they think we want prescribing rights. That's not what this is about. This is about...what's been documented amply, is that when pharmacists work with chronically ill patients, we can help to reduce readmissions. It saves money. And that's the direction health care is headed. But right now, by and large, we can't get paid to do that so people aren't doing that. [LB858]

SENATOR GLOOR: Okay. Senator Campbell. [LB858]

SENATOR CAMPBELL: Thank you, Senator Gloor. And thank you for serving on the Board of Health... [LB858]

KEN KESTER: You're welcome. [LB858]

SENATOR CAMPBELL: ...too, I appreciate that. You may not be able to answer this question, but at some point, I would like to have somebody maybe...Joni can check for us, but...so I go into my neighborhood pharmacy. [LB858]

KEN KESTER: Uh-huh. [LB858]

SENATOR CAMPBELL: I'm going to take you out of the clinic now. I'm in my neighborhood pharmacy. [LB858]

KEN KESTER: Uh-huh. [LB858]

SENATOR CAMPBELL: And the neighborhood pharmacy, like many across the United States, are now becoming a health center or billing themselves somewhat as that. You can go to a kiosk and come in at 2:00 and find out whether you have the flu or just a cold. [LB858]

KEN KESTER: Uh-huh. Uh-huh. [LB858]

SENATOR CAMPBELL: If that pharmacist sat down with me and went over some of the things in my record and visited with me, would you see that as a reimbursed provider expense? [LB858]

KEN KESTER: Yes. [LB858]

SENATOR CAMPBELL: According to the bill? [LB858]

KEN KESTER: Yes. [LB858]

SENATOR CAMPBELL: Okay. [LB858]

KEN KESTER: There are two ways it could be a reimburse in that setting. One is, you pick up a prescription and that's, of course, a traditional model. You get paid for dispensing a medication. And then we also, hopefully, would spend time talking with the patient about that medication. What we're talking about is something different. And Senator Howard kind of stressed this, cognitive or clinical...I'm not a big fan of the word "cognitive" frankly, in this setting because you have to be able to think to make IVs, too, you know. But the point is, it's not associated with a product. We would like for you to be able to come in and have a real consultation on your medications that doesn't involve you buying something from us, but we have a way to bill for that because we think the evidence shows that's worth paying for. [LB858]

SENATOR CAMPBELL: Because right now, if I go into the pharmacist and say, can you go over my record? Are there any conflicting prescriptions? [LB858]

KEN KESTER: Uh-huh. Yep. [LB858]

SENATOR CAMPBELL: Or, you know, should I be seeing a doctor about this one? You can answer all my questions, but you can't bill for that time. [LB858]

KEN KESTER: Right. And simple questions, we should just do, you know. And frankly, pharmacists usually rate pretty high on the trust... [LB858]

SENATOR CAMPBELL: Uh-huh. Right. [LB858]

KEN KESTER: ...what do you call that, the trust level people have in professionals. Nurses are ahead of us somehow. I'm not sure how that happened, but it did. We're usually... [LB858]

SENATOR CAMPBELL: Because they're standing by the bedside, sir. [LB858]

KEN KESTER: ...but we're usually...yeah, yeah. We're usually number two. But I think that's because, in part, because we give a lot of free advice, you know, which is good. And we should do that. What we're talking about is a way to...you know, typically, what they won't do is take 20 minutes to just review your whole profile and your past records and come up with a real plan. That's a little different than...and I'm not minimizing this because this requires skill, too. But that's different than running through and making sure we don't have any drug interactions, that sort of thing. [LB858]

SENATOR CAMPBELL: Right. So do you think that the bill clearly defines and gives a definition to when it's just, well, Mrs. Campbell, you know, we'll talk through this product. And when there's a billable...is it hours or visit or instance or... [LB858]

KEN KESTER: I don't think the bill necessarily clearly outlines that because it's pretty sparse and pretty much sticks the word "pharmacist" in next to all of the other recognized providers. [LB858]

SENATOR CAMPBELL: Got it. [LB858]

KEN KESTER: I think the clarification would partly come with the codes that are used for billing purposes whether it's with Medicare or with the insurance companies. [LB858]

SENATOR CAMPBELL: Okay. Thank you for the information. [LB858]

KEN KESTER: You're welcome. [LB858]

SENATOR GLOOR: Other questions? Seeing none, thank you. [LB858]

KEN KESTER: All right. Thank you. [LB858]

SENATOR GLOOR: Next proponent, please. [LB858]

ANN FROHMAN: Good afternoon, Senator Gloor, members of the committee. My name is Ann Frohman, for the record, spelled A-n-n F-r-o-h-m-a-n. I am here on behalf of the Nebraska Medical Association to testify in support of LB858. In listening to some of the earlier questions, the Nebraska Medical Association when we were first approached by Senator Howard in terms of our position on this, our members were supportive of the bill for the reasons that we had just heard in earlier testimony. We've been talking patient centered. We've been talking team based. This is what this is about. It is a team. You know, I don't know that they're the quarterback of the team. But, clearly, the pharmacists play an important part in making sure that, at the end of the day, the patient understands what they're doing, whether it's in medication therapy management, dealing with the chronic conditions. And knowing that, you know, health care delivery is moving forward, it's changing, and we have to be, you know, recognizing that everybody on the team has a critical role. And to acknowledge that they get reimbursed for the services that are provided is a good thing, ultimately. Thank you. [LB858]

SENATOR GLOOR: Other questions? Seeing none, thank you, Ann. Other proponents? Seeing no further proponents, are there opponents of this bill who would like to be heard? Anyone in a neutral capacity? Good afternoon. [LB858]

JEFF HUETHER: (Exhibit 3) Good afternoon, Chairperson Gloor and members of the committee. My name is Jeff Huether. For the record, that is spelled J-e-f-f H-u-e-t-h-e-r. I'm the director of pharmacy for Blue Cross Blue Shield of Nebraska here today to testify in a neutral capacity on LB858. LB858 includes a number of concepts which we are very interested in. We agree that pharmacists are great partners and have great potential to provide services to our members in a cost effective and convenient way. We have seen this with the development in payment for certain vaccinations. We watched as pharmacists began to provide vaccinations and we have moved away from the traditional payment paradigm where the pharmacist is paid for the pharmaceutical, the markup on the pharmaceutical, and a dispensing fee to payment of an administration fee as well. We have moved in the direction without a change in the law and we will continue to look for opportunities to increase access for our members' convenient, cost effective health care. So in some contexts, we already do provide payments to pharmacists outside of the context of the pharmaceutical and a dispensing fee. But as written, we believe that the bill includes significant potential for unintended consequences. By creating a separate statutory right for payment for specified services to specified providers, we are concerned that the bill would impede the development of

certain types of accountable care organizations or ACOs and other forms of bundled payment in our state. Instead of payments being structured in a capitation basis for all of the health care delivery services of X dollars for a specific person or persons, we would need to structure them as X dollars minus any other amount for specific pharmacist services. There are mandates requiring payment for specific services. We cannot, however, identify other areas in which the statute specifically calls out a specific provider who is entitled to separate compensation. This is one example of where the language could cause unintended consequences. In addition, the bill appears to be trying to get away from the old model of pharmacist reimbursement, that is, that a pharmacist is paid for the pharmaceutical and a dispensing fee and that's it. However, it does so in a way that would be difficult and expensive for insurers to administer. Currently, we contract with pharmacies across the state. By requiring separate payment to pharmacists, we believe we would need to go through negotiating separate contracts with a significant number of licensed pharmacists. This would be expensive and time consuming and, at the end of the day, isn't necessary if the goal is separate payment. We understand that pharmacists do more than provide a pharmaceutical and dispense the pharmaceutical and that there is a range of services they can provide that are a benefit to our members. We are on the lookout for these opportunities. However, we want to avoid potential unintended consequences that could come about as a matter of drafting. We are appearing in a neutral capacity because we are interested in working with proponents over the summer to develop language that would provide a solid framework for recognizing the role of pharmacists in the health care delivery system. I would also like to comment briefly, Senator Gloor, on your question around vaccines and provided in my testimony today. A couple of years ago, Blue Cross Blue Shield of Nebraska has been reimbursing for certain vaccinations, an administration fee above and beyond the cost of the pharmaceutical, as well as a dispensing fee. Thank you. [LB858]

SENATOR GLOOR: Mr. Huether, as I read the bill, I don't see that there is any risk of impeding development of at-risk contracts with ACOs or whomever. What the bill says is that, if I'm reading it correct, that insurers may contract with pharmacists for health care services which are separate and distinct from drug dispensing and counseling, not that they have to. In other words, if there's an ACO that wants to do an at-risk contract, I would expect they'd go looking for pharmacists who are willing to take a piece of that at-risk contract regardless of...and as part of its negotiations, negotiating what they get paid and how much they get paid and including this component. I wouldn't see that we're putting in statute that they must get paid for doing this. And if that were the case, you want the contract, you'll do it for a penny as opposed to a traditional fee because we're trying to do a roll-up of risk here. But as I read this, I don't think it puts at-risk contracting at any degree of risk; pardon the beating to death that word. Any comment on that? Or you may want to carry that message back to see if they still feel that way. But it doesn't look like it's interfering with those contract negotiations to me, as I read the bill. [LB858]

JEFF HUETHER: Okay. I'll take that back. [LB858]

SENATOR GLOOR: Okay. Other questions? Senator Campbell. [LB858]

SENATOR CAMPBELL: Yes, sir. Thank you for your testimony. I'm sure you heard my exchange between Dr. Kester and myself. Do you have any...so you would consider at this point, the administration fee that you're paying to give a vaccination. What if, then, that pharmacist then sat down with me and went through my record and answered questions and said, you know, let's have a little bit better monitoring plan. You might want to stop in and we'll take your blood pressure. Would you pay the pharmacist separate for that? [LB858]

JEFF HUETHER: Currently, that is not reimbursable today. [LB858]

SENATOR CAMPBELL: Okay. So the pharmacist would just be doing that of their own volition and not have any payment nor any way to elicit payment? [LB858]

JEFF HUETHER: That's correct. [LB858]

SENATOR CAMPBELL: Okay, thank you. [LB858]

SENATOR GLOOR: Other questions? Thank you for your clarification of one of my questions, too. [LB858]

JEFF HUETHER: Thank you. [LB858]

SENATOR GLOOR: Thank you. Other individuals who would like to present in a neutral capacity? Seeing none, Senator Howard, you're recognized to close. Senator Howard waives. And that ends the hearing on LB858. We'll now move to LB831. Senator Christensen. [LB858]

SENATOR CHRISTENSEN: Thank you, Chairman Gloor and members of the Banking, Commerce and Insurance Committee. I'm Senator Mark Christensen, C-h-r-i-s-t-e-n-s-e-n, I represent the 44th Legislative District. LB831 would require insurers to apply the reimbursement for covered medical equipment to the deductible in the year in which the request for approval of coverage was received by the insurer. In addition, it would amend section 44-1540 by adding a new subsection (19) that includes, "Unreasonably delaying a request for preapproval of coverage of medical equipment." This makes it part of a list of unfair claim settlement practices. Currently, some insurers that receive a request for approval of coverage for medical equipment towards the end of a deductible year will unreasonably delay the approval of coverage of the medical equipment reimbursement until after the start of a new deductible year.

Therefore, voiding the reimbursement payment because the new year resets the insurer's deductible. This shifts the cost of medical equipment away from the insurer to the insured, even though the medical equipment is a covered item. LB831 seeks to curb this type of insurance practice from occurring in Nebraska. I'll give you a little personal story. This hit right at home. This happened to be with my daughter and my granddaughter, the same granddaughter that is...was sent home to die. And so I don't know if anybody will testify behind me, but this is just one of them situations where...and the reason I left twice is I was on the phone with the doctor and he said...he give me his term. He says, always at the end of the year you're running into they'll request for additional need of medical necessity, referrals, and things this way. And when we was going through this problem in December, I called the insurance company, visited with the lobbyist and he took good care of me. And we got it handled right away. But the solution was, well, if you just go pay for it now...because we had a preapproval number, but we didn't have their acceptance to go get it. And they just said, well, just go pay for it. If you pay for it before the first year, it's covered because you know it's going to be because you've got that preapproval number. But yet they were denying the request through the doctor which was no big deal. It was a $700 item. But my question is, what if it would have been a $5,000 or $10,000 item? Not something that most people could write a check for. To me, that was wrong. And once we just paid for it, it was over, done, covered, thing went away, showed to me it was an unnecessary delay. And I'd loved to have had my daughter here to explain this situation, but with the case that we're in, you know, I didn't even tell her. She didn't know till a little bit ago and the doctor called me and then she called me and said, well, I didn't know you had even introduced the bill. But the fact is, you know, you're going to hear from people saying, well, we give them 60 days to go purchase it once it's approved so they can put it on either year. Well, that's no different than if it's 15th day of December, my deductible starts over in January and I don't want it till next year's deductible, I'll wait till January 2. I mean, I don't understand why...and, like I said, the doctor I just got off the phone with says this is a common practice at the end of the year. And, you know, I wished I had called him because he'd come testify. He's been here before. But anyway, that is what precipitated this bill. I know you're going to have a number in opposition here. I don't know if anybody will be in support. But I wanted to explain the situation that happened with my granddaughter, trying to get a little bit of medical equipment that was approved and was not...had some unnecessary delays. And the doctor told me, said, it's just a medical necessity and we want referrals. As soon as we paid for it, it was over, done, it was paid for, went on last year's deductible because that got 100 percent covered because they'd met the need. So that's kind of a little history behind the bill, why I brought this. And my hopes is through the discussion of this, whether the bill goes forward or not, it can end the practice. So are there questions? [LB831]

SENATOR GLOOR: Thank you, Senator Christensen. Senator Christensen, how are we going to define "unreasonable" since that's going to be built into the statute? I mean, from insurance company to insurance company, it may be different. And how are we

going to have a standard that's going to help determine that? Otherwise, it would seem to me, if we can't define "unreasonable" it's going to be difficult to enforce. [LB831]

SENATOR CHRISTENSEN: Well, I agree. But if you go back in the...on line 3 of page 4, in the current statute it says "unreasonably delaying." It's already a word in statute. And so it is already the practice because that's what the drafting people said to use was because that is already currently used. And I'm not sure that I have found that it is defined. [LB831]

SENATOR GLOOR: What was that reference, again. I missed...page 3? [LB831]

SENATOR CHRISTENSEN: Okay, go to page 4, line 3. [LB831]

SENATOR GLOOR: Page 4, line 3. Sorry. [LB831]

SENATOR CHRISTENSEN: It just says "unreasonably delaying the investigation or payment of claims." They said this is a term that's already used in insurance so that's what drafting said to use. [LB831]

SENATOR GLOOR: Okay. [LB831]

SENATOR CHRISTENSEN: I don't have a good answer for you, though. [LB831]

SENATOR GLOOR: Well, that's a pretty good one. Any questions at this point? Thank you, Senator Christensen. We move to proponents. Opponents? [LB831]

ERIC DUNNING: (Exhibit 1) Good afternoon, Chairperson Gloor and members of the committee. My name is Eric Dunning. For the record, that's spelled E-r-i-c D-u-n-n-i-n-g. I'm the director of government affairs for Blue Cross Blue Shield and a registered lobbyist here today to testify in opposition to LB831. LB831 requires reimbursement for medical equipment costs to be applied in the deductible year in which the request for approval of coverage was received by the insurer. Currently, the deductible is applied based on when the goods are purchased and not based on when they are preauthorized. We oppose a change in this area because it will lock into statute when this deductible is applied whether or not the member would want the deductible applied differently. As an example, if the member receives a preauthorization late in the policy year, for example, in December. That preauthorization is typically good for a period of several months. The member currently has the freedom to purchase the goods in December or January or later. The member might want to have the claim apply in the following year's deductible because they have not made claims in the prior year and will not meet the deductible in that year. However, they may know that they've just been diagnosed with a new condition and they will meet the deductible in the following year. In this case, (LB)831 would restrict the freedom of our members to make this decision

on their own. In addition, LB831 only applies to medical equipment. That's a term not used in our policies. Durable medical equipment is a term we use and apply, but it appears that medical equipment may be broader than durable medical equipment. I'm more concerned about the implications for that for administration. Last, we believe that section 2 of the bill is unnecessary. We have a contract with our members which requires us to act in good faith. We don't believe we have the ability to unreasonably delay requests for preapproval of coverage of medical equipment under current law. And we ask that LB831 not be advanced. [LB831]

SENATOR GLOOR: Thank you, Mr. Dunning. Are there questions? Seeing none, thank you. [LB831]

ERIC DUNNING: Thank you, sir. [LB831]

SENATOR GLOOR: (Exhibit 2) And we also have a letter in opposition from Coventry Health Care. I'll have copies of this passed out by the pages. Other individuals in opposition to this bill? Anyone who would like to provide testimony in a neutral capacity? Seeing none, Senator Christensen, you're recognized to close. [LB831]

SENATOR CHRISTENSEN: Thank you. Couldn't decide whether to close or not. But as you can see, the main objection, that was what I brought up to begin with. It gives them the flexibility to move it to the second year which, again, if it was late in December and somebody didn't want it till their next deductible period, they could wait and request for it in January. And so I don't think that that's anything that sets a bad precedent for the insurance holder to choose because I can tell you right now, where I'm at on my deductible for the year and...because I keep track of that pretty close because I watch it. Especially at the end of the year I know where I'm at because if I'm wanting something to get done because I'm already there and don't know where the next year will be, I'll make sure I get the procedures done or whatever it is. Or if I'm not going to hit it that year, I'll delay it. That's just a choice that we have as individuals and that's an easy way of handling the situation. And again, the doctor had told me the thing that it's done on most often is medical equipment or durable medical equipment. I agree with Eric's correction there on the terminology. And so I just think it's something that does occur. And I can sure get, if you want, some doctors that would testify to that. Thank you. [LB831]

SENATOR GLOOR: Any final questions for Senator Christensen? Seeing none, thank you, Senator Christensen. And that will end the hearing on LB831. We'll now move to LB953. Senator Howard, for the remainder of the afternoon, as a matter of fact. [LB831]

SENATOR HOWARD: (Exhibit 1) I think it's Sarah Howard day today, I'm thinking. Good afternoon, Chairman Gloor and members of the committee. For the record, I am Senator Sara Howard, H-o-w-a-r-d, and I represent District 9. Today I am introducing

LB953 to further the development in our state of health information initiatives. Using a health information exchange or initiative, providers and insurers can see certain information in patients' health records. This means that if you are admitted to a hospital and if your hospital and physician are health information initiative participants, it's much easier to share those records. This will improve care and avoid unnecessary duplication of services. The best example I have is, if I live in Omaha, my primary care provider is in Omaha, and they are participating in a health information exchange. And I go to Kearney and I get into an accident and I go to the hospital. They would be able to see my records from Omaha and know what meds I'm on and know what tests I've had in order to avoid duplication of services. Our best example of a health information initiative in Nebraska is NeHII, the Nebraska (Health) Information Initiative. Because of NeHII, Nebraska is a leader in encouraging the sharing of health information by connecting various electronic health record systems. NeHII is often described as a private, public partnership or a public, private partnership. On the private side of the partnership, the bill requires participation of both private sector and public sector insurers and a health information initiative so that all Nebraskans have the opportunity to benefit from improved management of care, improved outcomes, and reduced medical costs. On the public side, the bill would create the Health Information Initiative Support Fund made up of gifts, appropriations, and a $1 million annual distribution from the Comprehensive Health Insurance Pool Distributive Fund; it's also called CHIP. The CHIP Distributive Fund was created in 1985 for Nebraskans who were not able to access affordable insurance because of preexisting conditions. Because of the Affordable Care Act, coverage became available to Nebraskans regardless of their health status and preexisting conditions. The program subsequently ended on December 31, 2013, although there are still about 60 folks who are still in the program. This new fund that the bill would create would be administered by the Division of Public Health of the Nebraska Department of Health and Human Services. And it would award grants to health information initiatives seeking funds to support the secure exchange of clinical information. This allows representatives of the public sector and the private sector to work together and to identify priorities for the sharing of electronic health records. I realize there are questions about how we have funded this and I intend to work with the Appropriations Committee to resolve those issues. Deb Bass, the chief executive officer of NeHII will be testifying on the bill. So if you have anything that's system specific, because I don't work in NeHII although OneWorld does have a view-only NeHII license, she would be the best person to ask for those questions. Before I conclude, however, I would ask that you consider one specific amendment. The introduced version of the bill would have included Medicare supplement policies in the list of health insurers required to participate. However, it was brought to my attention that this line of insurance should not be included in the bill as these insurers must pay any claim that Medicare pays. This means that their insureds cannot benefit from the health information initiative. And I don't think it would be fair to include them. Thank you for your time and attention to LB953 and I would be happy to answer any questions you may have. [LB953]

SENATOR GLOOR: Senator Howard, by putting this in statute, do we expect the CHIP pool or the CHIP funds to be available in perpetuity? I mean... [LB953]

SENATOR HOWARD: That's a good question. Director Ramge did send a letter to the effect regarding the CHIP pool and I would defer to him about the availability of that pool. [LB953]

SENATOR GLOOR: But as written right now, we would be obligating ourselves to $1 million every year. [LB953]

SENATOR HOWARD: Yes, until the fund was gone. Until the CHIP funds were expended. [LB953]

SENATOR GLOOR: But are we sure that even till the...does the bill say until the funds are expended? [LB953]

SENATOR HOWARD: I would be happy to amend it to that effect. [LB953]

SENATOR GLOOR: Okay. Other questions? Seeing none, thank you. [LB953]

SENATOR HOWARD: Thank you. [LB953]

SENATOR GLOOR: And we know you'll stay to close or, at least, stay. [LB953]

SENATOR HOWARD: Yes. [LB953]

SENATOR GLOOR: We'll move to proponents. Good afternoon. [LB953]

LINDA BURT: (Exhibit 2) Chairman Gloor and members of the committee, my name is Linda Burt. I am the chief financial officer of Nebraska Methodist Health System based in Omaha. I am here in support of LB953. [LB953]

SENATOR GLOOR: Linda, could I ask you to spell your last name, please? [LB953]

LINDA BURT: B-u-r-t. [LB953]

SENATOR GLOOR: Thank you. [LB953]

LINDA BURT: I am here in support of LB953, the Nebraska Health Information Initiative. I would like to describe some of the benefits of the health information exchange. First of all, failure often occurs at the point of hand-off. Any of you who have studied process improvement know that the point of hand-off is often the point you'll find process inefficiencies. This is true in health care as it is in all industries. In health care, dealing

with one individual patient, we have many people and facilities that may be involved in the care of that patient. When it comes to doctors, in the hospital setting you have an attending physician, you often have several consulting physicians which may be specialists, there may be an emergency physician involved or a surgeon. Among these...in addition to the physicians, we also have several professionals, nurses, pharmacists, therapists, and dieticians who all care for the patients. As I mentioned first of all, there may be several facilities involved also. In several cases in Nebraska, we have patients who start out in small rural hospitals who are transferred to large urban hospitals. In some cases, they are transferred back. Or they may be coming from a skilled nursing facility and transferring back to those facilities after care. Knowledge of the unique patient and his or her history as well as tolerances are key to patient safety and appropriate treatment. Complete information at the point of care can reduce the likelihood of an adverse event and avoid unnecessary delays in treatment. NeHII...one of the advantages of NeHII, is it does incorporate a master patient index. All those various physicians and facilities I mentioned all have their own clinical systems and within those systems they have all a unique patient identifier for each patient, but they're all different. So within NeHII it brings all that together and forms a master patient index so we can identify an individual patient and pull the information from these various sources. Electronic access to patient information is very critical, particularly in situations where there is emergent or urgent needs for the care of that patient. Immediate access to comprehensive information can impact patient outcomes. But also a big benefit is the elimination of the transfer of information via paper, phones, or faxes which is both inefficient, but can also cause errors or omissions. NeHII or a health information exchange is an enabler to help with the transition of care in these many situations. When we look at quality standpoints and some of the changes going on in health care, many physicians in health care organizations, such as my own, are working together with other health care organizations to develop evidence-based protocols to eliminate variation in care and improve outcomes while trying to manage costs. NeHII provides the infrastructure that is an enabler to these types of initiatives. The development of a infrastructure on a statewide basis allows us to minimize the duplication of effort and costs that would take place in many organizations across the state. In summary, I see NeHII has a technology enabler that moves health care organizations such as Nebraska Methodist Health System closer to the triple aim of goals of improving quality and outcomes, providing good customer service, and managing costs. Methodist Health System strongly supports NeHII and hopes the committee advances the bill to General File for debate. Funding for NeHII is critical to its continued success and future enhancements. Thank you for your time. [LB953]

SENATOR GLOOR: Thank you, Ms. Burt. Here's a question that is a concern of mine. First of all, NeHII is the right thing and the inevitable thing to do. But how do we avoid million dollar requests coming in every year from the same institution that's got its act together and instead of the million dollars going to various institutions across the state, one larger institution that needs a million dollars to do this gets it every year for two or

three years straight? But it might have been something they were going to do anyway. So what we've done is reduce their expense to do this, but those funds haven't gone out to some institutions that might be much smaller and could have used $100,000 of those monies for them to be able to get up and going with NeHII. It's a fairness in distribution issue and how we sort that all out. [LB953]

LINDA BURT: Could be. And I know Deb Bass knows the finances better than I do. But I do hear that there are some organizations across the state that are trying to develop their own health information exchanges so they are actually investing monies on their own right now to duplicate what we're doing here. You know, I still think if we had a very strong, well designed, statewide platform, that would save us all. Because those organizations that are developing their own now, they're only connecting with certain organizations that they're pulling into the network. So organizations such as mine who subscribe to NeHII, we may not be able to exchange any information with those organizations who are off doing their own. So to me... [LB953]

SENATOR GLOOR: Or they with you. [LB953]

LINDA BURT: Or they with me, right. [LB953]

SENATOR GLOOR: Yeah. [LB953]

LINDA BURT: So we've got pockets out here doing things on their own where if we did it on a very well structured, well designed, across the whole state, I believe both it would be more cost effective for everyone and then we have the opportunity to communicate. Now I do believe the pricing is somewhat different in the smaller organizations than it is in the large organization. So I think, you know, they try to take that in consideration, the size of the organization when they set out the pricing. But...and I...the couple of years that I've been involved now, I've already seen that there has been advancements in the types of functionality that has been offered through NeHII. So I know they're continuing to enhance and improve the information too. So to me, it just makes a lot more sense to have a very strong, statewide platform as opposed to multiple little pockets throughout our state doing the same thing. [LB953]

SENATOR GLOOR: Well, I guess that comes down to definition of statewide. And I think one of the things we have to be careful of and measure is that we're not seen to be picking sides if we're going to take money out of this pool, which is supposed to be available to everybody. [LB953]

LINDA BURT: Uh-huh. [LB953]

SENATOR GLOOR: Or then allocating this pool strictly to NeHII which may or may not be a decision, for better or worse, may or may not be the platform that all hospitals

decide they want to connect with. I think that's...and I'm stating it now so Deb can think about it... [LB953]

LINDA BURT: Yeah. [LB953]

SENATOR GLOOR: ...as she decides on how to respond. That's one of my questions, I think. I see somebody...I thought somebody had a question over here. Senator Campbell. [LB953]

SENATOR CAMPBELL: Thank you. And I probably need to hold the question for Deb, then, because I was wondering what percentage of physicians and hospitals are connected to NeHII now. [LB953]

LINDA BURT: Deb could answer that for you, yeah. [LB953]

SENATOR CAMPBELL: Okay. And my second question has to do with we had a bill in Health and Human Services Committee last week, I believe, Senator Lathrop's bill having to do with drug monitoring. [LB953]

LINDA BURT: Oh, yeah. [LB953]

SENATOR CAMPBELL: And one of the...I think one of the questions was what would it take to bring NeHII up to that? And it was not $1 million, it was considerably higher. So part of my concern is, you know, plugging in $1 million...somewhat like Senator Gloor. I mean, what really is the total picture we're looking at here? And if we do need a prescription drug monitoring program, do we want to set that up separate from NeHII? But the costs were much higher. Maybe Senator Gloor or Senator Howard remember the total. But it was not...I mean, it was higher than $1 million. So we're just...that's kind of the direction. [LB953]

LINDA BURT: Okay. [LB953]

SENATOR GLOOR: Other questions? Seeing none, thank you very much. [LB953]

LINDA BURT: Sure. [LB953]

SENATOR GLOOR: More proponents? [LB953]

MICHAEL WESTCOTT: (Exhibit 3) Good afternoon. I am...Chairperson Gloor and members of the committee, my name is Dr. Mike Westcott, M-i-k-e W-e-s-t-c-o-t-t, and I'm the president of the board of directors for the Nebraska Health Information Initiative and I'm the regional chief medical informatics officer for Catholic Health Initiatives. And the regional part isn't even dry yet, Senator Gloor. I now have St. Francis. I'm here to

talk to you today about the sharing of electronic health records from a provider perspective. I'm testifying in support of LB953. I'm also here today in my role as president of the board and as someone who has used NeHII in the work that I do at CHI. NeHII has been developed to be helpful for physicians and hospitals as well as many other providers and patients. We've had some important successes I'd like to talk to you about today, as well as some of the stories that have been shared with us by providers who have used the system. However, I'd like to begin the testimony on the patient side. Many of us have had situations in our personal lives where we've experienced complex medical conditions faced by ourselves or our loved ones. Patients in these situations have interactions with many medical providers. These can include their pharmacists, the local hospital, a regional hospital in more complex cases, and their primary care physician. Many see specialists. It isn't that long ago that the patient bore the major share of bringing the responsibility of bringing all the pieces together and explaining all the drugs they were taking or the tests they had recently had. And they had to wait to begin treatment plans because their medical records had to be sent to the provider who needed them. And having been in private practice, I mean, it's pulling teeth to get records from other facilities, so. Sharing electronic health records between providers allows much of that work to be done on a more coordinated basis. It allows us to work together more collaboratively to help our patients. NeHII provides improved patient safety through the availability of a complete medical record at the point of care, especially lab tests and medication history. NeHII improves efficiencies in provider interactions in developing a treatment plan for consultations. NeHII can help us reduce hospital readmissions through increased efficiency and transition of care across the continuum of health care providers from acute care to post-acute care. And reducing medication errors should result in fewer adverse reactions or hospitalizations. We've heard from providers that since NeHII allowed increased and easy access to medical records via an Internet browser with no additional software required, it allows even technology phobic providers to use the tools available. We've heard that NeHII is fluid, easy to use, and straightforward. But we've also heard from emergency department physicians who had situations with confused and sick patients who had had three ER visits in the past 12 months. But when they were able to look up the patient in NeHII, found that they actually had over 30 visits. As you can imagine, the treatment plan is much different for 3 ER visits than 33 ER visits. NeHII is a great tool for health care providers. We've had good adoption of NeHII services in Douglas County and throughout the Platte Valley. However, we have challenges in other parts of the state. We believe that by increasing the resources available to NeHII we can develop even more tools and incentives that will bring more health care providers to participate in NeHII. Nebraskans benefit when their health care providers have a good way to share electronic health records across the state. Nebraska is at the leading edge of these efforts, but we need your help to keep the process moving forward. And just some personal testimony, I actually began my medical career in Holdrege from where Senator Carlson is from. And, you know, we've got a regional highway going through that city. And very frequently we got confused patients and trauma patients. We had no access to

any medical information, especially in the middle of the night or on a weekend. And we were just dead in the water. We had to just use our best judgment. So I suffered through that for several years and then I became an emergency physician in Omaha and suffered through it another 20 years. You just can't get records when you need them and sometimes it's extremely critical. And even if the patient tells you what medications they're on, they frequently will tell you that it's a green pill or it's a white pill and you don't know what it is. So we're...you know, this makes...some of our biggest users are the providers that treat emergency conditions right now, the smaller town, rural facilities and the emergency departments across the state. And I'll tell you, we have done a great job in Nebraska. We're...we have a great health information exchange. It's been going on now for several years. The reason that it's done well is we have such a grass-roots support. From the very beginning, we involved dozens and dozens of stakeholders. When we have our annual meetings now, we still have 100 to 150 people come and hear about NeHII. We're just on the threshold of doing some other great things. We already mentioned the prescription drug monitoring program that we hope to incorporate within NeHII. There's economic incentives, you know, to decreasing the number of lab tests. You know, that's a kind of a payer side benefit. But there's just other patient safety things. If you think about how many kids get CT scans, if we had a method of monitoring how much radiation they got to keep them out of trouble with that. How we could improve outcomes across our state, how we could improve the epidemiology, you know, figure out things happening across the state before other agencies were able to figure that out. It's just hugely beneficial to us. And I think you're going to find that in even some of our neighboring states, very soon you're going to find some of their health information exchanges that are going to be folding because they haven't had enough support. We have. We've been really blessed with the health systems and the payers that have contributed so far. But this is a very expensive proposal to keep on going on a sustaining basis. And this will ensure that we can keep NeHII at the forefront in the health information exchange. And my day job really is electronic health records. And, you know, you hear now how lots more and more systems are going to kind of centralized or one vendor. We'll never get to one vendor in electronic health records. IBM was the leader for a while till Apple came along. Then when Apple, you know, was riding high, here comes Dell. That's what's going to happen in our industry as well. So we'll never have one, unified medical record across our country. It's not going to happen. We need some way to be able to access various disparate systems on a very timely basis. So I urge you to support LB953. [LB953]

SENATOR GLOOR: Thank you, Dr. Westcott. [LB953]

MICHAEL WESTCOTT: Uh-huh. [LB953]

SENATOR GLOOR: Interesting information. And I'm thinking of my comment to Ms. Burt. And I'm trying to reformulate it in a different way which is, I don't think anybody argues that NeHII is an admirable goal. But my question really gets to the realities of the

market. And as we already know, individual systems have their own platforms that are important to them for reimbursement purposes and measuring markets. Is NeHII going to play second banana to those individual platforms that systems put together for their own needs and purposes? Is there a way that we can have a common platform that everybody agrees to work on cooperatively? Or is NeHII going to become, for want of a better term, sort of superfluous as the state begins to align along the larger systems and contracting with employers? [LB953]

MICHAEL WESTCOTT: Yeah, you know that NeHII has been coming along for several years now. And, you know, we've gotten to where we're at because of the great work that's been done. This is not an easy thing to do. And I think that some of these little one-off systems are going to come to that realization before too long. I think we have to take a much higher road and think about our patients. I mean, this is a patient safety initiative. We can't do it just from our own economic, our own local perspective. And I think that as we get the word out to more and more people, that that's what people will realize. [LB953]

SENATOR GLOOR: Is a million dollars going to make much difference in the grand... [LB953]

MICHAEL WESTCOTT: It's going to make a huge difference to us because we...you know, for example, we only have one physician trainer at the moment. And we have people asking us to come out and be trained and we just don't have the bandwidth to get it all done. [LB953]

SENATOR GLOOR: But isn't there an assessment to the users? [LB953]

MICHAEL WESTCOTT: There are. There is, yes. [LB953]

SENATOR GLOOR: Is it on an institution basis or is it on a provider basis? [LB953]

MICHAEL WESTCOTT: So it's on an institution basis and we also have payers that pay for it. And Deb will get into the financial considerations in more detail. [LB953]

SENATOR GLOOR: Okay. Okay. Senator Carlson. [LB953]

SENATOR CARLSON: Thank you, Senator Gloor. Dr. Westcott, welcome to the committee. [LB953]

MICHAEL WESTCOTT: Thank you. [LB953]

SENATOR CARLSON: And I've been off the committee, it was a couple of years. Have you been here to testify before? [LB953]

MICHAEL WESTCOTT: No, I just became the president of the NeHII. [LB953]

SENATOR CARLSON: Okay. Well, welcome here. [LB953]

MICHAEL WESTCOTT: Thank you. [LB953]

SENATOR CARLSON: Who benefits most from Nebraska Health Information Initiative? Who benefits the most? [LB953]

MICHAEL WESTCOTT: You know what? The bottom line, Senator, is it's the patient because you're not going to get...you know, if your provider knows your current medications, they know your allergies, they know what examinations you've had done and the results of those examinations, your care is delivered much more safely, much more completely, and it leads to definitely improved outcomes. [LB953]

SENATOR CARLSON: Is it really important to the health providers? [LB953]

MICHAEL WESTCOTT: Absolutely. The example I just gave where you're just kind of dead in the water. [LB953]

SENATOR CARLSON: Yeah. [LB953]

MICHAEL WESTCOTT: When a patient came in, you didn't know what medical conditions they had or what medicines. I mean, there's a lot of medicines that you use in the emergency situation that are contraindicated when patients are on certain cardiac medications. If you don't know that, you know, you can do more harm than good. [LB953]

SENATOR CARLSON: And you feel like the million dollars is enough to provide this service? [LB953]

MICHAEL WESTCOTT: It will go a long way in getting us further down the road. [LB953]

SENATOR CARLSON: How much more would be necessary before it would be enough? [LB953]

MICHAEL WESTCOTT: How much is enough? I know. My kids used to ask that. I won't hazard a guess. That would be speculative. I mean, if we had two or three times that amount, I think we would go even further. But we have to start somewhere and we are all very realistic. [LB953]

SENATOR CARLSON: And this is a hard question. You wouldn't...I don't expect an answer. But I think of the hospitals and the clinics throughout the state, if they were to help fund this, it wouldn't involve very much per unit, would it? [LB953]

MICHAEL WESTCOTT: Correct. And Deb will tell you just what the pricing structure is for the hospitals and providers and payers across the state. It's not large for hospitals, the community access hospitals, it's graduated based on your volume and your bed count. [LB953]

SENATOR CARLSON: Well, when you used the example that you're kind of dead in the water and you were making your best judgment, it would seem like that if you didn't have to worry about that and you had the information so you'd make the right judgment, that's got to be worth something. [LB953]

MICHAEL WESTCOTT: That absolutely is. One of the initiatives that we're working on now is, you know, a single sign-on product where if you're in your own native EMR, you have a button that you can click and take you right to Tom Carlson's record. I mean that will just be fantastic. [LB953]

SENATOR CARLSON: Okay. All right, thank you. [LB953]

SENATOR GLOOR: Senator Campbell. [LB953]

SENATOR CAMPBELL: Thank you, Dr. Westcott. [LB953]

MICHAEL WESTCOTT: Certainly. [LB953]

SENATOR CAMPBELL: Can the patient access their own medical records? [LB953]

MICHAEL WESTCOTT: I'm not sure I can answer that question. Deb will answer that. [LB953]

SENATOR CAMPBELL: Okay. [LB953]

MICHAEL WESTCOTT: I've done it all from the provider perspective. Uh-huh. [LB953]

SENATOR CAMPBELL: Okay. I just have to say that I'm now on a system where I can go anywhere in the world and... [LB953]

MICHAEL WESTCOTT: Oh, yes. Our system does, too, and that's exactly right. [LB953]

SENATOR CAMPBELL: And I can access my records... [LB953]

MICHAEL WESTCOTT: Uh-huh. [LB953]

SENATOR CAMPBELL: ...for any medical... [LB953]

MICHAEL WESTCOTT: Uh-huh. [LB953]

SENATOR CAMPBELL: ...work that I need done. [LB953]

MICHAEL WESTCOTT: Yep. Thank you. [LB953]

SENATOR CAMPBELL: Thank you. [LB953]

SENATOR GLOOR: Senator Schumacher. [LB953]

SENATOR SCHUMACHER: Thank you, Senator Gloor. Thank you, Doctor, for your testimony. [LB953]

MICHAEL WESTCOTT: Uh-huh. [LB953]

SENATOR SCHUMACHER: Senator Campbell's question has prompted the thought, what control does a patient have over what information is put on this computer system? Can they instruct the health professional and say, you keep this stuff off here? [LB953]

MICHAEL WESTCOTT: They can. [LB953]

SENATOR SCHUMACHER: Okay. [LB953]

MICHAEL WESTCOTT: And so we are an opt-out state so that when they come in for services at any particular provider, they can actually opt out if they so desire. [LB953]

SENATOR SCHUMACHER: Can they opt out of part of their records going on there? [LB953]

MICHAEL WESTCOTT: They can. [LB953]

SENATOR SCHUMACHER: And is that...are they told about that ahead of time? [LB953]

MICHAEL WESTCOTT: Yes. An interesting fact is that, when patients opt out and they learn more and more about NeHII, we have a large group that opt back in. And Deb has those numbers as well. [LB953]

SENATOR SCHUMACHER: Thank you. [LB953]

MICHAEL WESTCOTT: Uh-huh. [LB953]

SENATOR GLOOR: Other questions? Seeing none, thank you for your testimony. [LB953]

MICHAEL WESTCOTT: Thank you. [LB953]

SENATOR GLOOR: (Exhibit 4) I also have a letter of support here from the Nebraska Hospital Association I'll ask Emily to pass out. Welcome, Deb. [LB953]

DEB BASS: (Exhibit 5) Thank you. Good afternoon, Chairperson Gloor and the members of the committee. My name is Deb Bass. For the record, that's spelled D-e-b B-a-s-s. I am the chief executive officer of the Nebraska Health Information Initiative known as NeHII. And I want first to say that we support this legislation. And we're here to offer testimony on NeHII's efforts to further the sharing of electronic records. We believe that bringing all payers to participate in NeHII and creating a formal structure for continued state assistance to NeHII will assure the future of this project. To start, I'd like to give you a brief background on NeHII. It is a nationally recognized system that allows health care providers to exchange health care records in a secure environment. NeHII is not a data warehouse. We do not collect the records, we just allow them to be exchanged. The best analogy is to the roads. NeHII is the highway, better known as the exchange, and we are not the trucking companies nor are we the stores at the end of the highway. We understand that Nebraskans are very sensitive about their private information. It is very important to know that patients are allowed to opt out of the system if they choose. And they can do so however often they desire. Yet less than 3 percent of our 2.7 million lives in our system have chosen to do so. NeHII is a nonprofit organization whose participants include health care providers and insurers in the state of Nebraska. NeHII's goal is to improve the quality and safety of health care through the exchange of medical information, completely free of charge to the patient. Fifty-one percent of the beds in the state are already connected. More than 3,500 hospitals, medical clinics, physicians, pharmacists, and various health care professionals currently participate in NeHII across Nebraska. We also have significant participation from payers, but in order for this system to work and be sustainable over the long haul, we need more payer participation, and we need sustainable, predictable, public help for this public/private partnership. NeHII is currently supported largely with funds from our participants with limited funding from the federal government. It is important to note that the state has committed $250,000 in an effort to draw down federal matching funds. Two $500,000 appropriations have been made, but this $250,000 is the amount that has actually been committed to the matched funding. But these are one-time appropriations from the state and there is no other sustainable state contribution. We are largely financed through the payments by our members. Our standard participation fee for payers is $25,000 per year plus $2 per member per year. Every entity that helps

to pay for the system has a voice in running NeHII. Every dollar paid into NeHII yields a vote so that everyone who participates in NeHII has an opportunity to move the project forward in ways that make sense for them. We are governed by the NeHII board which sets the vision for NeHII with day-to-day supervision performed by our executive committee. Members of our executive committee include representatives from health systems, associations, and payers. Our larger board includes representatives from a broader spectrum of health care providers and state representation, including the Lieutenant Governor, Vivianne Chaumont, and Dr. Joseph Acierno. This is according to the NeHII bylaws that were approved in 2008. We have built a system Nebraskans can be proud of. It has been described by physicians and office staff as easily used even for noncomputer wizards. I think that's what I'm most proud of. LB953 will provide a predictable, sustainable source of state funding for future NeHII projects. The bill diverts money from the Comprehensive Health Insurance Pool to fund a grant program where NeHII could develop future projects and bring them to the state to consider for funding. We intend to use this money to make NeHII sustainable over the long term by adding even more functions that will be valuable to health care providers who will then join NeHII on their own. We want to continue the electronic health record integration. It is not enough for the provider to simply view information in the HIE. For robust data analytics there can be no gaps in data collection through the HIE. Therefore, NeHII must continue the EHR integration efforts for bidirectional exchange of data to and from the HIE and the physician's EHR. We want to improve our ability to facilitate sharing the radiologic results of X-ray exams and radiologic diagnostic testing procedures. There is functionality available today to allow the sharing of diagnostic-quality images across the health information exchange which is a value add for hospitals, physicians, and consumers as well as a menu objective for Stage 2 of meaningful use. We want to explore functionalities to improve population management services. Providers could use new functionalities to identify the chronically ill populations in their practices and then manage the care effectively and efficiently. With added functionality, care coordination and case management techniques could be offered through the HIE in support of the providers to manage the chronically ill and to prevent hospital readmissions. We want to develop NeHII to allow it to be a tool for providers to use for admission and discharge planning. Ultimately, however, we believe that Nebraskans benefit when their health care providers have a good way to share electronic health records across the state. Better data will help with better coordination of care which leads to better outcomes at lower costs for Nebraska. Nebraska is at the leading edge of these efforts, but we need help to keep the system moving forward. LB953 will do just that. I ask that you advance LB953 and would be happy to answer any questions that you have. And I've included just a one-page informational document at the end of the testimony. And Dr. Westcott included some testimonials from other physicians and health care providers. [LB953]

SENATOR GLOOR: Thank you, Deb. [LB953]

DEB BASS: Thank you. [LB953]

SENATOR GLOOR: Let me comment about my questions about, are we talking about this being funding into perpetuity or are we talking or getting a sense that NeHII may fall to second place behind platforms that are being built by systems that see that as a market necessity? [LB953]

DEB BASS: Some of that is a policy decision, Senator Gloor. You know, because of the federal funding, CMS is encouraging all the states to build these kinds of systems. So NeHII has been very proactive to work with our state's team, the state public health, state Medicaid. NeHII funded a consultant to help the Nebraska Medicaid write the IAPD application. And that's how we were able to get some of this...we're seeking to get this matched funding that I was talking about. So, you know, there are other HIEs that are called private HIEs in the state, that they're connecting their hospitals and their health system. But they've even, too, talked to us about eventually connecting to the statewide HIE for the public health purposes, reportable diseases, syndromic surveillance, immunizations. But then also just to get information from all the rest of the hospitals across the state. We are a very mobile state thanks to I-80, so. [LB953]

SENATOR GLOOR: Sure. Senator Schumacher. [LB953]

SENATOR SCHUMACHER: Thank you, Senator Gloor. And thank you for your testimony today. You described NeHII as being the highway, not the trucking company, not the store. I guess I don't have a real good picture of what you are, then. You have a doctor's office. The doctor's office has got a piece of fiber optic cable or a phone line or an antenna of some kind and it collects information. And then what? Does it send it up that wire? [LB953]

DEB BASS: It's the Expedia model for health care. So when you enter...when you're going on a vacation and you enter your location and then that system pulls all that information in for you to decide from about your vacation. NeHII operates in that same way. And to avoid technical terms, what we do is we enter the patient's name and we send... [LB953]

SENATOR SCHUMACHER: By "we," you mean the doctor's office? [LB953]

DEB BASS: The providers. The hospitals. [LB953]

SENATOR SCHUMACHER: Okay, the providers. Okay, all right. [LB953]

DEB BASS: Right. You have to have a direct treating relationship with the patient... [LB953]

SENATOR SCHUMACHER: Okay. [LB953]

DEB BASS: ...in order to view this information. We also audit these records to make certain that you have a direct treatment relationship. And we have a privacy and security committee that meets every month because we certainly don't want to have any HIPAA violations, so. But what the system does is it sends crawlers across all of the different hospital systems that are participating in NeHII. We identify the match, that's called that master patient index, and we pull that information into view on what's called the virtual health record. [LB953]

SENATOR SCHUMACHER: So in other words, you've got a server someplace... [LB953]

DEB BASS: An ED server, yes. [LB953]

SENATOR SCHUMACHER: ...that goes out and has the codes or whatever so it can go to every one of your members and suck out the information. [LB953]

DEB BASS: Right. [LB953]

SENATOR SCHUMACHER: Okay. Now that's set...that looks like a workhouse rather than a highway. Would that be better? [LB953]

DEB BASS: It's called a hybrid federated model. And the reason that it's called that is that it is a virtual and that it brings that information into view. But when the provider clicks off of that page, it goes back to the systems, the edge servers. So it is not stored in a data warehouse within that hospital system. [LB953]

SENATOR SCHUMACHER: So the data is never stored other than on the location of the provider? [LB953]

DEB BASS: And every hospital has their own separate edge server where their data is stored. There is no commingling of data. [LB953]

SENATOR SCHUMACHER: So your central brain, then, goes out and makes a request. It then goes and queries a bunch of other computers that are sitting out in the providers' offices. [LB953]

DEB BASS: Not in the providers' offices. It's in a data center on the two coasts. Again, we have extreme security on all of these systems. And we manage the vendor that delivers the health information exchange. [LB953]

SENATOR SCHUMACHER: So the doctor's office, then, uploads to this server on the coast and that's what you query? [LB953]

DEB BASS: Right. [LB953]

SENATOR SCHUMACHER: So it's not the doctor's office at all? [LB953]

DEB BASS: No. [LB953]

SENATOR SCHUMACHER: So your medical records are sitting in California or... [LB953]

DEB BASS: In highly secured data centers. [LB953]

SENATOR SCHUMACHER: Well, you know, the Iranians just got into the Navy yesterday, so. Okay, I understand a little better now. Thank you. [LB953]

DEB BASS: Uh-huh. [LB953]

SENATOR CAMPBELL: Senator Gloor. [LB953]

SENATOR GLOOR: Senator Campbell. [LB953]

SENATOR CAMPBELL: Thank you, Senator Gloor. Deb, I'm reading this as the $1 million is really kind of a sustaining effort. And I should not think of it as the same as the drug monitoring program that we talked about last week. Would that be accurate? I mean, I shouldn't try to commingle the two because the drug monitoring is a lot more money. It's a special project of NeHII. Would that be accurate? [LB953]

DEB BASS: I would answer that in the fact that NeHII is interested in not...we exist to avoid the duplication of services. And we do offer medication history through the Health Information Exchange. And the medication history is what other states are using for prescription drug monitoring programs. Because they're traditional, they tend to have built two separate siloed...they have their HIEs and they have their PDMPs. And so you spend dollars, time, and people supporting two separate, siloed systems. So, you know, we feel, and other states are starting to follow suit, that this information should be put into one central system so that we can avoid redundant and unnecessary costs. [LB953]

SENATOR CAMPBELL: We're actually taking a look at that from a committee on the Children's Commission for all of the information that's out there in terms of the child welfare system. [LB953]

DEB BASS: Uh-huh. Right. [LB953]

SENATOR CAMPBELL: And they are trying...they're coming to the same point, that

there is a need for a central warehouse. But you know, getting to that point and dealing with the legalities of it are sometimes a whole new question. So thanks. [LB953]

DEB BASS: NeHII has been recognized, Nebraska has been recognized for the leadership that we've played in our privacy and security. Other states have copied our policies that we've developed. [LB953]

SENATOR CAMPBELL: Thank you. [LB953]

SENATOR GLOOR: Senator Carlson. [LB953]

SENATOR CARLSON: Thank you, Senator Gloor. And thank you for your testimony. On the front page of your letter in the third paragraph, a short paragraph, talking about patients allowed to opt out of the system. Yet less than 3 percent of the 2.7 million lives in our system have chosen to do so. And we have a population of 1.8 million. How do we have 2.7? [LB953]

DEB BASS: If you'll flip on the back page, the map of Nebraska, what we cut off to get a good...bigger sized map of Nebraska was the Iowa portion that we cover. And the other piece of that is that thanks to the quality of the health care in our state, we have many individuals that travel from out of state to get their health care in our metropolitan areas. So 32 percent of our master patient index, those individuals have addresses outside of the state of Nebraska. [LB953]

SENATOR CARLSON: Okay. But then I would think we have people that cross our lines to go out for treatment, too. But our importation is more than our outflow. [LB953]

DEB BASS: Uh-huh, and then we have Iowa hospitals that participate, too. [LB953]

SENATOR CARLSON: Okay. All right, thank you. [LB953]

DEB BASS: Uh-huh. [LB953]

SENATOR GLOOR: But this isn't a plus or minus. In other words, 2.7...if there are other systems like this in Colorado and Kansas and Iowa, you would show up as a patient if you'd sought care over there. [LB953]

DEB BASS: Right. [LB953]

SENATOR GLOOR: And you would also show up in this state if you sought care in this state. [LB953]

DEB BASS: Correct. [LB953]

SENATOR GLOOR: So it's possible that your name shows up in multiple reiterations of this across the country. [LB953]

DEB BASS: Correct. [LB953]

SENATOR GLOOR: In fact, if you were traveling and were hospitalized in California, you'd be part of that system. [LB953]

DEB BASS: Right. [LB953]

SENATOR GLOOR: Maybe a small amount. Maybe it was a quick visit to an emergency room for a sprained ankle or something. But...okay. [LB953]

DEB BASS: Right. Yeah, you would. Uh-huh. [LB953]

SENATOR GLOOR: Senator Campbell. [LB953]

SENATOR CAMPBELL: Thank you, Senator Gloor. Yeah, but I just thought maybe I should ask this question because I don't...I'm not sure I know. The membership is with the hospital or with a physician... [LB953]

DEB BASS: Uh-huh. [LB953]

SENATOR CAMPBELL: ...or, you know, a clinic. And they would pay a flat $25,000 whether they're the largest hospital in Douglas County or a small doctor's office, right? They all pay $25,000 plus $2 membership? [LB953]

DEB BASS: No. Excuse me, I didn't make that clear. That's for the payers. And we have different kinds of license fees for each type of participant. For the payers it's $25,000 a year plus $2 per member per year. [LB953]

SENATOR CAMPBELL: Okay. [LB953]

DEB BASS: So we base it upon their membership, their eligibility files. For physicians, independent physicians that are not affiliated with a hospital, it's $20 a month to use the virtual health record. And then for the hospitals, we base those fees upon their bed size. And there's eight different categories. The critical access hospital is $750 a month. And then we have the largest category, which is over 1,000 beds, and that's $20,000 a month. And then there's all the ranges in between. I believe it's $750, $2,000, $3,000, $5,000, $10,000, $12,000. [LB953]

SENATOR CAMPBELL: That's affordable. [LB953]

DEB BASS: Right. [LB953]

SENATOR CAMPBELL: So the largest people who would pay the most at NeHII would be your payers. Would that be right, rather than your hospitals? [LB953]

DEB BASS: We've kept track of that from the very beginning and I can tell you that we have, you know, Blue Cross Blue Shield and Coventry are currently participating. And over the history, it's been about an even balance between hospitals and payers. [LB953]

SENATOR CAMPBELL: Hospitals as a group or individually? [LB953]

DEB BASS: As a group. [LB953]

SENATOR CAMPBELL: As a group? [LB953]

DEB BASS: Right. [LB953]

SENATOR CAMPBELL: Okay. As payers, so if you clumped all the payers together and all the hospitals, they'd be about equal. [LB953]

DEB BASS: Yes. [LB953]

SENATOR CAMPBELL: What about the physicians? [LB953]

DEB BASS: We just...and, again, with employed physicians, we just implemented what's called the site license model. And so hospitals, because it's an attraction to recruit physicians, are signing up for the site license. And then those physicians don't pay anything at all. And so particularly for the hospitalists in the ED. So yeah, it's...did I answer your question? [LB953]

SENATOR CAMPBELL: Yes, you did. [LB953]

DEB BASS: Okay. [LB953]

SENATOR CAMPBELL: Thank you. [LB953]

DEB BASS: Uh-huh. [LB953]

SENATOR GLOOR: So I think I figured out my question which is, the million dollars we're talking about tapping into here really goes into, for want of a better term, general funds for NeHII. You're not looking to distribute that million dollars every year to institutions. You do that already. I mean you're already providing some degree of help

and grants to institutions of whatever size, maybe. [LB953]

DEB BASS: Uh-huh. Uh-huh. [LB953]

SENATOR GLOOR: But it says...well, it doesn't say that. We'll have to ask Senator Howard to address it when she gets up here. Yeah, I'm a little confused about where the million dollars goes. I shouldn't say...I know where it goes, how it gets distributed and whether it's to NeHII for distribution or whether the department makes decisions about distribution of that million dollars in collaboration with NeHII. But perhaps Senator Howard can address that. [LB953]

DEB BASS: That might be more of a policy. I can tell you how we've operated in the past... [LB953]

SENATOR GLOOR: Sure. [LB953]

DEB BASS: ...is that we put together proposals to the Department of Public Health and then they accept them or deny them or we negotiate. And we've, you know, worked since 2010 with the HI cooperative grant funds with the state. And that's how we were able to connect to the immunization gateway. So I think...feel free to talk to those folks, but I think we've got a pretty good relationship going. [LB953]

SENATOR GLOOR: And a system, apparently, already in place for evaluation and distribution of some of those funds. [LB953]

DEB BASS: Right. [LB953]

SENATOR GLOOR: Okay. [LB953]

DEB BASS: Okay. [LB953]

SENATOR GLOOR: Any final questions? Thank you. [LB953]

DEB BASS: Thank you. [LB953]

SENATOR GLOOR: Any other proponents? Good afternoon. [LB953]

WENDE BAKER: (Exhibit 6) Hello. My name is Wende Baker, that is W-e-n-d-e, Baker, B-a-k-e-r. Senator Gloor...Chairman Gloor, good afternoon, and members of the committee. I am the executive director for a Nebraska private, nonprofit corporation called the Electronic Behavioral Health Information Network. Thank you for the opportunity today to testify in support of LB953. Specifically, we would ask that health information initiatives focused on behavioral health providers also be named in the

legislation to potentially benefit from the funding in addition to those focused on physicians in general. eBHIN is a regional health information organization, that's a RHIO, that has been operating a health information exchange among behavioral health providers since June of 2012. There are currently 550 end users on the system in Behavioral Health Regions 5 and 6. Together, these regions represent 65 percent of largely uninsured patients that are served through 30 safety-net organizations operating in these two service areas. The people served through organizations that utilize the eBHIN system, suffer from disabling mental health and/or substance use disorders and their care is delivered largely through public assistance for both the Division of Behavioral Health Services and Medicaid. There is a big overlap between those served by the Division of Behavioral Health and Medicaid as some patients move back and forth in eligibility between the two systems. The organizations that are reimbursed for substance disorder treatment services...they are reimbursed from funding provided by the Substance Abuse Mental Health Services Administration and it's passed through to providers by the Division of Behavioral Health. They are subject to a higher privacy standard as described in the Code of Federal Regulations, 42 CFR Part 2. These regulations require that a patient consent for information sharing from setting to setting; this is called opting in. And that's in an HIE environment. Because of the very strict requirements of this environment, eBHIN has evolved as a network independent of NeHII which operates on an opt-out basis. And just because I've heard the numbers here, our opt-in rate is 80 percent and it's all information in or all out. Although we continue to explore ways to collaborate, technology is not yet available to allow interoperability on a query basis. Now what query basis is, is the use of that MPI, the use of the master patient index in order to find a patient in the system. Development in the industry is led by SAMHSA, this federal organization, and it will make this kind of interoperability possible within the next three to five years. The cost of care for Americans with behavioral health disorders have been well documented. In 2011, roughly 18 percent of the U.S. population had some form of diagnosable mental illness. On average, Americans suffering from major mental illnesses die anywhere from 14 to 32 years earlier than the U.S. average. These deaths are largely due to physical health problems such as cancer, heart disease, stroke, pulmonary disease, and diabetes. The need for integration between the behavioral health and primary care treatment setting have been proven to be a significant factor in improving outcomes and decreasing the cost of care for this group. One study suggested that implementing a collaborative care approach for depression alone in the U.S. Medicare system would result in cost savings of approximately $15 billion annually. Multiple studies have demonstrated that hospital readmission rates can be reduced with effective care coordination. HIE's have been demonstrated as a means to improve care coordination for managing all chronic conditions, as chronic disease treatment most often requires collaboration among multiple treatment modalities. Up to this time, eBHIN has developed from multiple federal grants, including the state administered HITECH funds that Deb mentioned. Operating support has been received from the regional behavioral health authorities, private foundations, and provider organizations. Through this time, we have received

minimal direct support from the state of Nebraska. And we believe that the state stands to benefit from our work. For example, we are currently working with the Department of Justice in exploring ways that our information infrastructure can support collaboration between state probation and behavioral health providers to potentially increase success in behavioral health treatment and thereby reduce recidivism into state correctional facilities. There is interest in expansion to other regions beyond Regions 5 and 6 of the state, but our growth has been limited due to the capital investments this would require. Behavioral health services operated by safety net organizations are delivered by professionals who are not made eligible in the CMS EHR Incentive Program. And resources to build IT infrastructure are otherwise very limited. We estimate it will cost between $1 million to $2 million to offer services statewide. Once we can offer services on a broader scale, the annual operating cost of $1.5 million become much more reasonable for individual stakeholder organizations, making the transition to sustainability more secure. Just a couple of things I'm going to add, but just because I heard questions and I'm just anticipating they might be asked again. One is that, you know, we are a centralized data repository. And one of the long-term goals of our network is to use our centralized data repository as a way to deliver better population health and management of very high-risk patients through collaboration among the providers and others who they will share records with. So we're kind of at a chicken or egg situation here because it takes capital to invest in technology and we know that technology offers better outcomes. But if you don't have the technology to produce the better outcomes, then you can't, then, gain the reimbursement rates that would help you afford the technology to start with. And so what we are asking for is support for us to be able to expand our network so that we can put our providers in a better position to offer better outcomes and potentially get better reimbursement rates for the services they provide. From that, then, they would help support the information technology that allowed them to get there to start with. So with that, thank you, again, for the opportunity to testify and I welcome any questions you might have. [LB953]

SENATOR GLOOR: Ms. Baker, have you had conversations with NeHII? I'm assuming you have had conversations with NeHII in the past about the path that you're both traveling which is parallel, certainly, and crosses over at various times also. But they're not...I mean, this isn't a surprise to NeHII that you made a request to be addressed in the legislation. I'm trying to decide what the...what having you addressed in the legislation would provide for. Would it then give you, do you think, access to being considered for the funding? [LB953]

WENDE BAKER: Correct. [LB953]

SENATOR GLOOR: Okay. That really is the only thing here that is a concern for you. [LB953]

WENDE BAKER: That's correct. We support wholeheartedly the funding and for NeHII,

definitely. [LB953]

SENATOR GLOOR: But there's no reason to think that you wouldn't be eligible for that funding anyway, is there? [LB953]

WENDE BAKER: No. We are asking, specifically, that behavioral health providers, though, be included. As physicians are named here, that we would also, then, name behavioral health providers. Unfortunately, sir, the Medicaid incentives when they were designed, were not designed around the behavioral health system that really involves providers that are at a lower level of care. While physicians and APRNs, which are the eligible professionals within...you're shaking your head, you know what I'm talking about. So behavioral health on the public assistance or the safety net side is delivered largely by psychologists, licensed mental health professionals, licensed alcohol and drug abuse counselors. These are paid, reimbursed services in the state and yet they were not included in the incentives on the Medicaid side. So, you know, our concern is that, again, the needs of this sector will be eclipsed by the larger demand when we know that the costs toward this sector of the population are big. They are big contributors on the Medicaid and the public side. And when it comes to allocating public funding, then it needs to be considered when there's a significant public benefit to be made. And we believe that better care for these patients is in the public interest. [LB953]

SENATOR GLOOR: Okay. But you're here as a proponent. It's just that you'd like to be named in the statute. [LB953]

WENDE BAKER: That's correct. [LB953]

SENATOR GLOOR: Okay. [LB953]

WENDE BAKER: That's correct. [LB953]

SENATOR GLOOR: Other questions? Senator Schumacher. [LB953]

SENATOR SCHUMACHER: Thank you, Senator Gloor. And thank you for your testimony today. You make the point that it takes capital to invest. [LB953]

WENDE BAKER: Yes, it does, sir. [LB953]

SENATOR SCHUMACHER: From this investment, who's going to make the money? [LB953]

WENDE BAKER: Well, it's a private, nonprofit corporation. And so what that means is, the operating costs are really just contributed by the members. We really don't have any kind of investment that would, again, pay back investors. Now we do have to plan for

things like capital replacement and cash operating reserve, but beyond those requirements, it's operated at cost. [LB953]

SENATOR SCHUMACHER: Are the members going to come out ahead if we have this system? [LB953]

WENDE BAKER: Well, from the standpoint of operating more effectively and delivering their services in a more efficient way. And in some regards, actually we've seen improvements in the privacy of the records. But they will benefit from the standpoint of being able to get increased reimbursement if they are able to demonstrate better outcomes. [LB953]

SENATOR SCHUMACHER: Okay. So the members will get more reimbursements, theoretically, have less costs, theoretically, stand to gain financially. You're not...I mean, the whole thing doesn't amount to much money, only $1 million or $2 million. Why don't they just set up a corporation of some kind, sell a little stock, and make some money? [LB953]

WENDE BAKER: You know, our network consists of safety net organizations. So these are organizations...so you may be familiar in Lincoln with some of the organizations. This is like Cornhusker Place, our detox facility; the Mental Health Center; the Crisis Center; Houses of Hope; St. Monica's. And generally, these are not environments that are really investor driven. Recognizing that that is, potentially, the new marketplace, certainly they have to be positioned in order to be able to be in that marketplace. And that was that chicken or egg problem that I mentioned, that you have to have those investments in order to make that additional reimbursement. They don't have those resources. Regional behavior health authorities have already contributed significantly, and the safety net organizations don't have the margin. They operate at a margin of 1 to 2 percent. [LB953]

SENATOR SCHUMACHER: If there's an increased revenue stream generated by this, though, then get outside investors. [LB953]

WENDE BAKER: You know, that's something certainly I can say that our board of directors has not considered. Being in a private, nonprofit model, I think there may be some concerns that would be expressed about offering an investment with a system that had been developed largely with public funding. So you've used public funding in order to develop a system and then you use that as a way to, then, become a profit-making entity. And so I think we might have some serious questions about the use of public funds in that interest. [LB953]

SENATOR SCHUMACHER: But isn't that a lot of medicine, a lot of the modern world, whether it's universities, health care, telephone companies, anything like that, the public

throws a bunch of money at it and the privates make a lot of money? [LB953]

WENDE BAKER: Well, I can't answer your question, sir. I think it's rhetorical, largely. [LB953]

SENATOR SCHUMACHER: Okay, thank you. [LB953]

SENATOR GLOOR: Senator Campbell. [LB953]

SENATOR CAMPBELL: Wende, it would seem to me that the...if I heard you correctly, you were saying that if you were named in the bill, then the providers could obtain more money, which in essence, would then go to support eBHIN. [LB953]

WENDE BAKER: Yeah. The funding... [LB953]

SENATOR CAMPBELL: Yeah, I mean, am I reading that right? [LB953]

WENDE BAKER: Yeah, eBHIN, right. The Electronic Behavioral Health Information Network. [LB953]

SENATOR CAMPBELL: No. I mean, the fact that if they got named then they could draw down some dollars, which then, could be put back in. [LB953]

WENDE BAKER: Yeah, and I think actually, you could potentially anticipate that, you know, another private interest could potentially apply. You know, I think actually that's something the committee may need to consider because I really do see that there may be additional interests beyond even just even in NeHII around delivering these kinds of services. I think it's important to recognize that if it's public funding that it needs to be operated in the public interest. You know, Deb mentioned several services that NeHII provides that are definitely in the public interest. Things like syndromic surveillance are extremely important for public health. And yet when it comes to a market that would help support those services, I think it's very limited. And so that speaks to the argument of public funding for public benefit. [LB953]

SENATOR CAMPBELL: Thank you. [LB953]

SENATOR GLOOR: Other questions? Seeing none, thank you for your testimony. [LB953]

WENDE BAKER: Thank you very much. [LB953]

SENATOR GLOOR: We continue with proponents. [LB953]

ERIC DUNNING: (Exhibit 7) Good afternoon, Chairperson Gloor and members of the committee. My name is Eric Dunning, for the record, that's spelled E-r-i-c D-u-n-n-i-n-g. I'm the director of government affairs and a registered lobbyist for Blue Cross Blue Shield of Nebraska here to testify in support of LB953 because Blue Cross Blue Shield believes it's necessary to encourage the development in our state of an effective information technology infrastructure that allows the sharing of electronic health records. By requiring payer participation in a health information initiative and providing a stable source of state funding, LB953 will continue Nebraska's effort to link the various electronic health records systems around the state. NeHII benefits our members by improving care and reducing administrative costs. Administrative costs are reduced by helping us with verification of provider licensure, communication with providers, and support of other self-service administrative functions. We're able to improve process efficiency with the ability to receive electronic health information instead of fax or phone calls. For our largest providers, NeHII helps us receive transactions through a single portal rather than using multiple technical interfaces. NeHII helps us to improve provider relations and member satisfaction. We believe that NeHII will help us improve the care our members receive. It helps us avoid duplication in testing and improves the timeliness, accuracy, quality, and completeness of the health data available to our case managers. NeHII allows us to monitor episodes of care and manage coordination of services. It helps our members by avoiding potentially unnecessary duplications of tests and hopefully reducing the rate of medical errors if all of the providers who are involved in a member's care have effective access to our members' records. For all of these reasons, we believe that Nebraska, as a whole, benefits or has the potential to benefit from NeHII, which is why we're in support of the bill. NeHII is often described as a public/private partnership. On the private side of the partnership, we believe that it's important that all Nebraskans have the benefit of the exchange of health records and so we believe that required payer participation is appropriate. However, we have heard some suggestions that if the bill requires payer participation, then safeguards need to be put in place to avoid having those payers taken advantage of in some way. We agree that doing so would make the bill better, and we'd like to be part of putting together those provisions. The NeHII finance committee and board of directors currently approve all fee levels. And a fee increase or fee setting would be voted through that system. On the public side of the partnership, we think it's important that the state's contribution to NeHII be made in a sustainable, long-term way. As introduced, the bill diverts $1 million from the CHIP Distributive Fund to create a grant program. That grant program, administered by the Division of Public Health, awards grants to support the secure exchange of clinical information. This allows representatives of the public sector and the private sector to work together to identify those priorities. We believe it's an important accountability feature of the bill to create a formal and open structure to develop those funding proposals. Sustained and predictable support from the state is important to the long-term success of that public/private partnership. Before I close, what we don't want to see is a future in which the private sector has done what it could to get this started and given up for lack of broader interest. If that day comes, all the

work that NeHII has done thus far will have to be duplicated and patients will be impacted as this effort is to support quality measures. We just don't believe the quality measures can be tracked in a paper-based world. [LB953]

SENATOR GLOOR: So, Eric, the issue of safeguards need to be put in place to avoid having those payers taken advantage of. Does this relate to fees, fee scheduling? [LB953]

ERIC DUNNING: This would relate to the issue of the fee schedule. [LB953]

SENATOR GLOOR: Okay. [LB953]

ERIC DUNNING: That's a concern that I've heard expressed and I think it's legitimate. [LB953]

SENATOR GLOOR: What do you...you know, the history here is Blue Cross Blue Shield was the original...one of the key, original movers and shakers in the development of NeHII. [LB953]

ERIC DUNNING: We have supported... [LB953]

SENATOR GLOOR: ...and funder of this initiative, I think, early on. [LB953]

ERIC DUNNING: Early on and consistently through the entire history of the project. [LB953]

SENATOR GLOOR: So what do you think of Senator Schumacher's suggestion that after rolling all that money into it, maybe there's an opportunity to sell it and privatize? I'm putting words in his mouth, more or less, but, you know, is this a commodity? [LB953]

ERIC DUNNING: That is not an opportunity that I believe we've explored. I just can't really speak to that point effectively. [LB953]

SENATOR GLOOR: Well, if dollars are a challenge, certainly private investment would bring an influx of...potential for an influx of capital to make that jump, along with price increases, I'm sure, for accessing the information. [LB953]

ERIC DUNNING: Senator, not to be argumentative, but we've had pretty considerable private investment in this project as is. [LB953]

SENATOR GLOOR: Yeah, but it's been private, not-for-profit money. I doubt very much that you've had proprietary funds come in there. Then you could make the argument

that that's public money in a different sense. But I'm just wondering. [LB953]

ERIC DUNNING: Okay. [LB953]

SENATOR GLOOR: Any other questions? Senator Campbell. [LB953]

SENATOR CAMPBELL: I just want to make sure. So you're saying that the phrase "payers taken advantage of" really has to do with the fee structure? [LB953]

ERIC DUNNING: It would have to do with the fee structure. And again, right now, you have a fee structure based on a recognition of several different sizes of health care providers. [LB953]

SENATOR CAMPBELL: Right. Right. [LB953]

ERIC DUNNING: Historically on the payer side, it's been a couple of insurers and that's it. So I don't know that there's been a need to develop a more nuanced, you know, provider or fee schedule. [LB953]

SENATOR CAMPBELL: So going forward, how does NeHII entice the rest of the folks on the map? [LB953]

ERIC DUNNING: NeHII entices the rest of the folks on the map by constantly trying to improve what it's currently doing and demonstrating its value to some of the providers in other parts of the state. And that's really the heart of the bill. [LB953]

SENATOR CAMPBELL: Okay. Thank you, Mr. Dunning. [LB953]

SENATOR GLOOR: Seeing no other questions, thank you. [LB953]

ERIC DUNNING: Thank you. [LB953]

SENATOR GLOOR: Other proponents? Good afternoon, again. [LB953]

ANN FROHMAN: Good afternoon, Senator Gloor, members of the committee. My name is Ann Frohman, that's spelled A-n-n F-r-o-h-m-a-n. I'm the registered lobbyist for the Nebraska Medical Association here to testify in support of LB953. The Nebraska Medical Association supports the notion within the bill to create this depository for the public/private funding of the partnership and that it makes sense to have an analysis of how those grant awards are disseminated. The component dealing with the fee under both the health insurer tax and the payers, which include the providers, is one that we see as tied together. And as I read the bill, I read it in two ways. One, first that the million dollars that comes in comes from, in fact, the General Fund revenue. It's

premium tax based, of course, so it's reflected in a payment from the health insurance industry originating from policyholders to purchase health insurance policies. So to me, that makes sense, in some regards, that you're still within the realm of the health insurance world that finances this at the end of the day. I do not see CHIP as being all that relevant because the way this is drafted, whether CHIP is around--meaning the Comprehensive Health Insurance Pool, not the other CHIP--whether or not it's around, this would survive not simply one year in an assessment for this program, but on an annual basis, is the way I read the law. And we view that as critical because, again, providers will be assessed annually as well. Should there be sufficient revenue for this to sustain either without the continued requirement coming from the health insurer premium tax or from providers, we would love to see all of that go away and see it survive on its own. Again, whether it would be something that investors would jump to with the HIPAA and the COBRA and all the other health information privacy regulations deeply imbedded in this whole program, I couldn't imagine. I would surely steer you towards pharma or medical equipment or something else. But with that said, we do want to support this. Also a point of note, the prescription drug monitoring bill legislation last year, LB1072 this year, would suggest to me that the horse has already left the barn in terms of, you know, who is the all-state provider of this health information exchange because within that context a few years ago, the Legislature deemed the prescription drug monitoring program to serve on the chassis of NeHII, recognizing that that might be, today as we're sitting here, the avenue for the all-state access to that information. So in some respects, it makes sense too, you know, from what I've heard earlier, that that discussion focuses on NeHII, but recognizing that it's broader than that. And we think that's a good thing as well. [LB953]

SENATOR GLOOR: Thank you. Questions? Seeing none, thank you. [LB953]

ANN FROHMAN: Thanks. [LB953]

SENATOR GLOOR: Other proponents? Anyone who would like to speak in opposition? Anyone who would like to speak in a neutral capacity? [LB953]

COLEEN NIELSEN: Good afternoon, Chairman Gloor and members of the Banking, Commerce, and Insurance Committee. My name is Coleen Nielsen, spelled C-o-l-e-e-n N-i-e-l-s-e-n, and I am the registered lobbyist for Express Scripts, a pharmacy benefit manager doing business here in the state of Nebraska. I am testifying in the neutral capacity mostly because my client didn't have enough information at this point or quite understand the bill to know which position to take. And the more that I hear about testimony in this bill, the more concerned I do become because pharmacy benefit managers are, as the bill indicates, a payer. But rather than giving you information, I really just have questions to offer you to think about in terms of the payer. As I've listened to the testimony, it sounds like...well, this bill does say that, "Each payer shall: (1) participate in a health information initiative". And the question is, is there going to be

more than one or are we talking about NeHII here? And are we mandated to participate in NeHII? And that is a concern in the sense that, this appears to have an emergency clause on it and so Express Scripts has not been at the table at this. And so they just...they want to be compliant and they want to know what they need to do. But they also want to be part of this discussion. It indicates that they shall implement the required interfaces to connect with the health information initiative. What are those interfaces? And is there a cost associated with those interfaces? Must "Meet the qualification requirements to participate in a health information initiative". Not sure what those are. And we'd like to be part of that discussion in determining what they should be. Number (3), "Sign a participation agreement agreeing to meet the standards to participate in a health information initiative". The question is, what does the participation agreement look like? Is it going to be negotiable? That was basically the question there. And then we get to the fees. "Pay the fees required to participate in the health information initiative." And I didn't hear any figures until this...until I came to this hearing. And I think that I heard $25,000 a month. So my client is not aware of that at this point. I haven't reported that to them. And...but I hear that they're offering some safeguards. And I'm not sure what that would look like other than would those fees be negotiable as well? The question I also got from my client, is this modeled after something that is already in place somewhere else in the United States because Express Scripts does business in multiple states. And they are concerned about the connectivity and whether or not they can talk with the surrounding states, particularly, in our area. And I did hear that apparently there is some connectivity with Iowa. And what is the time line because it does have an emergency clause? And finally, does NeHII...I don't know enough about NeHII. I haven't been a part of that discussion. But I don't...does it currently operate in real time because I've been told that real time really doesn't exist yet in some of the spheres of this operation. But I'm not sure about that. So all I have are questions. I'll try to answer any questions that you might have but I don't have a lot of information. [LB953]

SENATOR GLOOR: Are there any questions? Seeing none, thank you. [LB953]

COLEEN NIELSEN: Thank you. [LB953]

SENATOR GLOOR: (Exhibits 8 and 9) Other neutral testifiers? We have two letters here in a neutral capacity, one from Coventry Health Care and the other from the Department of Insurance. Welcome back, Senator Howard. [LB953]

SENATOR HOWARD: Thank you, Senator Gloor. And thank you for your time and attention to LB953. My intention was more that we would be able to have a state funding source for health information exchanges and health information initiatives. NeHII is, obviously, the big dog on the block, but eBHIN is also a health information initiative that we use at OneWorld as well. And presumably, my intention was that they would also be eligible for this funding as a health information initiative. In regards to

Senator Lathrop's bill, I did look up the fiscal note and it was $1.2 million to $1.4 million to create a PDMP within NeHII, specifically. The PDMP is actually how my family first became familiar with NeHII, was when my mother worked on the prescription drug monitoring program after my sister passed away. And so my experience with NeHII has really been as a platform for providers in order to understand the health background and the health status of their patients. Specific to your question about child welfare, Senator Campbell, what I found interesting is I've been doing some work with the Douglas County Juvenile Detention Center. And their health clinic has a viewer-only license so they can update immunization records for the kids who come through and make sure that they're receiving the same meds that they were getting from their PCP, which is really nice. But I think there's a lot more that we can do. And from an epidemiological standpoint, health information initiatives are really exciting. At OneWorld, we use NeHII to monitor births because we have to report our birth outcomes to the federal government. And we don't...we are not a birthing center. We partner with hospitals that are birthing centers but...and the only way for us to report our births, is to be able to look into NeHII and see whether or not a child was born, say, with a low birth weight. And that's the only way for us to report and monitor the efficacy of our prenatal care. So I would be happy to try and answer any other questions, but I do appreciate the time that you took to hear all of the testimony on (LB)953. [LB953]

SENATOR GLOOR: Are there any questions for Senator Howard? Seeing none, thank you. [LB953]

SENATOR HOWARD: Okay. [LB953]

SENATOR GLOOR: And that ends the hearing on LB953. And we will transition, hopefully, as quietly as everybody can to help us move on with LB926. Senator Howard. [LB926]

SENATOR HOWARD: This should be very quick, I'm hopeful. Good afternoon, Chairman Gloor and members of the committee. For the record, I am Senator Sara Howard, H-o-w-a-r-d, and I represent District 9. Today I'm introducing LB926 at the request of the Department of Insurance. LB926 changes the rule-making language in the Burial Pre-Need Sale Act, the Motor Club Services Act, and the financial conglomerate section to allow the Department of Insurance discretion to determine whether there is a need for a rule. Last year, the Legislature passed my bill, LB242, which required timely promulgation of regulations. However, I understand that sometimes regulations are not promulgated because issues are complex or because despite a statutory requirement for such regulations, a change is not actually necessary. Instead of simply ignoring the regulation required, the responsible thing to do is request that the statutes be changed. This is exactly what LB926 seeks to address. The bill addresses three specific areas, financial conglomerates, burial pre-need sales, and motor club services. The department is working on issues related to pre-need sales and

financial conglomerates that may interfere with promulgating a regulation at this time. In addition, both the Burial Pre-Need Sale and Motor Club Services Acts are clear and do not, at this time, need a rule to enhance the law. These changes will give the department the flexibility to determine if and when a regulation is necessary for these statutes. Thank you for your time and attention to LB926. I would be happy to try to answer any questions you may have. [LB926]

SENATOR GLOOR: So, Senator Howard, the only change in the bill, I mean, is striking "shall" and putting in "may"? [LB926]

SENATOR HOWARD: Yes. [LB926]

SENATOR GLOOR: And that's what we're doing on this? Okay. Any other questions? Seeing none, thank you. [LB926]

SENATOR HOWARD: Thank you. [LB926]

SENATOR GLOOR: We'll move to proponents. [LB926]

BRUCE RAMGE: (Exhibit 1) Good afternoon. Good afternoon, Senator Gloor and members of the Banking, Commerce and Insurance Committee. My name is Bruce Ramge, for the record, that's spelled B-r-u-c-e R-a-m-g-e. I'm the Director of Insurance and I'm here to testify in support of LB926 which Senator Howard was kind enough to introduce at the department's request. This bill would make mandatory rule-making discretionary with the Burial Pre-Need Sale Act, 12-1109; the financial conglomerate supervision section at 44-165; and the Motor Club Services Act at 44-3719. In these instances, rules were not adopted either because a rule was not actually necessary to make the statute work, which is the case of the Motor Club Services Act, or in the case of financial conglomeration supervision, no entity sought regulation under the statute. We are now at a point where the department is working with the pre-need burial industry to update the act which was originally enacted in the 1980s. We are working with international regulators and the National Association of Insurance Commissioners on financial conglomerate issues which, if a regulation is adopted now, may conflict with the current work being done. As you know, if an agency does not adopt regulation pursuant to mandatory rule-making authority within a three-year period, then a public hearing is required. Under last year's LB247, this requirement now applies to all laws no matter when adopted. This hearing would be a waste of time for the Legislature and the Department of Insurance. We would like to keep authorization to adopt rules just in case, but until there is a need to adopt rules, we do not believe it is necessary to do so. I ask that you move this bill to General File. And I'm happy to answer any questions you might have. [LB926]

SENATOR GLOOR: Thank you, Mr. Director. And so this is sort of a king's X or a time

out on development of the rules. Okay. [LB926]

BRUCE RAMGE: Yes, exactly. [LB926]

SENATOR GLOOR: Any other questions? [LB926]

SENATOR CHRISTENSEN: Yeah. [LB926]

SENATOR GLOOR: Senator Christensen. [LB926]

SENATOR CHRISTENSEN: Thank you, Director. So in other words, all we're...until you hear of a problem, then there won't be rules put in place? So if a bad actor would come in on the one side then that's when we'd implement the rules? [LB926]

BRUCE RAMGE: Yes. If there was a need discovered or there's a clarification needed in how the department would interpret the law. But again, two of these acts have been around for a long time and that's not been necessary. In the case of the conglomerate supervision act, there's kind of some work going on internationally. And we don't want to adopt a rule that would be in conflict with what they're trying to accomplish on the international front. [LB926]

SENATOR CHRISTENSEN: Okay, thank you. [LB926]

SENATOR GLOOR: And so you would...from what you know, there's a possibility sometime in the future, who knows when the future may be, that NAIC recommendation would be something that comes back to us as relates to financial conglomerates? [LB926]

BRUCE RAMGE: Yes and it could be something easily handled with a rule. It might be something where we're going to be coming back here and asking you for an update. [LB926]

SENATOR GLOOR: Okay. Thank you for your testimony. [LB926]

BRUCE RAMGE: You're welcome. [LB926]

SENATOR GLOOR: Any other proponents? Anyone here in opposition? Anyone here in a neutral capacity? I didn't think so. Senator Howard waives, hoping that this will be a consent agenda, I'm sure. And that ends our hearing on (LB)926 and ends our hearing today. [LB926]