[LR422 BRIEFING]

The Committee on Health and Human Services and the Committee on Banking, Commerce and Insurance met at 10:30 a.m. on Friday, November 14, 2014, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing. Health and Human Services Committee Senators present: Kathy Campbell, Chairperson; Bob Krist, Vice Chairperson; Sue Crawford; Mike Gloor; and Sara Howard. Senators absent: Tanya Cook; and Dan Watermeier. Banking Committee Senators present: Mike Gloor, Chairperson; Kathy Campbell; Tom Carlson; Tommy Garrett; Sara Howard; and Paul Schumacher. Senators absent: Mark Christensen, Vice Chairperson; and Pete Pirsch.

SENATOR CAMPBELL: (Recorder malfunction)...Banking, Insurance and Commerce Committee and the Health and Human Services Committee. We are hearing two reports today and we have looked forward to hearing on both of those reports. Before we start we'll do a little housekeeping. If you have a cell phone, be sure that it is turned to silent or is turned off, or any device, an iPad or whatever, that might make noise. And I think we're going to have...we know pretty much who's testifying today, but if you are testifying, we would ask that you fill out one of the orange sheets and print as legibly as you can. And then you just can give it to the clerk, Brennen, who's sitting at the end of the table when you come up to testify. We will not have the light system today because we know that the reports, some of them are lengthy in nature. So I think that is it. And as is our custom here, certainly in the Health Committee, we have the senators introduce themselves. So I'm going to ask the senators to indicate their name and district, whatever, and what committee they serve on. So we'll start to my far right. Senator. [BRIEFING]

SENATOR GARRETT: Tommy Garrett, District 3. I'm on the Banking, Commerce and Insurance Committee. [BRIEFING]

SENATOR CARLSON: Tom Carlson, District 38, live in Holdrege, Banking, Insurance and Commerce. [BRIEFING]

SENATOR HOWARD: Sara Howard, District 9, midtown Omaha. I'm on both Health and Human Service and Banking, Commerce and Insurance. [BRIEFING]

SENATOR SCHUMACHER: Paul Schumacher, District 22; that's Platte, parts of Colfax and Stanton County, and I'm on the Banking, Insurance and Commerce Committee. [BRIEFING]

SENATOR GLOOR: Mike Gloor, District 35, which is Grand Island. I'm also on both committees and chair the Banking, Commerce and Insurance Committee. [BRIEFING]

SENATOR CAMPBELL: And I'm Kathy Campbell and I serve District 25, east Lincoln and eastern Lancaster County. I serve on the Banking, Commerce Committee and chair the Health and Human Services Committee. [BRIEFING]

MICHELLE CHAFFEE: I'm Michelle Chaffee. I serve as legal counsel to the Health and Human Services Committee. [BRIEFING]

SENATOR KRIST: Bob Krist, District 10; that's northwest Omaha, unincorporated parts of Douglas County, and Bennington, and I am on the Health and Human Services Committee. [BRIEFING]

SENATOR CRAWFORD: Good morning. Senator Sue Crawford. I serve District 45, which is eastern Bellevue, Sarpy County, and Offutt area, and I serve on the Health and Human Services Committee. [BRIEFING]

BRENNEN MILLER: My name is Brennen Miller, committee clerk for the Health and Human Services Committee. [BRIEFING]

SENATOR CAMPBELL: And our pages today are J.T. and Emily. And they are over here and they would be glad to provide any assistance you might need. So you can feel free to kind of wave at them and they certainly will help you. This morning we have two reports that are coming before us. And the first we have asked representatives from the Health Care Data Base Advisory Committee update briefing. This is a bill, LB76, that put into motion and I think this is the bill that went through Banking, Commerce and Insurance if I remember right. [BRIEFING]

SENATOR GLOOR: I think you're correct. [BRIEFING]

SENATOR CAMPBELL: I think it started there anyway. And they, the advisory committee has been working and has a report due. But we thought this was a great opportunity for the two committees to hear an update. So for the record, would you each identify yourself with your name and spell your name. And then feel free to start the presentation. [BRIEFING]

BART KARLSON: Yes, Senator, that's actually a part of our testimony. [BRIEFING]

SENATOR CAMPBELL: Oh, good. [BRIEFING]

BART KARLSON: We have a script. [BRIEFING]

SENATOR CAMPBELL: All right. Well, start out with the script then. Thank you. [BRIEFING]

BART KARLSON: (Exhibit 1) Good morning, Chairperson Campbell and Chairperson Gloor and members of the Banking, Commerce and Insurance Committee and the Health and Human Services Committee. My name is Bart Karlson and that is spelled B-a-r-t K-a-r-l-s-o-n, and I am the chairperson of the Health Care Data Base Advisory

Committee. I am employed by ConAgra Foods in Omaha and I represent large employers that purchase health insurance for employees on the committee. I am joined by vice chairman of the committee, Dr. Anne Lucille O'Keefe of the Douglas County Health Department. [BRIEFING]

ANNE O'KEEFE: Good morning, Chairperson Campbell and Chairperson Gloor and members of the Banking, Commerce and Insurance Committee and the Health and Human Services Committee. I'm Dr. Anne O'Keefe spelled A-n-n-e O-'-K-e-e-f-e of the Douglas County Health Department. And I represent Nebraska local health departments. [BRIEFING]

BART KARLSON: Thank you for the opportunity to come before the Legislature today to talk about all-payer claims data bases. And thank you for the willingness to move this portion of the hearing up to accommodate other commitments I have in Omaha later this afternoon. As you know, last legislative session, the Legislature passed and the Governor signed into law LB76 also known as the Health Care Transparency Act. LB76 required the director of insurance to appoint the Health Care Data Base Advisory Committee that was required to make recommendations regarding the creation and implementation of the Nebraska Health Care Data Base. According to the law, the data base is to be a tool for objective analysis of healthcare costs and quality, promote transparency for healthcare consumers, and facilitate the reporting of healthcare and health quality data. Director of Insurance Bruce Ramge appointed ten members to the committee to join the three ex officio government official designated by the law. Members include a wide range of talented individuals with a variety of interest including researchers, medical providers, insurers, and others. We first met as a committee on May 6, 2014, and have had four subsequent meetings where we have discussed LB76, learned about all-payer claims data bases in other states, and have worked on the report which is due to the Legislature and Governor by December 15. We plan on one final meeting in early December to finalize the report and our recommendations. During these last seven months, the committee has learned a great deal about all-payer claims

data bases, but I am confident in stating that the committee still has much to learn at this point. [BRIEFING]

ANNE O'KEEFE: As an example, at our latest meeting we heard a presentation from the all-payer claims data base in Colorado and learned the history of the project. Colorado has been studying and implementing their data base since 2008. And a real-time demonstration of their Web site was found useful by the committee to see results of their efforts. The Colorado Web site has statewide public information on a high-level utilization by zip code. A Web site user also has the ability to compare medical service prices for maternity and hip and knee replacement by hospital and payer type, such as private insurance, Medicaid, etcetera. The Colorado database will also release data requests to researchers who meet various criteria related to privacy and purpose as determined by a data release committee. The Colorado example is one example of an approach a state can take. Another presentation the committee heard in September was from the Health Care Cost Institute and it represents another approach. The Health Care Cost Institute is a nonpartisan, nonprofit organization that already collects a significant amount of payer claim data nationwide. It already collects about 20 percent of the claim data for Nebraska. It collects data from private and public payers such as some private insurers and some Medicare payments. Academic researchers can apply for data access to conduct research on healthcare costs and utilization. The institute has already established the funding and expertise to successfully handle an all-payer claims data base and is currently working with one state: Vermont. [BRIEFING]

BART KARLSON: In our meetings and in working with LB76 in preparing the report due next month, the committee has identified a number of challenges moving forward. First, the committee is concerned that LB76 is perhaps too all encompassing in that it could be or should be narrowed. As an example, the legislation asks the committee make a recommendation related to data standardization before an actual analysis of whether or not creation of an all-payer claims data base would be beneficial to the state. The

committee has also identified a variety of other challenges such as the collection of self-funded data, funding mechanisms, data governance, privacy, security, sustainability, and overlap with already existing data bases. These challenges have led to the main recommendation of the draft report which I would like to share with you with the caveat that it is draft and subject to a final vote by the committee. The committee's recommendation is at this time it has not received information that would indicate that an all-payer claims data base could be recommended to address all the needs identified in the legislation. While conceptually these ideas have merit, significant questions remain regarding the potential use of the data, the scope of the information to be gathered, and the cost associated with creating the data base. The committee believes that the idea deserves further consideration and recommends a more formal study to be performed by consultants retained by the committee. The study should include a request for information from potential vendors and a formal evaluation of the results of the RFI that addresses how the state could best move forward to meet the needs outlined in the legislation. Of course, the final report recommendations are more robust and contemplate all the recommendations sought by LB76, but in summary the committee's report will indicate additional time and study is warranted. Thank you for the opportunity to testify today. Dr. O'Keefe and I will be glad to answer any questions you may have. [BRIEFING]

SENATOR CAMPBELL: Thank you, Mr. Karlson. Questions? Senator Gloor. [BRIEFING]

SENATOR GLOOR: Thank you, Senator Campbell. And I want to thank you both for taking the time to participate and provide some leadership on this issue. I have two questions and I think the first will lead into the second. My guess is that coming up with the information on cost is the easiest part of this equation, that the quality data piece is the challenge. Could you, either one of you or both you address that issue? [BRIEFING]

ANNE O'KEEFE: Do you want to try it? [BRIEFING]

BART KARLSON: I'll try. [BRIEFING]

ANNE O'KEEFE: Okay. [BRIEFING]

BART KARLSON: Senator Gloor, I would agree with you. And not only do other members of the committee feel that as well, but in my own personal experience as working head of benefits for ConAgra Foods, we have put in data base tools to help our people understand cost because we high-deductible health plans for our people. And it helps them to understand cost of...whether going for some procedure or a facility or a doctor. That we're able to do because we're able to take our own claims data and mine through it and to the extent a person has visited that facility or doctor previously, we retain that information to help guide the next person who may want to see that same provider. That's working very well for us and about 40 percent of our people covered in our salary program that have access to this tool use that today on a semi-regular basis, and by that I mean they visited the tool at least three or more times. So I would agree with you that cost is much easier to get at in terms of data for quality. We are pulling as much data as we can from organizations like Leapfrog, for example, and other public available data bases including what might be a surprise, Angie's List, believe it or not, in terms of healthcare. And that data is incorporated into our tool. Additionally, our people are allowed at ConAgra Foods to actually write commentary on their visit to the doctor to give the next person who might want to see that doctor some insight in terms of their experience. I've heard from other experts in this area that sometimes that can be more about bedside manner than it is about quality. But I've also heard other experts suggest that typically people understand when they're getting good quality and they're very comfortable with person reviews. That tool also has the access, as you dig through a few more clicks, to actually find whether a doctor has had sanctions from the AMA or any other public information that is available that would be of interest to someone trying to select a quality provider. [BRIEFING]

SENATOR GLOOR: Yeah, I think the equation that I recall from my days in healthcare was that that cost plus quality equals value, that spending a lot of money doesn't necessarily buy you anything except a lot of services. And therein lies the challenge for us. My second question is basically, did you look to NeHII...are you familiar with NeHII, Nebraska Health Information Initiative? Anyway, NeHII, did you look to NeHII as a potential data base or did you look...as I recall, NeHII was built more for clinicians to help with things like registries and record sharing as opposed to what we're talking about here which, transparency, consumerism is clearly a major focus. But is there a way to mesh the two, or do the two complement each other? [BRIEFING]

ANNE O'KEEFE: So Deb Bass, the executive director of NeHII is on the committee... [BRIEFING]

SENATOR GLOOR: Good. [BRIEFING]

ANNE O'KEEFE: ...and was involved in all the discussions. From what I am familiar with with NeHII and I think that addresses your first question is how are you going to look at quality if you don't have any clinical data to add to that data base? And so that's kind of...that's one reason that we felt we needed more time and expertise is because you would have to figure out a way to link these two things together. And of course, there's all sorts of data security and issues with that. [BRIEFING]

SENATOR GLOOR: Privacy issues. Yep. [BRIEFING]

ANNE O'KEEFE: Privacy issues. And then what does that data mean? And I think Bart's example was a very good illustration of how do you define quality? It's very difficult. [BRIEFING]

SENATOR GLOOR: Okay. Thank you. [BRIEFING]

BART KARLSON: I would say, just to add, that one of the slogans that we have in our department is that quality costs less. So it's always a lot cheaper to do it right the first time because healthcare is like that open checkbook. You know, as much as a person may need to utilize a facility or see a physician, the plan will pay. So typically, good quality comes from institutions that do a lot of a procedure. And typically, you would find that it costs less, which is one of the learnings that we have to put our people through when we're explaining our tools to help them get pricing because so often I think there's a misnomer or a misconception that when you pay more for something you're getting better quality. And in my opinion, that is not true with respect to healthcare. [BRIEFING]

SENATOR GLOOR: Thank you. [BRIEFING]

SENATOR CAMPBELL: Other questions from senators? Senator Crawford. [BRIEFING]

SENATOR CRAWFORD: Thank you, Senator Campbell, and thank you for your work on this task force. I have a couple questions about the Colorado Web site. And I'm assuming perhaps you've had discussions with people about that and their use of that. So as I understand from your testimony, it focuses on high utilization, prices just for a couple of target services and that's the key focus. So a pretty partial start on that. So I just wondered what you have heard so far about the usefulness of having that much information out there available to people in the state. [BRIEFING]

BART KARLSON: May I? I would...with respect to Colorado, and we're looking at it from a business perspective in terms of the project that they have...and by the way I think it's a very noble effort that they've undertaken in Colorado to do that collection of data and to do that work. But what we learned as a committee is that the funding of Colorado is from various grants, for example, whereas in business I have to actually prove the ROI of the money I'm spending on a tool. The Colorado data base has been in existence for some time. I think...was it 2008? [BRIEFING]

ANNE O'KEEFE: Um-hum. [BRIEFING]

BART KARLSON: Yeah, 2008. And this it my perspective, not necessarily the committee's, but very limited number of procedures that are visible on the Colorado data base to help consumers. A ton of money has been spent on that project. So when I look to Colorado I say, there's an organization that had almost infinite resources to get up and running. But I think Colorado, in my opinion, is going to be going through a challenging time because they let us know that their funding is probably getting to that point where it might be running out and they're going to have to look at how to make their data base sustainable by maybe charging access fees to people wanting to do certain research. But they haven't solved that at this point. [BRIEFING]

SENATOR CRAWFORD: Okay. [BRIEFING]

BART KARLSON: If they can't get that done in Colorado and if they don't get new grant money to fund it, we would likely see the Colorado data base either diminish or shut down for lack of additional funding. And whereas I think of us in Nebraska, and part of why our recommendation is to study this more is this committee is all volunteer. I mean, we I think as a state, we are more frugal with our funds and that we need to be more careful. So there are times where it's better to walk before you run or take a big project like this LB76 is and bite perhaps a smaller piece of it and really study it. It's better to be right than right now. [BRIEFING]

SENATOR CRAWFORD: Thank you. [BRIEFING]

SENATOR CAMPBELL: Other questions? Senator Carlson. [BRIEFING]

SENATOR CARLSON: Thank you, Senator Campbell. I'm going to make a statement. And then I may make you uncomfortable and I don't really mean to do that. And if you don't want to answer the question you certainly don't have to. But I'm going to express

my prejudice. I'm uncomfortable with the Affordable Health Care Act right from the start. So I just have to say that. And there have been some statements that I've listened to in the last week and I think they're authentic. The professor from MIT, that apparently it can be determined that he really wasn't the base architect of the Affordable Health Care Plan and talked about fooling the stupid public because they had to do that or it wouldn't have been accepted. And so that gets in my mind and it taints about everything that I think about. But I didn't even ask for this information this morning, ran across an individual that I would guess is probably in about the 50-year bracket, age bracket. And he wasn't even talking to me; he was talking to somebody else. But he said, we just got our notice of our health plan for next year premium. And our deductibles went to $7,500 a piece and it's either covering him and his wife and one or two children. And our premium went up by $4,000. And initially, you know, we were under the idea that the typical family is going to be able to save about $2,500 a year. Well, it isn't even close. We know that. The costs are just skyrocketing and I say out of control. And so here's the hard question. You don't have to answer it. What's your opinion of the Affordable Health Care Act? [BRIEFING]

BART KARLSON: I would love to answer that actually, if I could. I'm a single employer. I represent a single employer. And we're a responsible employer in that we provide our employees healthcare. The Affordable Care Act actually has very, very little impact on what we're providing our employees, what we're charging in premiums. You may have heard in the Affordable Care Act the pay or play or the $3,000 penalties when an employer charges unaffordable healthcare. That has minimal impact to ConAgra Foods. So the Affordable Care Act was not about people who already had healthcare or insurance; it was about people who didn't have healthcare or insurance. And from what I gather, we're still not solving that by the Affordable Care Act. But even saying that, it's here. It's law and it would probably be very difficult for the national government to repeal. So I think that if you look at Affordable Care Act today, you better take a picture. It's probably going to change quite a bit in the next few years. So I'm not a big fan of the Affordable Care Act personally. But I think that we all have to work through it because it

is likely here to stay in some form or another. Does that help you, Senator? [BRIEFING]

SENATOR CARLSON: I don't know if it helps or not, but I appreciate the honest response. [BRIEFING]

SENATOR CAMPBELL: Dr. O'Keefe, did you want to comment? [BRIEFING]

ANNE O'KEEFE: Sure. My perspective is from a public health perspective. And I've been working in public health for many years. So that's my bias. And a lot of the Affordable Care Act focuses on prevention of disease and on public health as a partner in trying to do that. It costs less money to prevent something that it does to keep treating and treating and treating. So my bias is towards, I'm glad something was done. I don't necessarily know if that was the right way to do it, but at least something has been done. [BRIEFING]

SENATOR CARLSON: Okay. [BRIEFING]

ANNE O'KEEFE: And maybe we can tweak it if we need to. [BRIEFING]

SENATOR CARLSON: And that's good. We've got kind of two different views here from different perspectives. So thank you. [BRIEFING]

SENATOR CAMPBELL: Other questions from the senators? Senator Schumacher. [BRIEFING]

SENATOR SCHUMACHER: Thank you, Senator Campbell. As you talked about various states having efforts in this areas--I think you mentioned maybe five, six states--and they all seem to be trying to grapple with the issue. I guess what came to mind is the Wi-Fi technology that we're all familiar with. And we have a bunch of different companies making a bunch of different toys. But they all start out with a basic standard

that was adopted by the industry as to how Wi-Fi is going to talk and use a particular frequency. And that's why the system works. Now is there any higher level think tank, a government whatever, National Institute of Health, something like that saying look at these data bases, this is the data fields that are going to be in them. This is how it's going to be stored. This is how it's going to be addressable. This is what security codes have got to be so that Colorado doesn't start inventing a system and then it run out of money. Nebraska starts doing all the thinking and inventing the wheel a different way. And in the end we have a hodgepodge of things that when somebody moves from state A to state B, it just will not be had because they can't talk to each other. Is there such a mechanism out there? [BRIEFING]

ANNE O'KEEFE: The Health Care Cost Institute actually, we learned a lot from them. And that is a lot of what they're doing is trying to standardize all this information across the country. And they did talk about how each state is developing these data bases but, you know, they...you can try to standardize them, but they're going to be different and it's going to be very, very hard to compare the data between states. But the Health Care Cost Institute, that's one of their main concerns is to build this on standards. [BRIEFING]

BART KARLSON: I'd agree with that statement and I would just add a...as we focus, what we've called an RFI, a request for information as an idea for this committee to go forward to request more information, to gain more knowledge. I think that is an important aspect of that RFI that we need to make sure because it's important to count all the numbers, but you've got to make the numbers count. And if we have different data bases working in different formats it's just not going to be comparable and we'll all be less efficient in how we mine through that data. [BRIEFING]

SENATOR SCHUMACHER: Should we be working maybe first towards some type of a interstate agreement among sister states, at least nearby sister states or ones with common demographics so that we don't all invent wheel? We're only 1.8 million people

and we're really tight when it comes to spending money, particularly from the state. So should we be saying, hey, Iowa, Colorado, Kansas, South Dakota, Texas, whatever, you know, let's get together and do one project instead of all inventing the wheel and some of us ending up with square wheels? [BRIEFING]

BART KARLSON: I would agree. [BRIEFING]

ANNE O'KEEFE: The Health Care Cost Institute, the one drawback to that was that you had less control of the data and less control over the analysis and reports. So there was definitely a give-and-take. If we had our own, we would have more say in what we want it to do and what we want to read from it. But the Health Care Cost Institute data would be standardized and you could compare across the country. And there probably would be ways that we could get special analyses for just Nebraska, but it would be more difficult to do that. [BRIEFING]

SENATOR SCHUMACHER: But are we getting value? I mean, is the cost of inventing our own system so that we have more control worth it when what you lose is interoperability? [BRIEFING]

ANNE O'KEEFE: That's the big...I think that came up a lot. [BRIEFING]

BART KARLSON: I would go so far as to say likely not. I think that standardization is going to be something that we need to have because we could build the best Ferrari out there, right? But if we don't have someone who knows how to drive that car, it's going to be the most expensive thing in the parking lot. So I would agree with you, Senator. [BRIEFING]

SENATOR SCHUMACHER: Thank you. [BRIEFING]

SENATOR CAMPBELL: I think you're...oh, sorry, Senator Gloor. I think you're going to

find an interesting...for the senators that are here today, I think you're going to find an interesting connection. And that's probably what Senator Gloor was going for. That's the reason that you're on the agenda today and LR422 is on the agenda because for the senators you are going to see these ideas cross. And the LR422 workgroup and at the conference there was a great amount of discussion and has been and Dr. Rowen Zetterman is here to provide a report to the senators. And much discussion has gone on about data and we are seeing there. I mean, I had no idea that there is a regional group of universities. We have a person, Dr. Chris Kratochvil at UNMC who is sitting on that. And they are working regionally among universities I think. I'm looking Bob Bartee, make sure I'm saying this correctly. And so we began to see all these circles of data out there knowing that at some point this all has to be brought together. So if you...we'll make sure that you get a copy of Dr. Zetterman's report to the senators. But there's a great overlap today from what the senators are going to hear. So your report is very helpful. [BRIEFING]

BART KARLSON: Well, good. [BRIEFING]

SENATOR CAMPBELL: Questions? I'll do Senator Krist and then Senator Crawford. [BRIEFING]

SENATOR KRIST: Thank you, Chair. Just for the record, could you define the Health Care Institute that you're talking about, its independence, its formulation. [BRIEFING]

ANNE O'KEEFE: Yeah, it's...I think...I don't know if I can do more than just "nonpartisan, nonprofit." [BRIEFING]

BART KARLSON: It's got a great Web site. (Laugh) [BRIEFING]

ANNE O'KEEFE: But, yeah, it's a national organization. And they're funded...who are they funded by? [BRIEFING]

BART KARLSON: You know, I'm not personally sure, but I do know they have a Web site that... [BRIEFING]

ANNE O'KEEFE: They were going to try and sustain their funding by charging researchers for access to that data. [BRIEFING]

SENATOR GLOOR: I think it was started by business and industry in its origins, with maybe some healthcare entities involved like medical associations, hospital associations. [BRIEFING]

ANNE O'KEEFE: And I think the price for that data access is pretty high. And that's how they were going to try to fund it. [BRIEFING]

SENATOR CAMPBELL: Michelle printed off for me a rather large report from them. And we'll be glad to provide it to all of you from the Health Care Institute. We first heard of it, some of use, from Nebraska as we sat in sessions at NCSL, which is the National Council of State Legislatures. And that's where we heard about it, on a panel. And I'm sitting there thinking, this gentleman is talking about that they have a data base of all Medicare and Medicaid across the...and I'm thinking, wow. I mean, just to begin looking at that kind of data base that could be shared with states was very interesting at NCSL. People started really talking about it. So I appreciate that you've looked at it and brought him. I'm sorry that we couldn't hear him. But there is a big report, Senator Krist. I'd be glad to share it with you. [BRIEFING]

SENATOR KRIST: Thank you. [BRIEFING]

SENATOR CAMPBELL: And I don't know how they're funded. Michelle, do you know? [BRIEFING]

MICHELLE CHAFFEE: No. They started though working mostly with insurance companies across the country too. And they're one of the only certified, nationally certified to be able to get certain data bases and have the level of security that's mandated by CMS in order to get the Medicaid and Medicare data. I know at this point they work mostly with higher ed institutions and research and have major utilization in that way. But Vermont is one that has a contract in which they get specific data from Vermont to compare their cost and quality and issues. And they, I think, just published a report on Vermont within the last couple months. [BRIEFING]

SENATOR CAMPBELL: It would be helpful. [BRIEFING]

ANNE O'KEEFE: But, yeah. I think a lot of it is the data access, charging for data access. They're also working with the American Academy of Pediatrics to look at pediatric issues. And I think they even...the AAP even funded a position to have someone in the institute to actually look at that nationwide. [BRIEFING]

SENATOR CAMPBELL: And I'm sure Dr. Zetterman is going to cover and talk about it. But the committee then looked at how do you utilize this data. It's one thing to have it and to pay to put it all together, but what's it used for? So most likely, you know, news at 11, the next report will come in on that one. Senator Crawford, did you want to follow up? Any other questions? Senator Gloor. [BRIEFING]

SENATOR CRAWFORD: No, that's fine. [BRIEFING]

SENATOR GLOOR: Just because I massacred the acronym NeHII, it's the Nebraska Electronic Health Information Initiative. And it is not a manufacturer of orange soda. [BRIEFING]

SENATOR CAMPBELL: I do have a question before the two of you leave. Will we need to have a reauthorization bill to continue the work of the committee, do you know?

[BRIEFING]

BART KARLSON: Is that a legal question or is that...? [BRIEFING]

SENATOR CAMPBELL: Well, it's just...was the legislation, were you written for just one year? Does anybody know? [BRIEFING]

ANNE O'KEEFE: I think it's supposed to end in December. [BRIEFING]

BART KARLSON: I think our...yeah, unless you invite us back to continue work. [BRIEFING]

SENATOR CAMPBELL: But would the committee be willing to continue if we reauthorized the work and worked with you when we saw the report, what you might need? And you don't have to answer that today, but the committee may want to talk about that, whether there needs to be reauthorizing legislation. [BRIEFING]

BART KARLSON: Every person on the committee is volunteering at their own cost. There is no reimbursement for anyone that's doing this. And I think every person realizes that this is for the public good and is happy to serve on the committee. So I would likely say that every single person would be happy to continue to serve for that public good. [BRIEFING]

SENATOR CAMPBELL: But oftentimes when we put committees in statute and we ask specific things of them, that cost can be cover, at least your mileage could be. So we'll look into that. [BRIEFING]

BART KARLSON: And you know, whether you provide money for mileage or not, I don't think it'll change anyone's willingness to serve on the committee. [BRIEFING]

SENATOR CAMPBELL: Okay. You know, that's one of the most, I think, reassuring to all senators as they sit on committees is the great expertise across the state of Nebraska of people who volunteer to help us in policy decisions and who give up their time to be involved. So I agree with you, Mr. Karlson. We're very lucky in Nebraska. Any other questions or comments? Thank you so much for your report and we'll be back in touch with you I'm sure. [BRIEFING]

BART KARLSON: Actually, Senator, can I ask a question because, you know, one of the thoughts I had as I was trying to prepare for this is the kind of questions that might be asked. And if you don't mind, I'd just like to share my perspective on some things of transparency that this... [BRIEFING]

SENATOR CAMPBELL: Absolutely. [BRIEFING]

BART KARLSON: ...that the Unicameral may consider in revisions to the law... [BRIEFING]

SENATOR CAMPBELL: Okay. [BRIEFING]

BART KARLSON: ...or perhaps in stages. But I've always learned in our work that it's easier to bite off bits of it as you go. And I think as one of the senators mentioned earlier, one of the easiest things to do in the state is to bite off transparency in healthcare first and then get to the quality, although I think it's getting better towards quality. So I would encourage that we all work towards at least the transparency for the procurement healthcare and whatever quality is available, trying to pull something like that together. And also...and I'm not a lawyer. And I know probably many of you are. But the ability to be transparent in healthcare is still a problem in the state and in this country because, while probably more prevalent 10 years ago, providers in the marketplace have antitransparency clauses in their contracts which prevent the provider from helping a consumer with the pricing of healthcare because by providing that

transparency, you're now providing steerage perhaps to a lower cost provider. And that's against the contract to the higher cost provider. So while I would ask that consideration be made towards just making such contracts--and I don't know if this is possible--but such contracts should not exist today as we try to bring transparency to healthcare. Further, there are insurance providers that feel that all the claims data that comes from what you pay as an employer or as a state, probably one of the largest healthcare providers in the state, there are certain providers that say that that claims data does not belong to the state. It belongs to us the healthcare provider. And because you don't have access to that data, you're not as easily able to give transparency to your own employees as a state. To the extent it's possible, I would love to see how the state could work towards making healthcare transparency available for all insurers, make it a condition of doing business in the state of Nebraska. And further, and this goes into greater complication, as I've done work in the procurement of...you can tell I took this opportunity to give my position. But the pharmaceutical industry makes it very complicated in procuring medications, generics for example. You'll find that there are these things in contracts called maximum allowable charge or MAC list. They're deemed to be proprietary, but I suspect that if we could make that more transparent, we would help people procure drugs more cheaply and make healthcare more affordable for us all. It's kind of like myself as a retirement actuary, I've seen where there's been greater transparency in the retirement system. We've seen the fees associated 401(k) plans, property sharing plans diminish because transparency helps bring the marketplace to a more competitive position and it lowered the profit margins of those people who were providing those services. If we can help transparency by helping to make an environment that allows greater transparency, I think that we would all be doing a great service. [BRIEFING]

SENATOR CAMPBELL: Thank you, Mr. Karlson. We're going to take one question and then I need to move on because of the time. [BRIEFING]

SENATOR KRIST: And this will be very simple. You're talking specifically about

regulations regarding insurance companies. Doesn't the reciprocal of that have to exist with healthcare providers as in CHI and the Alegent system, etcetera? [BRIEFING]

BART KARLSON: Well, perhaps. That's where I was getting to with the antitransparency clauses that may exist in contracts. So the contract that a healthcare provider--I'm not going to mention a name--may have with Alegent, for example, may prohibit the use of data to support transparency. We need to make that something that cannot exist as a condition of doing business in Nebraska. And we need to make those healthcare providers who will not share that data with the person who is paying the bill, us, right. We need to make that so that they cannot put a clone of secrecy around that data. We need to be able to use that data as best as we see fit to support transparency. And by the way, this was all my opinion. [BRIEFING]

SENATOR KRIST: Thanks for clarifying that. Thank you. [BRIEFING]

SENATOR CAMPBELL: Thank you, Mr. Karlson and Dr. O'Keefe. We appreciate you coming today. And we'll be back in touch with the committee, for sure. [BRIEFING]

BART KARLSON: Thank you. [BRIEFING]

SENATOR CAMPBELL: We will move on to the next report that the two committee are receiving this morning. Dr. Zetterman is here. This is the developmental policy recommendations towards transformation of the Nebraska Health Care System pursuant to LR422. LR422 was proceeded by LR22. And we are pleased to have Dr. Zetterman with us today. And, Senators, in front of you are two pieces of information that you'll need to follow along. Am I saying that right, Dr. Zetterman? One is the eight building blocks that has come out of the work. And then Dr. Zetterman has put together a presentation PowerPoint, but we decided it would be easier for you probably to follow along if you had your own copy. So, Dr. Zetterman, welcome. And we'll start out. [BRIEFING]

ROWEN ZETTERMAN: (Exhibit 2) Thank you very much, Senator. Senator Campbell, Senator Gloor, members of Health and Human Services and the Banking, Insurance and Commerce, it's a pleasure for me to be here today. I am Rowen, R-o-w-e-n, Zetterman, Z-e-t-t-e-r-m-a-n, and I've had the great honor and pleasure of being the LR22 and now the LR422 workgroup coordinator that's worked with a group of 15 or 16 volunteers who have looked a variety of issues that were raised by LR22 and LR422 and ultimately have delivered today to you the eight building blocks. We'll also write a formal document by the end of the year that will provide the full details of our deliberations. We were charged with many aspects and today I want to go through some of those things that we were charged with. We were charged with looking at the costs of U.S. healthcare because one of the questions obviously for all of us is how do we control the burgeoning costs that are going on? We were charged with looking at the current status of U.S. healthcare and also of Nebraska healthcare. So I'll talk a little bit about Nebraska's health score card and also some of the rural Nebraska health issues looking at health by county, healthcare worker numbers, issues, a little bit of the issues in health insurance. And then I'll end by talking about what we delivered as what we consider to be the eight building blocks for future Nebraska healthcare. First of all, let me just touch a little bit on U.S. healthcare costs because we're influenced obviously in our state by what goes on at the federal and national level. We obviously buy our products that we distribute to our patients from a variety of national healthcare providers. As you know, healthcare in this country now represents about 18 percent of the gross domestic product of the United States. One of the interesting things, however, is that actually the annual cost of healthcare is still declining. Now there was a lot of thought that it would make a big jump this year, and as it turns out it hasn't made the big jump and increase along the way. I read an article with interest yesterday in The Wall Street Journal looking at what will be the costs on the federal healthcare exchange for the state of Nebraska. And it said it would increase about 3 percent next year over this past year. I think it's useful to also look back at how our employer-sponsored insurance premiums have been increasing in this country. If you look at the four years from 2012

and earlier and I chose those specifically so we don't get into this issue about, what's the Affordable Care Act doing to the cost and all those, but looking at what costs were in the years immediately before it came into play, we actually were increasing our healthcare costs at 6 percent per year; our premiums were going up. So employer-sponsored insurance premiums were increasing about 6 percent per year. Medicare was doing a little better than that, but there are some reasons why they should be able to control some of their costs. But despite that, we still had a large number of patients who went without care because of the cost of overall healthcare. In 2007 in the United States, about 10 percent of Americans chose not to receive care because of the concerns about costs. By 2012, it actually had risen to 13 percent. So these are people who say, gee, it's too expensive. I just can't afford to do things along the way. And there's no question we have to look at models of healthcare. And those are some things that we should all do at the healthcare side. And in fact, I will tell you that if you look at pediatric practices, family medicine practices, general internal medicine practices across Nebraska, you'll find a greater number of them are actually engaged in what's often termed the patient-centered medical home. We're building accountable care organizations, not to be confused with the Affordable Care Act, the acronyms sometimes get so close together. And we're looking at ways to control waste obviously along the way. I mean, if you think about healthcare you've got the costs of healthcare, but what are we spending money on that we don't need to spend money on? But it's not as simple as just cost or waste. As you've heard in the earlier presentations, it's really about value. And the value of healthcare can be looked at as simply as, if I go out and buy a shirt I look at the quality of the shirt, I look at the cost of the shirt, and that ratio is how I decide whether it has value for me or not. And those are the sort of things that we have to do. We have to be able to look at the quality of healthcare so that we can then judge the cost of healthcare. And that actually has to eventually come around by individual groups of providers or individual hospitals or perhaps by that individual practice so that we can deliver value sorts of information. Well, what is the state of U.S. healthcare in the United States? And I gave you some data in here that compares 1990 to 2010. It came out of a medical journal. And they

looked at the Organization for Economic Cooperation and Development. I think it was 34 countries actually in that organization. So these are mostly western industrialized countries. These aren't the poorer countries of the world. And they looked at what happed, how the U.S.A. ranked in healthcare compared in 2010 to how we were in 1990. And although our life expectancy had increased for Americans over that period of time, actually our age standardized death rate in the United States worsened. Where we were 18th in 1990, we're now 27th. If you look at years lost to premature death, you know, this is an easy thing for businesses to look at because if somebody dies at age 50, you've lost 15 or 20 years of profitable life for somebody that's well trained in your business. If you look at that, we went from 23rd down to 28th. And if you look at years lived with a disability, as it turns out in this country we now on average live six to ten years of our life with disability of some kind, whether you talk about depression or arthritis or any one of the number of conditions along the way. And perhaps as tragic as anything, our life expectancy, though it improved, our rank went from 20th to 27th. So here we are, 27th out of 34 countries in overall life expectancy. And our healthy life expectancy dropped from 14th in 1990 to 26th in 2010. And if you look at the factors that are important in that aspect, you'll find they're all things that we deal with every day. We all have the opportunity to take some personal responsibility for some of these things. Dietary risks was the number one factor overall. And that added greatest to the death rate in the United States amongst the 17 factors that were looked at. Tobacco smoking: 20 percent of Nebraskans still smoke. And I can't imagine you're not going to get some bills over the electronic cigarettes that are coming out because there's just a great article today in the The Wall Street Journal showing that I think it's somewhere around 5 percent of high school students now are using it and about 1 percent to 2 percent of middle school students are using electronic cigarettes thinking that it's safe. But as we now know, it's actually an opportunity for them to experiment and then they end up with cigarettes down the road. High blood pressure: Simply screening Nebraskans for high blood pressure, the third-leading cause of morbidity and mortality in this country, if we just got everybody care for their high blood pressure. High body mass index, another area, and as you know in Nebraska more than 25 percent of us are

overweight. Physical inactivity, high fasting blood glucose, high total cholesterol, all things that we can have some effect on either personally or through our healthcare or all those sorts of things along the way. And I want to just make a comment. And it's difficult to bring up this issue because it raises all sorts of interesting questions in everybody's mind about a variety of things. But if you look at overall healthcare data in this country, lack of healthcare access, whether that's because you don't have insurance or it's you don't have adequate insurance or, you know, for any number of reasons, it's basically our younger adults in the United States that don't have coverage. It's the group that are below age 44 overall in this country. And if you look at people who are poor, if you look at people who have inadequate healthcare access, their overall health is considerably less adequate as compared to everyone else in this country along the way. And we know that this inadequate access to healthcare leads to fewer years of productive work, developmental losses in children, greater cost to public programs because these people end up on Medicare, Medicaid, Social Security disability, and all the other things. And in fact, you know, adequate health in a population definitely helps economy. And a weakened local economy occurs when you don't have adequate access to healthcare. And there have been studies to show that this can be beneficial. There were three states that actually increased the number of people who had better access to healthcare and they had an overall decline in mortality in their state by 6.1 percent. I'll come back and show you some data about Nebraska and overall mortality. The Commonwealth Fund puts out a scorecard every year and looks at each state and says, how good is this state in their healthcare? And in 2014 the report that's there--and that's basically 2012 data and before because it's got a couple of years to look at the data--we're in the second quartile. Well, that's great. We're in the second quartile. But that means that 25 states for sure are worse than we are, but it potentially means that 24 states are better than we are along the way because all I know is that we're in that second group of 12. One of the things they looked at is access and affordability. And the thing that really surprised me more than anything else in the study is that 32 percent of Nebraskans live at less than the 200 percent federal poverty level. A third of Nebraskans basically live within 200 percent of the federal poverty level. And when you look at out-of-pocket

expenses, those people who make less than 200 percent of the federal poverty level or less spend 30 percent of their total income on healthcare, okay? Okay. But if you look at the group that is 400 percent of federal poverty or better, people like myself and I'd assume many of you, only 2 percent of your income gets spent on healthcare. It's a remarkable number. So when you're poor and you don't have a lot of money, your healthcare costs are higher proportionally in what you actually pay out of pocket. When you look at things like prevention and treatment, the percent of children in Nebraska that receive both medical and dental preventative care is about two-thirds. A third of children in Nebraska go without preventative care. If you look at the group of children that get their vaccines, however, by age three, it's about 85 percent. So we do well in some areas along the way. But I could turn that around and say it's also not 100 percent because we know that vaccination is a key element in order to protect people along the way. If you just think back for some of us who are old enough to remember the days of polio along the way. And the percent of adult age 50 and older who are receiving recommended screening and preventative care is only 40 percent. This is a state that in which 1 in 18 Nebraskans gets colon cancer and we need to basically be screening all of the people age 50 and older for colon cancer through some sort of means. Avoidable hospitalizations, let me just talk about diabetes. We're admitting diabetics at a rate of about 181 admissions per 100,000 population. That's higher than the national average, which is about 149. And when you look at healthy lives, infant mortality rate, we're not too bad but it's 5.7 deaths with a best state rate of 4.5. Thirty-one percent of children in Nebraska are listed as overweight or obese. Our breast cancer death rate is higher than the national average. Our colorectal cancer death rate is 18.5 deaths per 100,000 with a best state rate of 13. And as I've told you before, 20 percent of Nebraskans smoke. Now, overall death rates in Nebraska actually are pretty good. We're in the top quartile. Overall, our average is about...we're in the 57 to 67 deaths per 100,000 population. For whites in Nebraska, it's about 60 per 100,000, but for blacks in Nebraska, it's 145, so more than twice the death rate amongst the African-American population in this state than amongst the white. If you get it down to the county level, the good news is that male mortality overall has decreased in this country but it's actually increased in some

of the counties. Reduced county mortality across the country is related to several interesting factors but not a surprise: higher household income, greater population density around where you live, more adults with college degrees, all those things reduce it. But one of the other interesting things that I found fascinating in this article is the greater your percentage of Hispanic population, the lower the mortality in your county, in spite of the fact that we may think that their access to healthcare is less adequate. Perhaps the tragedy in Nebraska for men is that actually county mortalities--and they're all rural counties--increased in 7 of 93 counties for men. Amongst women, again female mortality decreased a little bit. But across the country, 42 percent of the counties in the United States had an increase in female mortality between 1992 and 2006. And that increased mortality was related to household smoking by someone in that household, whether it was themselves or a spouse. But I would point out that the tragedy in Nebraska is of our 93 counties, mortality of women was said to have increased in 51 out of the 93 counties over that roughly 10 to 15-year span. And those are incidentally all rural counties; every one of them is a rural county as I look at the map, or at least what I would classify as a rural county. And, yes, I grew up in a rural county so I have some understanding of what healthcare can be like there. We know that our rural counties have lower healthcare access than others. And the uninsured rates in Nebraska are highest in our rural counties. All of the counties that have more than 20 percent uninsured in Nebraska actually are rural counties. And we've got healthcare worker shortages. You all know that. Other than along the Interstate 80, if you go look, the counties along there...and not every one of them actually has adequate healthcare coverage. We have an enormous need for family medicine, internal medicine, general surgery, dental workers, pharmacists and all and perhaps our biggest problem is mental health coverage because only Lancaster County and Douglas County and Sarpy have adequate mental health coverage across the state. And as you know, that's an area of enormous concern. And we do have a state loan repayment program for our healthcare workers. We have a single program. Many states have many. And I highlight that more than anything because we're going to come back and talk about that in the eight building blocks. And many of the things I've just told you about are all elements that

have led us to the eight areas that we're going to talk about along the way. The last thing I want to talk about is population health. And this gets back to some of the issues you just heard about with claims of...payment and claims data bases as well as a population data base. We know that the health of a population in general depends on the environment--rural versus urban--the education to the people that are there, available jobs along the way, access to healthcare, the quality of that healthcare, and of course the individual behavior along the way. And importantly, social factors: poverty, education, and social networks turn out to be stronger determinants of health of a population than in fact does the delivery of healthcare itself. So we need resources to do all these things. Why do I bring that up? Because we have to begin to think not about the care of a single person but we have to think about the care of Nebraska in general because we need to solve the problems that are there at multiple areas along the way. And so while we want wonderful care for each of us individually, we've got to begin to look at how we can reduce the burden of chronic disease amongst our populations to control our costs and look at the issues about disparities. No matter what your ethnicity, the more you are educated, the greater is your health overall and that's true. I found a study that looked at whether people eat or get medications, kind of interesting. It basically came down to the fact that they had surveyed 10,000 Americans and found that one of three chronically ill people that they talked to were unable to afford food or medications or both--one of three. That's a remarkable number when you think about it. And again, that data is data from 2012 and earlier. And we know of course we've already talked about the fact that income has something to do overall with mortality. I've come to the opinion that there are three major issues that we have to think about when we talk about this: One is health, one is poverty, and the other is education. And I figure if you can fix one of them, the other two will get better. But if you can fix two of them the third one will disappear as a problem. So health, poverty, and education are the population health issues that we need. And I think it was summed up best in the final statement of the Commonwealth Fund when they said that improving health will likely require public health interventions as well as a healthcare system improvement. Well, how did we get to where we are and why am I giving you this presentation? Well, as you

all know, you approved two legislative resolutions in 2013 and '14: LR22 and LR422. And these were to be comprehensive reviews of state healthcare cost and coverage demands. We were to bring together the stakeholders to work on controlling costs and improving healthcare and healthcare quality; provide strategies for the design, implementation, and accountability of services that would make care, quality, health, value, etcetera, be brought to all Nebraskans. We had a workgroup, a volunteer workgroup that worked with us: Bob Bartee from the University of Nebraska; Stacie Bleicher who's a pediatrician in Lincoln; Jennifer Carter from Nebraska Appleseed; Marty Fattig is a hospital administrator of one of our critical access hospitals; Ann Frohman who is a healthcare lawyer; Tom Henning, a businessman in Kearney, Nebraska; Sade Kosoko-Lasaki an ophthalmologist at the Creighton; Chris Kratochvil, a physician at the University of Nebraska; Linda Lazure, who is on the nursing faculty at Creighton; Gerry Luckey, a family physician in David City; Cory Shaw, who works with UNMC Physicians; Tom Werner, who's a family physician in Grand Island; and myself along with Senators Campbell and Gloor, Michelle Chaffee, and Margaret Kohl. And we worked over the last year and a half in a variety of things. We've looked at more than 500 publications of a variety of kinds whether those are traditional medical publications or state health plans, healthcare reform manuscripts, etcetera, and culled through all of them to look for the best ideas. In October of 2013, we held a meeting of stakeholders. There were about 160 stakeholders there. And we asked them for two basic questions. What did they think Nebraska's healthcare system should look like in 15 years from now? And what would be the opportunities and challenges of getting to that point 15 years from now? And then that data was...which collected, which actually amounted to about five or eight pages of materials, were given to the workgroup. And they formed the basis of the workgroup then as we looked at that and eventually came up with what we consider to be the important eight building blocks for a future Nebraska healthcare. In October of this year, we again got the stakeholders together. It was a little broader group of stakeholders this time, but all the people that were there last year were also invited back this year. We again had about 170 stakeholders there. And we presented to them the eight building blocks for a future Nebraska healthcare and asked them

several questions. Are there things that we didn't find that we should add to this list? And importantly, is there a ninth building block or a tenth building block that you feel is so important that we have to have it there? And so I would like to go through those. You have the handout there and just to make a few brief points about each one. The first building block is that assures healthcare is available to all Nebraskans. And it basically says we need to look at how we optimize both public and private funding of healthcare, making sure that we have the necessary regulatory and legal changes that can help us assure that there's uniform coverage to all Nebraskans but throughout Nebraska because there's a difference between our urban and rural areas in what's available and how easy access to healthcare really is. The second element was to support effective models of healthcare delivery, financing, and payment. Patients need to choose good programs for their healthcare. They should look at the quality. They should look at the issues about cost. And perhaps at this moment in time, they should look at whether or not they should be part of a patient-centered medical home or accountable care organization. Though I'm sure we'll develop other models of healthcare that will be equally good to those, those happen to be the ones that are coming along the way. We need innovative insurance opportunities that decrease the number of uninsured and increase the number of insured, that reduces cost and improves the coverages for small groups of Nebraskans throughout the state, that utilizes private sector programs for low-risk, self-funded consortia or pools. We need to assure transparent healthcare pricing, a controversial point, but we need to be sure that people know what the cost of services are going to be. Why is that important? Not only are people using more deductibles but people are using various accounts to control their overall costs. So they pay their first amount of money out of their accounts. They need to know what they're buying up front along the way. We need to reward providers for improving care. If you run a higher quality organization, shouldn't you get better care? I mean, if buy a Maserati, I expect to pay a good deal more than when I go out and buy the Ford that I currently drive. Obviously I'm buying quality. Therefore, that person that's selling it to me is presumably selling me a higher quality car. Shouldn't we do the same thing for healthcare? If quality is good, shouldn't we look at the issue of value in the way we do

reimbursements? Integrated care systems, systems that work together, coordination of care, if I send my patient to some of other physician, making sure that I get adequate reports back, or to a hospital system, that they provide all the information to me that I need. Working in teams, we no longer have the luxury of having the one captain of the ship. We need a ship's team of physicians, nurse practitioners, nurses, physician assistants, physical therapists. We can name them all together. We've got to learn how to do that and we've got to come to grips with addressing the issues of end-of-life care because that's where Medicare spends the majority of its money. We need public transparency, the third element, public transparency of healthcare quality and patient safety. You should know, again, the quality of the care you're receiving and how safe that care will be. Medicine is not without risk. We will never, ever have a perfectly safe healthcare system, but we can certainly make it less risky than it is today. Making sure that we transition the assessment of quality of care from claims-based to outcomes-based measures, for example, along the way. And removing barriers for the adoption of comprehensive healthcare information technology. The fourth building block establishes and supports a state data base. You've heard a discussion this morning about an all-payer claims data base. The answer is yes, we need that along the way. But it only gives us a small element of information. If I'm wanting to know how good of a job that somebody does in the care of diabetes, a claims data base will tell me if they check on a thing like a hemoglobin A1c level: what we would use as an element of judgment of quality of care of a diabetic. I can tell from a claims data base if they ordered one. But it doesn't tell me if it's 6 or 16. And the real question is we need a data base that not only tells me that they did the test but tells me what the value is so that I can see how well the diabetics are cared for by that physician or that nurse practitioner or PA so that I can choose who provides my care based on the quality of their care. So we need a much more robust data base than simply an all-payer claims data base, though it's a great beginning and I applaud the fact that you passed a bill that is looking at that sort of a question. All necessary healthcare data has to be there. We need the data from the VA system, the Medicaid system, the Medicare system, the private insurance system, and we need to deidentify it because the patient safety issue that's

there, of course, is gaining knowledge about somebody's health and then using that perhaps to charge them higher rates for something along the way. So we probably need to look at a deidentified data base in which to work. You've heard about that today. And in fact, the University of Nebraska is currently working in a consortium as Senator Campbell said with Missouri, Kansas, and Iowa organizations deidentifying their patient data base and then beginning to ask questions about population health of the population. We need to know, are there areas in Nebraska in which there's more cancers that we can go out and begin to look at the public health issues that are there? The fifth element is to utilize population health-based interventions. We have spent a lifetime, most of us in healthcare, taking care of a single patient. The time has come in which we must take care of the population. Yes, I still need to take care of the individual patients, but I need to figure out what identifies...and identify the factors that influence healthcare outcomes across a broad range of patients. We've got to emphasize public health and disease prevention, provide public education on public health to the people of Nebraska, work with at-risk groups. If I've got a population of people that have a greater risk of cancer, perhaps farmers because of things that they're exposed to, I need to be able to educate them about ways to reduce that risk of burden. And of course, population health is the way we're going to reduce the burden of chronic disease in...amongst our patients and that of course will help us control costs. The sixth element is promoting personal responsibility for wellness. We need to have a tack in which all of us do as good as we can in providing our own health. I have a cartoon that I use sometimes that shows...and I've blocked out of my mind--this is my age--I've blocked out of my mind the name of the cartoon. But it shows somebody in a coaster wagon at the top of the hill and they go screaming down the hill in their coaster wagon and they crash. And then at the bottom he yells out, give me free healthcare. Well, the answer is we all have to figure out not to get in the coaster wagon and ride down the hill. We have to control our smoking, control the things that we can control, look at our diet, look at all the things that we can do. But we've got to teach people how to do that. This isn't intuitive. If it was intuitive, nobody would be overweight. Nobody would have any of the problems that we have. We've got to get out there and explain to people why

wellness is a responsibility that we all need to take seriously. And it has to be proactive and culturally competent. You know, education is more than just about telling me to do something. It's about making sure I truly understand how it fits into my culture, into my ethnicity, into my age so that I can work with it in management of myself and also preventing a variety of diseases. Seventh thing is addressing healthcare work force shortages. Anybody who lives outside of Lincoln, Omaha, Grand Island, Kearney, etcetera is well aware that we've got to develop strategies to attract healthcare workers to medically underserved areas. And we have to develop strategies that can deliver healthcare in those areas along the way. That may be different kinds of loan forgiveness programs or grants. It may be a variety of incentives in those local economies to make them useful so that they can attract other health...other workers as well as healthcare workers. If you are going out to look for a job and 20 percent of the people in that community don't have health insurance, you just lost 20 percent of your income in your community. Remember, physician practices, nurse practitioner practices, PA practices are small businesses. They have to look at it as a small business. They simply can't go out there and deliver free healthcare because you still have to buy a house, buy a car, buy all those sort of things. So we need to look at a variety of things. And telemedicine clearly is going to have to be an important issue in Nebraska. The group agrees that that and Internet capable care may be very important ways that we can do it. And then last, we've got to have coordination of statewide healthcare planning for Nebraska. All that data base that we talked about, claims data base, all the other data bases, we need someone who's looking at all that data and looking at the planning of healthcare for Nebraska soliciting information from stakeholders regarding health and healthcare delivery and using it to inform the decision makers such as the Legislature, state government in a variety of ways regarding state healthcare needs, creating a health profile of the state, identifying necessary public and private resources, and all the other things that are there. And importantly, eventually reducing health disparities across the state. Let me close with a statement that some of you have heard me say before but I think it's a wonderful comment on why in 2014 we need to be deciding about something 15 or 20 years down the road. Peter Drucker is probably the best management guru

that ever came along in this country without much question. And Peter Drucker said a long time ago--since he's passed away, I know for sure it was a long time ago--long range planning does not deal with future decisions but with the future of present decisions. So we'd like you to consider these eight building blocks as potential "usefulnesses" in building a healthcare system. And I thank you very much for the time and my very long presentation. [LR422]

SENATOR CAMPBELL: Thanks, Dr. Zetterman. Questions of Dr. Zetterman? Senator Carlson. [LR422]

SENATOR CARLSON: Thank you, Senator Campbell. I'm trying to find the page. Maybe you can help me with it, with the percentage of the young people across the state, children that don't have their shots. And I think it was 15 percent. [LR422]

ROWEN ZETTERMAN: Yeah, about 15 percent; 85 percent are said to be adequately. And that would be for you, it should be page 18. [LR422]

SENATOR CARLSON: Okay, but how do you get from 15 percent to 0 percent or 1 percent or 2 percent because part of this has to do with parents' decisions not to take them. And I don't think we ought to be legislating that they have to. So how do we get that? [LR422]

ROWEN ZETTERMAN: An interesting question, and there's no question that there are many factors that play into that along the way. But I don't think that accounts for the 15 percent. If you look at most vaccinations series, religious objections and a variety of other things usually come down to a few percentage points. Part of that's education. Unfortunately, a number of years ago in the journal The Lancet there was a study that said that autism was brought about by vaccination of children. And so lots and lots of parents for that reason began to not vaccinate their children. That article has not only been disproven, it's been withdrawn but yet it still lives on in the Internet and a variety of

other ways. So the data today that's there about safety I think says it's a lot better. And I can tell you that we have risks when we don't vaccinate along the way. But there's one other factor that I would draw attention to and that is, the other thing in Nebraska, although we have a program called Kids Connection or CHIP--the federal program is called CHIP--10 percent of Nebraska children that are eligible for Kids Connection don't participate, okay? So we've got 15 percent that aren't vaccinated. And I know of that, a bunch of them probably don't have insurance because of Kids Connection. And again, that was a parental decision. Their parents obviously didn't take the time to go and sign them up. So that probably also played a role in that number. So I think there's a variety of factors, but again, it's back to public education. It's the importance of public education. Why is vaccination important? It's because we protect everyone else along the way. You know, we eradicated polio not by vaccinating every person for polio in the state of Nebraska but vaccinating the majority, the vast majority. And by vaccinating the vast majority, the few who had religious objections and didn't want to have the vaccine still got the benefit of everybody else's vaccination along the way. So the greater the percentage I can do through education and a variety of things, the better. [LR422]

SENATOR CARLSON: Thank you. [LR422]

SENATOR CAMPBELL: Other questions from senators? Senator Schumacher. [LR422]

SENATOR SCHUMACHER: How does Nebraska's health compare with the major Western industrial countries other than the United States? [LR422]

ROWEN ZETTERMAN: You're talking about Nebraska itself? [LR422]

SENATOR SCHUMACHER: Well...and I suspect to a large extent that goes over into regional, maybe even national. How do we compare? [LR422]

ROWEN ZETTERMAN: I actually can't give you that data. I've never seen that really

broken down in that sort of a fashion. But if you think about the fact that we're in the second quartile, so we've got the whole overall quartile, four quartiles of the United States' states, and we know where we stand nationally as a country, and we're in the top half, you can predict that we're a little better than the U.S. average overall in any one of the factors that would be there amongst those industrialized countries. But we're not going to be dramatically better because we're not at the top of United States health. We're not the best state. We're not number one in the country. So all I can tell you is we're probably a little better than how the United States would fair, but we're still basically going to be just above the median of whatever that number is. [LR422]

SENATOR SCHUMACHER: So is it still a fair statement that we spend more on healthcare than any other Western industrialized country and we're nowhere near the top in performance? [LR422]

ROWEN ZETTERMAN: Absolutely. If you look at those 34...those countries I mentioned, United States spends on average two and half times more on healthcare than the other countries on average. [LR422]

SENATOR SCHUMACHER: And is it still an accurate statement that in all those Western major industrial countries except for the United States, they have a single payer universal system? [LR422]

ROWEN ZETTERMAN: No, no, they don't all. They don't all, many of them do. [LR422]

SENATOR SCHUMACHER: How does that correlate with performance? [LR422]

ROWEN ZETTERMAN: That's a great question. I've never really addressed that question in my mind well enough to give you a perfect answer. There are some advantages to single payer. If you look at Medicare, for example, as a single payer the administrative costs of running Medicare are less than it would be for a commercial

insurance company? Why is that? Well, because they've got a uniform population that are all handled exactly the same way. You either do it or you don't do. You're either in Medicare Advantage or you're in routine Medicare, but everybody's in whereas if you're selling insurance so to speak, I'm selling it one insurance premium at a time. Or I'm selling 50 to this business or 100 to this or 1,000 to this one. My administrative costs go down the more that I bunch people together to sell insurance. So in a single payer country, it's like Medicare. Everybody gets the same level of care and therefore their administrative costs are lower. So that helps them a little bit along the way. So it's really hard I think to go in and compare. If you look at quality measures though, since we're completely private and public system--we're both in this country--you know, we're...on average, our quality is not as good as many of those countries whether they are or are not a single payer system. [LR422]

SENATOR SCHUMACHER: So is our healthcare issues more arising out of the economics of how we deliver healthcare historic in nature and political perspective than it is actually health and technological? [LR422]

ROWEN ZETTERMAN: If you promise not to quote me, I'll tell you one study... [LR422]

SENATOR SCHUMACHER: Turn off the speaker. (Laughter) [LR422]

ROWEN ZETTERMAN: I don't mind that it's recorded, but just don't quote me. I'll tell you the thing that I found most interesting as I read through these 500 documents that we had. Somebody pointed out that in the United States, the percentage more that we spend of our gross domestic product on healthcare on average compared to those 34...those other 33 countries, it's about a 35 percent increase. If you go down and flip it around and compare what we spend on social programs in this country compared to those other 33 countries, it's about a third less. So what we don't spend on social programs is the argument of that particular article was because we don't spend things on social programs. Remember, population health isn't about individual care one at a

time. It's about making sure that everybody in a population is healthy. So what they spent on social programs that we don't spend, we spend on healthcare to catch up. It's an interesting question and I've never seen it studied in any other fashion other than that simple comment, but I found it really, really fascinating. Some people have suggested that we have a rescue mentality in our healthcare. Our idea is, yeah, we'll give you an open heart surgery and give you new coronary arteries, but we'll not worry so much about your cholesterol and whether you're overweight and you got diabetes and you got all these other risk factors down the road. But we'll rescue you. It's an interesting question of, is it the rescue mentality of our healthcare rather than the health of our healthcare that's really important? [LR422]

SENATOR SCHUMACHER: And then one final, at least one final question and then I'll...I see we're getting near noon already. Because of the rescue mentality, most of the rescues occur in the final stages of life, final few stages of life. How do the other countries deal with that issue? And is there any way that as a practical political matter we can deal with it? [LR422]

ROWEN ZETTERMAN: Yeah, I don't have a perfect answer to your question, but I would tell you that I have a belief that working on issues of palliative care and end-of-life care are very important in this country. And I think most physicians would tell you the same, that we need to begin to develop mechanisms to talk to patients earlier about, you know, we can...here's all the things that can happen. I think some patients don't have a good understanding of what they're going to go through if we keep giving them chemotherapy, for example, until the very last day of their life. You know, maybe there's a point along the way sooner that they can have some quality time at the end. I'm not an oncologist, so I don't want to really get into that in any greater detail. But I do think end-of-life care and making appropriate decisions are things that we can do a better job of in this country. And yes, if you look at Medicare, a large percentage of Medicare expense is in those last six to nine months of life for the person who has Medicare. [LR422]

SENATOR SCHUMACHER: Thank you, Doctor. [LR422]

ROWEN ZETTERMAN: You're welcome. [LR422]

SENATOR CAMPBELL: Senator Crawford, did you have a question? [LR422]

SENATOR CRAWFORD: Yeah. Thank you, Senator Campbell. I thought maybe for the record it might be useful just to clarify the difference between universal healthcare and single payer healthcare given Senator Schumacher's question. He was asking about other countries. You know, only a few of them have a single payer system. Maybe just clarify that distinction when we're looking at U.S. compared to other countries. [LR422]

ROWEN ZETTERMAN: You know, certainly there's all sorts of different ways to look at it. Universal access is a term that's also used in there along the way. And I would submit that universal access is, many would argue, we have that in this country. You can go to any hospital in this country and they can't turn you away for care. It doesn't make any difference where that hospital is, big or small, critical access or not. They have to deliver care to you. But once you depart that hospital, then nobody else has to give you...necessarily give you access with the same level of judgment. Universal healthcare, of course, would be that everybody is in something that provides them care whether that's a public or a private system. But everybody has some sort of care available to them that is paid for at least in part along the way. To me, that's what universal healthcare would be. And that universal healthcare can be done with public programs--Medicare, Medicaid, the VA, CHIP, or Kids Connection--or it can be done in private insurance whether that's Blue Cross Blue Shield or Coventry or Aetna or any one of a number of the other groups that are out there along the way. And that aggregate makes it universal across the way for everyone. Single payer in most countries and we have one state that has said that they would like to move to single payer, basically means that you have one insurance mechanism that everybody

receives their care through whether that's state run, whether that's nationally run in another country or whether that is even done with a commercial insurer, you still have only a single group that provides the care in the single payer market. [LR422]

SENATOR CAMPBELL: Senator Gloor. [LR422]

SENATOR GLOOR: Just by way of a comment, Senator Schumacher's question, we...in fact under building block number two, the final bullet point is, promotes palliative and end-of-life care as one of the changes to delivery models. So that's one of the areas that's been identified in this process. [LR422]

SENATOR CAMPBELL: I know I speak for Senator Gloor because we've talked about it, but in the past two years, we are very, very grateful for all the work Dr. Zetterman and certainly the workgroup. These are another group of Nebraskans who came together really on their own dime and worked diligently for over two years to get us to this point. For the senators, the eight building blocks, we are behind in other states. Other states have been working on a system to get to healthcare planning. And Senator Gloor and I are very grateful for the work of a lot of Nebraskans who came together in the two conferences because this has really set a path for the future. Granted, it's not about what we may do today, but the steps we take for the future will define where Nebraska's healthcare will be in 15 years. And we need to take some steps. So thank you, Dr. Zetterman, very much. [LR422]

ROWEN ZETTERMAN: Thank you. [LR422]

SENATOR CAMPBELL: We had not planned on a lot of public testimony so I'm going to ask those people to be very quick. And if you have a handout, please do not feel that you need to read it, okay? Yes, Dr. Michels. [LR422]

DALE MICHELS: Senator Campbell and Senator Gloor, members of the Health and

Human Services Committee, Banking, Insurance and Commerce Committee. My name is Dr. Dale Michels, D-a-l-e M-i-c-h-e-l-s. I'm a family physician who's practiced in Lincoln for over 40 years and I've been privileged to serve medicine in many capacities. Currently, I'm the chair of the Board of Health until next Monday, but I'm not testifying on their behalf because that gets me in trouble with somebody it seems like. I am testifying on behalf of the Nebraska Medical Association, on behalf of myself as an attendee of the two meetings for LR22 and LR422. I do not have prepared testimony as such, but you will receive an e-mail of this report. I chose to not run my copier today. During 40 years of practice--several attempts that I've lived through--regional planning make little changes to a less than perfect healthcare system and several attempts to impose a national system on Nebraskans. In my opinion, none of it has worked very well. The two meetings I attended, however, confirmed my opinion: Nebraskans know how to make healthcare work for Nebraskans. The process of involving multiple stakeholders and groups and then researching and developing recommendations that you just heard has been excellent. These are then being refined to give direction for the future of Nebraska well after I've retired and I am still working. To be just a small part of the process to help Nebraskans in the future has been very rewarding. Today, I would encourage you not only to continue the progress made by the meetings of the last two years but to consider establishing a more permanent Nebraska health advocacy office to continue this process. We do not need another bureaucracy. We don't need a new branch of state government, only a dedicated office with a small staff to collect ideas, communicate effectively with interested parties, and help with the implementation of a plan for Nebraskans. I believe it should be operated by the state since that will allow the use of its influence to bring people to the table, have conversations that won't occur without some encouragement, and keep those involved on task. As always, the devil is in the details but I have great confidence that the Legislature can put together an office and a plan that will benefit all Nebraskans for years to come. I look forward to your continued movement towards the implementation of measurable, comprehensive, and achievable plan that would meet the needs of all Nebraskans. Thank you very much. [LR422]

SENATOR CAMPBELL: Thank you, Dr. Michels, and thank you for always being the Doctor of the Day. Many of us taken you up on your good counsel and advice when we needed it. [LR422]

DALE MICHELS: Good. Thank you. Any questions? I'd be happy to try and answer. I realize the clock behind me is ticking, so. [LR422]

SENATOR CAMPBELL: Do send us that. [LR422]

DALE MICHELS: It will be. [LR422]

SENATOR CAMPBELL: All right. Thank you, Dr. Michels. [LR422]

DALE MICHELS: All right. [LR422]

SENATOR CAMPBELL: Our next testifier I believe is Dr. Rauner. And I believe you will be our last, is that right? Is there anyone else? Okay. Dr. Rauner. [LR422]

BOB RAUNER: (Exhibit 3) Okay. Dr. Bob Rauner, R-a-u-n-e-r, representing Nebraska Academy of Family Physicians. And I won't read the testimony. So I'll just hit the high points. One is we are strongly in favor of continuing this LR422 process of trying to transform our healthcare system. Advice we would have is one, to focus on a more private system. I think that is the better way to go. To follow up on Senator Schumacher's comments, there are other healthcare systems that are universal and private: Swiss, Dutch, German, for example. And yes, their cost is just as low and quality just as good. They're actually in the...some of them in the top ten as opposed to the U.K. and Canada not being in the top ten. They're better than us, but that's not saying much. Second, your comments about quality, that is huge. Quality does lower cost and if I had time and a projector, I could show you results on our Medicare and Blues data showing that. I work for a health system with clinics spread from Bellevue to

Ogallala. We have the results already. This isn't just theory. This is already in place. Our biggest problem we're finding is getting the insurance companies to settle on common measures of quality. And so we'd encourage you to emulate the process of Senator Gloor and Wightman's medical home group, which we have been able to do that. I included a copy of what both our physician groups and the insurers signed on to. And some of those insurance groups even followed through with it, not all. Third, we talked about vaccinations. What is the problem? Again, it's that commonality. We give vaccinations at our clinic but so does everybody else and not all of them communicate with everybody. For example, we're struggling because some of our large chain pharmacies will not tell us when they're giving patients flu shots and pneumonia vaccinations, so I can't track them. We have private entities that are not billing through their insurance companies so we can't get it through claims data and they're not telling us either. So if they're doing these health fairs giving out vaccinations, they've got to communicate with everybody. That's a huge problem. That's part of the reason why we're not...we shouldn't be 85. We should be 97 if you count for religious exemption. We're not there because there's no way to track and manage. You mentioned transparency. I would (inaudible) echo the previous gentleman's comments on transparency. That is the immediate low-hanging fruit. We've run smack dab into this. Our Blues plan right now, we would love to give our patients cost data. We can't. The legal has basically said all the contracts prohibit that. You cannot have an HSA. You cannot have a free market in any semblance if the people can't see the prices. If the physicians can't see the price and the doctors can't see the price, you're stuck. Other states have already done this. Massachusetts most recently, they're mandating (inaudible). You have to post your prices and other countries that are doing better than us. They post the price on the wall. We want to go there. We put our prices on the wall. We want everybody to do that. So that could be something that could be fixed legislatively. The other thing with Medicaid expansion, we would like it to...we like the tack it took last time, although we want it to go further. I've talked to a couple members about the churn problem. The studies show that if you simply expand Medicaid as is, half of those people will churn on and off every year and that limits your ability to do

quality. You need people in the same system for a year or two. And if you simply expand Medicaid you won't fix that because some of our Medicaid plans are working with us on quality and some are not. And so unless you're going to mandate that they work with us on quality, you can't...you shouldn't expand as is. You've got to fix that part of it. I think it's better to go for the private system. The churn is big issue. And the theme we use in there for government management, it's like railroad. We don't want them to run the railroad but we have to settle on a common width of track because it'll save everybody more money and it'll be more efficient. So that's the testimony. [LR422]

SENATOR CAMPBELL: Dr. Rauner, you covered a lot in that (laughter) short amount of time. Any questions from the senators? Dr. Rauner, it's been very good to stop in several times to see me and we've had some great conversations and always brings good information to help us improve what we're trying to do. So thank you for staying very much involved. [LR422]

BOB RAUNER: You're welcome. [LR422]

SENATOR CAMPBELL: And if you want to know more accountable care organizations, there's the gentleman, and has worked with Senator Gloor on patient-centered medical homes. Thank you for staying with us. [LR422]

BOB RAUNER: We have one in...our clinics are in several of your districts, by the way. [LR422]

SENATOR CAMPBELL: Absolutely. Take care. Good morning. [LR422]

LaDONNA HART: Good morning, Senator Campbell, Senator Gloor, members of the committee. [LR422]

SENATOR CAMPBELL: Just take a deep breath. We're fine. [LR422]

LaDONNA HART: (Exhibit 4) Yes, okay. I'll be brief as well. My name is LaDonna Hart, L-a-D-o-n-n-a H-a-r-t, and I am president of the Nebraska Nurse Practitioners Organization. I am also a practicing NP in Lincoln, Nebraska, and I've been practicing for 16 years. I work primarily in women's care and I am a family nurse practitioner. On behalf of the nurse practitioners and our 600 members, I would like to offer our support for LR422, me personally having attended those meetings came out really a very different person I think on the other side. And I know that our organization has benefited from the collaboration and the insight of all entities that are involved in making our system and better and increasing the health and wellness of Nebraska and our communities. And nurse practitioners are really positioned as highly capable healthcare providers focused on health, wellness, prevention, many of the eight building blocks are also represent nurse practitioners and our capabilities and where we are trained and are able to do. And I appreciate the comments of all of those testifying today. Population health management, specialties, we work in hospitals, clinics, and we own our own practices. And both in Nebraska and nationally, nurse practitioners are working to bring down the cost of healthcare through providing high quality care. And we talk a lot about quality and cost equalling our value. And I think that is something that nurse practitioners have really had a big stake in our healthcare system. Nurse practitioners are highly skilled practitioners. We bridge the...we can help bridge the provider shortage gap in our rural communities. I feel like in some ways as the organization and we've gone forward with nurse practitioner legislation and stuff and some ways that nurse practitioners have made a promise to Nebraska that how are we going to follow up on certain legislative changes to help Nebraska be better, to help the communities of which Nebraskans live, work, grow, and play be better and offering a better access to care than we have now our organization is truly committed. I love these eight building blocks and the work done by this workgroup. I think it's all given us a vision to come together that has really been absent for a very long time and we all work collaboratively together and just to see how collaboration does work is quite remarkable. And so we are committed as an organization and certainly as an individual nurse practitioner to help in

any way that we are possible to help propel forward these eight building blocks as been set forth by this workgroup to help the health and wellness of our Nebraska communities. And I think I'll end there. I just would also like to add that we were so grateful for the support that we received last year with LB916. And although disappointed that it did not make it past our Governor, we are very hopeful for this legislative session and working with all of you. And I am available for questions if you have anything. [LR422]

SENATOR CAMPBELL: Any questions from the senators today? Thank you so much for coming and for attending the two conferences. [LR422]

LaDONNA HART: Thank you very much. Yes, it was great. Thank you. [LR422]

SENATOR CAMPBELL: Good. For the record, we also received letters from the Children's Hospital and Medical Center, Aetna, and CHI, which we will have into the record. We want to thank you all very much for coming. The Health Committee will reconvene at 1:30 this afternoon in joint hearings in here. I think it's in here, isn't it? Brennen? Yes, in here with Appropriations. And while this committee does not have people who cheer, stand up, or clap, I just want you to know that we can all wish a happy birthday to Brennen Miller. Thank you one and all for coming today. [LR422]