[LB78 LB257 LB553]

The Committee on Banking, Commerce and Insurance met at 1:30 p.m. on Tuesday, February 10, 2015, in Room 1507 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB78, LB257, and LB553. Senators present: Jim Scheer, Chairperson; Matt Williams, Vice Chairperson; Kathy Campbell; Joni Craighead; Mike Gloor; Sara Howard; Brett Lindstrom; and Paul Schumacher. Senators absent: None.

SENATOR SCHEER: It's past the appointed hour so we will call the hearing to order. My name is Jim Scheer, I am the Chair of the Banking, Commerce and Insurance (Committee). I am from Norfolk and represent the 19th District. The committee will take up the bills as they are in the order posted on the outside. Our hearing today is your public part of the legislative process, your opportunity to express your position on any of the proposed legislation before us today. The committee members will come and go during the hearing. I, myself, have a bill up across the hallway as soon as I'm done here. So if we leave and come back or move around, it's not because we don't find your bill interesting or have a unique position on it, it just means we've got other things that we have to do as part of the process. To facilitate today's hearings, I would ask that your cell phones be turned to silent or off, whichever is easier for you. If you are going to be testifying, if you could move towards the front chairs so that we can keep track of how many might be still needing to testify. When you are going to testify, we have pink sheets in the back. Please make sure that you fill those out in its entirety. When you do come up to testify if you could first give us your name and spell both your first and last name for the transcribers so at least that's correct. If you are not wanting to testify, but want to be on the record either in support or opposition to a bill, there is white sign-in sheets at both doors. Please put your name and the bill number and if you're support or in opposition. I would ask that everyone be concise. We do use the lights in this committee. Green light means you start, you have five minutes total. The yellow light comes on, that means you have one minute left. The red light comes on, that means you are done. And if you can't be done within a short period of time, I will help you be done. So that's how the system will work as far as the five minutes. I will ask the members that are here today to start with, to introduce themselves. And I'll start with Senator Schumacher.

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

SENATOR LINDSTROM: Brett Lindstrom, District 18, northwest Omaha.

SENATOR WILLIAMS: Matt Williams, District 36, Gothenburg.

SENATOR GLOOR: Mike Gloor, District 35, Grand Island.

SENATOR SCHEER: Thank you, Senators. If you are going to have anything that you would like to be dispersed to the committee members, we will need ten copies. If you do not have ten copies, Jake Kawamoto is the page that we will have today, if you need copies, please have him do that for you, preferably before you testify. It helps us to have information in front of us when you are. Let's see. My staff, Bill Marienau is the counsel for the committee. Unfortunately, Jan Foster is ill this afternoon, but we've got a cleanup batter. Brennen Miller has graciously stepped in to fill in and I appreciate it very much, Brennen. We probably would not be doing anything right now if it were not for you, so you're the guy. So with that, I will turn the hearing over to Senator Williams and I will excuse myself and I will be back. Thank you.

SENATOR WILLIAMS: Thank you, Chairman Scheer. We'll now open the public hearing on LB78. Senator Gloor. [LB78]

SENATOR GLOOR: Thank you, Vice Chair Williams. And good afternoon, fellow committee members. I'm Mike Gloor, G-l-o-o-r, District 35, presenting LB78. I appreciate your listening to this bill. This is one of the many spin-off challenges that have hit certain areas of the state as a result of the difference of opinion and lack of agreements between CHI Health Nebraska and Blue Cross Blue Shield. The issue of unintended consequence seems to reach far and wide when it comes to health care issues in this day and age. And this is an example of one of them that we hope to try and remedy. I'm going to start by just referencing the bill itself, two pages of your green copy. And on the second page, this relates to the Intergovernmental Risk Management Act, which affects public agencies. And if you look at page 3, we're talking about the enabling language that allows: any two or more public agencies to make and execute an agreement providing for joint and cooperative action in accordance with the Intergovernmental Risk Management Act. And then it goes on to list areas where these public agencies may, in fact, come up with risk pools for general liability, damage and destruction, errors, omissions. But you get to line 17 and there is a line that says: Any two or more public agencies, other than school districts and educational service units, may make and execute an agreement providing for joint and cooperative action, etcetera, etcetera. There's an exclusion in here. And other than being a sign of very good lobbying for that to be added in here, you have to ask yourself, why? The answer to that, I would tell you, at least in years past is, that there was a good reason. A group of associations, school boards, school administration, the NSEA, the teachers, came together and put together a large risk pool called the Educators Health Alliance, which formed a large entity that was able to then leverage that size for what I'm going to assume was preferred coverage along with good pricing, given the sort of pool that they'd pull together, educators, the sort of folks that actuaries would probably salivate over. I used to have insurance through what used to be called Horace Mann. I think it's called Teachers Insurance now. But it was a private insurance company that provided things like car and homeowners and also worked with that pool of folks. Their rates were great because of the pool they worked with. And I have no doubt the same experience was at work with the Educators Health Alliance. And the reason for this language

was, of course, to make sure that the integrity of the Educators Health Alliance stayed in tact, that we didn't end up with fragmentation. I understand the business case behind why this was formed. I understand that during its day it provided great coverage at a great price. But that was then, this is now. And we're faced with a battle between CHI Health and Blue Cross Blue Shield who provides the back-room administration as well as the network for this large risk pool, the EHA. And it has put some communities--mine, in Grand Island, Kearney, Nebraska City, I think Schuyler, and a few other small communities that have sole community hospitals--and the employers, in this case the School District of Grand Island, who are part of this pool, puts they and specifically their employees in a bad spot because they can't go to the local hospital. They also can't set up another insurance pool because this language won't allow them to do so and that's a challenge. I think most of you know, but as a reminder, I used to work for CHI. That was seven years ago. But this wasn't brought to me by CHI, this was brought to me by the school district and they'll testify because they have a lot of employees who can't get coverage at their local hospital and with some of their favored physicians. And a lot of their employees are my constituents who have come to me and said, can't you do something at the legislative level to make this disagreement between the two entities go away? And the answer to that is, well, we've looked at it and I don't think so. But one of the things we might be able to do is at least free up from being tied down to this statute, free up this district, other districts who may want to do so, to be able to look at other risk pools. The days of statewide risk pools, the days of statewide coverage for all hospitals and all physicians and all therapists across the state I think are over. And so there's an inevitability, had not this occurred between CHI and Blue Cross, I think it was going to happen between some provider group and some insurer. It's just the nature of the market and what's going on. And this statute, given it had its day and served a purpose, is an anachronism and I think needs to come out. Thank you. [LB78]

SENATOR WILLIAMS: Questions for Senator Gloor? Yes, Senator Craighead. [LB78]

SENATOR CRAIGHEAD: Thank you, Senator Williams. Senator Gloor, I want to make a comparison with other legislation we have. This is kind of like a JPA. And in some situations--joint partnership--in some situations, each entity on their own is under certain rules and guidelines but when they combine to be a joint partnership those rules and guidelines no longer exist. Is that the same as this would be if we have...because this, to me, appears to be a JPA? [LB78]

SENATOR GLOOR: I can't tell you that. I can't answer that question. Hopefully, somebody who follows me can, Senator. [LB78]

SENATOR CRAIGHEAD: Thank you. [LB78]

SENATOR GLOOR: Good question. [LB78]

SENATOR WILLIAMS: Additional questions? Hearing none, thank you, Senator Gloor. [LB78]

SENATOR GLOOR: Thank you. [LB78]

SENATOR WILLIAMS: I would ask those that are going to testify in favor of this to please move up to the front part of the room and we'll start with the first proponent. [LB78]

VIRGIL HARDEN: Good afternoon, Senator Williams, members of the committee. My name is Virgil Harden, V-i-r-g-i-l H-a-r-d-e-n, and I am the executive director of business for Grand Island Public Schools. Thank you for taking time to listen to my testimony about this bill. Senator Gloor did a great job of introducing the bill and explaining where we're at and why we're here. And so I would like to talk to you about the 60,000 foot level and ask you to think about what might be labeled good public policy. And really it centers in on, is it good public policy to treat political subdivisions like school districts, cities, counties, villages, differently for no apparently good reason? I think that's where we're at with this. Senator Gloor also mentioned the fact that the landscape is different. If you think about the advent of PPACA, if you think about the consumerism, so to speak, of how people approach health insurance. People don't make these decisions lightly. It's certainly a very emotional topic for our employees. Other than pay, there probably is no other topic or benefit that we could offer employees...any employer could offer employees that's any more important than their health coverage. And so we're feeling that pain in Grand Island with the conflict that does exist. I would liken what we're asking for you to consider in this bill to be similar to the right to vote. We, as citizens in this country, have the right to vote. It doesn't necessarily mean we exercise that right to vote. Some people don't vote. Some people vote and they're uninformed. They just go to the poll and vote. Other people spend a great deal of time thinking about who they're going to vote for and why. And so I would postulate that if you would pass this bill, that's where we would be as a state. We would have school districts and ESUs that would have the right to vote as to how they want to structure the health insurance benefits and an opportunity for them to look at something other than what's on the field today. Right now, we have two choices as a district. We can do and participate in the EHA, which we do. And one of the points I would like to make is that we are not here to destroy or attack our friends at Blue Cross Blue Shield or our friends associated with the EHA. We simply want an option. It is not about tearing anything down, it's not about disrupting what might be of benefit to some other school districts, it's about having choice and opportunities. We feel that we simply don't have that the way things stand now, given our history with how we've offered benefits. It is about ESUs and school districts having choice. And we hope that you would consider this bill. So with that, I would conclude my comments. [LB78]

SENATOR WILLIAMS: Questions for Mr. Harden? Senator Schumacher. [LB78]

SENATOR SCHUMACHER: Thank you, Senator Williams. The operative language if the amendment is adopted would be that agencies can form a pool for providing employee group insurance for health, dental, accident, and life. Is that basically what this is intended to do? [LB78]

VIRGIL HARDEN: From our standpoint, absolutely. [LB78]

SENATOR SCHUMACHER: Okay. [LB78]

VIRGIL HARDEN: We're concentrated on specifically the health insurance component of that. That would include dental, so health and dental. [LB78]

SENATOR SCHUMACHER: So several school districts or conceivably a school district in a county or a school district in an ESU or a school district in a city can get together. And tell me how this pool works and where the liabilities are. [LB78]

VIRGIL HARDEN: Well, you know, that's a great question. You know we, in Grand Island and Hall County, obviously, the city, the county, and the school all operate and need that health insurance to offer their employees. And so then you don't go very far away and you have another metropolitan area like Hastings and Kearney and the same entities exist there, so you start to think big or down-the-road kind of thing as far as what might be an opportunity. So that's kind of the vision that if you said, what if we got to that point? Now as far as liability, I can't answer any specific, here's the legal structure of this. What we would be would be a pool through the act--I don't know if it's an interlocal cooperative act that would take over and allow us to set up an interlocal between the public entities--and so it's hard to spend a lot of time and effort and energy on those type of things when we don't have the right to go and do it. So I can't give you any specific answer on where the liability. But we wouldn't intend...one of our hopes would be and one of the aspirations would be that we wouldn't take on a large amount of district-only liability. We would want to get the benefit of pooling with other entities to spread that risk for health insurance. The one thing we don't want to do and one of the things I guess we could right now is go out on our own as an individual district. We feel that that is...we are risk averse and do not wish to do that. We don't think we would have a better situation for ourselves than being in the EHA. [LB78]

SENATOR SCHUMACHER: So basically whatever government entities are in this pool, throw money into the pool and they become their own mini insurance company up to a point. And then

I suppose there's some reinsurance or some insurance company that takes over if they get over their head? [LB78]

VIRGIL HARDEN: Yeah, you know the exact legal structure where there would be a fully self-insured, which would be one option I think or possibly then a reinsurance. You know, again, the details of how that would work certainly haven't been ferreted out from our end of the continuum because we just don't have the right. So it's hard to engage a consultant and it's hard to use public resources to go down that road when we don't have the legal right to do that. So we haven't done any of that legwork, so to speak, because of the inability to actually enter into a cooperative agreement. [LB78]

SENATOR SCHUMACHER: If...up to this point, are there any public agencies who have done this pool for health insurance purposes? [LB78]

VIRGIL HARDEN: Public agencies? No. The EHA is a Nebraska corporation and so they're not a public entity. [LB78]

SENATOR SCHUMACHER: Well, what I'm trying to do is see, does this mechanism work because right now other public agencies can do this. [LB78]

VIRGIL HARDEN: Oh. Yes. [LB78]

SENATOR SCHUMACHER: And have any of them done it? [LB78]

VIRGIL HARDEN: Yes, I do believe there is a pool that the counties have. I don't know all the pools that are out there, but I do believe other governmental entities have done it. [LB78]

SENATOR SCHUMACHER: And do you figure you can save costs other than if you...by using this pooling mechanism? [LB78]

VIRGIL HARDEN: That's the hope. I mean, we don't know. Like I mentioned, it's hard to invest the resources and time in something that you don't have as an option. And so that's...we would intend if given the option, we would then take the due diligence, is what I would call it. School districts don't enter into these type of things, interlocal...for whatever reason. We have interlocal agreements with our county to do truancy services. You know, we didn't do that overnight, we spent three years studying that program and then entered into it and it's worked really well. So we would have to do the due diligence to see if there's money to be saved. Because we would be given this right, if the bill was passed, does not mean we'd exercise it and that's why I likened it

to the right to vote. We may stay with the EHA. We don't...we're not mad at EHA or the Blue Cross Blue Shield folks. We simply want to have the right to look into this as a business model. We do need to try to drive costs down if we can. And that's just one more weapon in our arsenal, for lack of a better term. [LB78]

SENATOR SCHUMACHER: Thank you. [LB78]

SENATOR WILLIAMS: Other questions for the witness? Seeing none, thank you. [LB78]

VIRGIL HARDEN: Thank you. [LB78]

SENATOR WILLIAMS: Would the next proponent step up, please? [LB78]

WAYNE STELK: Good afternoon, Vice Chair Williams and members of the banking committee. My name is Wayne Stelk, W-a-y-n-e S-t-e-l-k, and I'm the executive director of human resources for the Grand Island Public Schools. I'm here this afternoon to speak in support of LB78. As was mentioned earlier, since September 1 of 2014, the local and primary hospital in Grand Island, Nebraska, has been out of network with the Blue Cross Blue Shield, our health insurance provider through the Educators Health Alliance. And as you can well imagine, that simply is a situation that is unacceptable for us as a district and for the employees of Grand Island Public Schools who participate in that health insurance plan. As a school district we have over 9,300 students. Of that student body, 54.8 percent of those students are minority students and 68.8 percent of those students live in poverty. If GIPS is expected to successfully educate these students in meeting the high expectations of state and federal accountability, we must hire, develop, and retain the best teachers, administrators, and support staff that we possibly can. During the next four to five months we will be hiring to fill an anticipated 60 to 80 teacher and administrator vacancies for the 2015-16 school year. As the human resources person for Grand Island Public Schools I can offer the best candidate great students to work with, competitive wages, great instructional support, and tremendous facilities. That will be a very attractive career opportunity for many of the candidates that I'll be interviewing. But then I have to review our benefit package and I have to explain to them that our current benefit package does not offer a local hospital within network coverage. That will be a deal breaker for some of our candidates. Admittedly, some candidates who are just starting their careers may not see the insurance benefit as the most important thing to them. I remember at that age I was invincible and didn't expect to ever use insurance either. But I can also tell you that we look at a lot of candidates who have either their own or family medical situations where that health insurance benefit, and particularly hospitalization at the local level, is going to be very important to them. I don't know how many candidates I may lose as a result of the current state of our insurance plan, but even if I lose one great teacher candidate, that's too many. We can wait and hope for the standoff between Blue

Cross Blue Shield and CHI to be resolved, which we have done for nearly six months. But waiting and hoping is not a strategy. We need to create a plan that will be proactive and that we will be able to move forward in meeting the needs of our staff. We know that going out and completely self-insuring as an individual employer is probably not a viable entity due to the size that we would be able to offer. The rates would be unaffordable and the plan would probably be unsustainable. But given the opportunity to look for other similarly situated employers or organizations that we could again pool our resources together with, we may be able to find something that meets our needs that is affordable and sustainable. In closing, I just want to emphasize that, as Mr. Harden emphasized, Grand Island Public Schools has no desire or intent to get into competition with the EHA or to break up the EHA. We simply ask the members of the banking committee to recognize that the current statutory limitation has put Grand Island Public Schools at an extreme disadvantage. And I just think back to the 9,372 reasons in Grand Island who need and rely upon us to meet their educational needs, and this is something that would greatly enhance our ability to do so. Thank you for your consideration of this bill. [LB78]

SENATOR WILLIAMS: Thank you, Mr. Stelk. Questions for Mr. Stelk? Ms. Craighead. [LB78]

SENATOR CRAIGHEAD: Thank you, Senator Williams. Dr. Stelk, thank you for being here today. Maybe I'm not correct on this, but I thought about two or three months ago there were five communities in Nebraska that, for lack of a better word, received a special dispensation between CHI and Blue Cross so that services were covered. Is that right or not? [LB78]

WAYNE STELK: Well, there were some exceptions and some special consideration provided for preexisting conditions. There have also been, what I'll refer to as, maybe some band-aids during this process that provided some additional benefits, but it created a situation where benefits were paid directly to the employees who then have to ferret out how much are they going to in turn pay to the hospitals. It's a cumbersome and a complicated process. Employees have a lot of things on their minds, especially when they're going through health situations. And one of the things that's always been greatly appreciated, and certainly Blue Cross Blue Shield has been one of the best of efficient and timely processing of claims and getting those payments accurately made to providers. To throw that on the shoulders of the employee, it's...like I say, it's a band-aid. It helped make a terrible situation not quite so terrible, but it's certainly not acceptable in the long term. [LB78]

SENATOR CRAIGHEAD: So even though it's inconvenient, services are covered. Is that correct? [LB78]

WAYNE STELK: They're covered to a certain degree. Not...there's still quite a bit additional out-of-pocket expense to the employee. [LB78]

SENATOR CRAIGHEAD: Thank you. [LB78]

SENATOR WILLIAMS: Other questions? Senator Schumacher. [LB78]

SENATOR SCHUMACHER: Thank you, Senator Williams. And thank you for your testimony today. I guess I'm still not connecting the dots between how you'd be able to this year, for example, offer a better deal to your perspective employees if you had the ability to join what would have to be a small pool because there's just not time to organize a big one. And the premiums to float the CHI costs would have to be reflected in the premiums that the district or somebody would have to pay, how that benefits your situation at all rather than staying with a big, ongoing operation like a Blue Cross sized operation and spreading the risk across a large population without having to go through the overhead and the work of setting up this pool and trying to be your own insurance company. [LB78]

WAYNE STELK: Absolutely. And I certainly do not believe that we would be able to get something like this in place by the beginning of the school year. It would take an extremely large effort to engage a consultant and to secure bids and seek possibly other members to join the pool and those kinds of things. The point that I would like to stress is that the current situation of having a health insurance plan where your local hospital, your only local hospital is out of network, is not a situation that we can live with for the long term. We simply cannot live with that for the long term. And we do not know what the future holds between CHI and Blue Cross Blue Shield. We can sit here and wait for another three months or four months or six months. It may or may not be resolved. But we...and our employees are depending upon us to find options, to find solutions so that our local hospital provides in-network insurance or is covered in a network insurance situation. So the specifics of your question, how would it work and what would the premium structure be? We have not had a chance or the time or legislatively the flexibility to go out and secure those bids. Right now, we have a very competitive health insurance premium. I'll argue that that premium is not really appropriate for us because we don't have the same in-network insurance coverage that other districts have who do have local hospitals who have in-network coverage for their local hospital. So it may be a little higher premium, but if it's better coverage because the local hospital is in network, then that's something we would have to look at. It's just not a situation that's acceptable to us long term as it currently exists. [LB78]

SENATOR SCHUMACHER: Thank you. [LB78]

SENATOR WILLIAMS: Senator Lindstrom. [LB78]

SENATOR LINDSTROM: Yeah, I was just curious how many other communities or districts are in your similar situation, do you know? [LB78]

WAYNE STELK: I believe five total had a CHI hospital as their only primary provider within the state of Nebraska. [LB78]

SENATOR WILLIAMS: Mr. Stelk, when did the Grand Island Public School system first start to look for an alternative to the EHA? [LB78]

WAYNE STELK: We started talking internally as we became aware that CHI was no longer going to be in network. I believe we had maybe 30 to 60 days advance notice to that September 1 date. So we started, Mr. Harden and myself and those within the Grand Island Public Schools, we started talking about, gosh, this is not going to be good. And we kept our fingers crossed and hoped that there would be a resolution. And then September 1 came and gone. And just as that time has continued to progress, we became at least of the belief and understanding that those negotiations completely broke down sometime in October, I believe it was. So that's the point where we started getting real serious about, we just can't have our local hospital out of network as our primary insurance coverage inevitably, for any long-term period of time. We were aware of the statutory limitations as we talked about options because of currently we have around 600 lives that are covered in the EHA insurance plan. That's not a large enough group for us to just go completely self-insured on our own. We're not going to do something that is going to put the district at a severe risk or that's going to create a worse situation than we currently have. So going out completely on our own as a self-insured group was not an option. So then we started talking about, well, are there other similarly situated or local groups of employees or organizations that might be interested? Or could we pool together with some other folks just to see if we could create a little bit larger group so that it would be viable from the standpoint of expected claims experience and things like that. [LB78]

SENATOR WILLIAMS: So Grand Island Schools didn't start thinking about this and thinking about potential...a legislative fix before the dispute even arose between CHI and Blue Cross? [LB78]

WAYNE STELK: That would be correct. That is correct, yes. [LB78]

SENATOR WILLIAMS: Senator Campbell. [LB78]

SENATOR CAMPBELL: Thank you, Senator Williams. Mr. Stelk, do you have to provide a certain period of days to notify EHA of your intent? I mean, is there a period of time in which you have to stay in the plan and with notification? [LB78]

WAYNE STELK: I don't know the specific answer to that. I would assume there probably is some sort of a notification period. [LB78]

SENATOR CAMPBELL: Okay, because I was just curious based on...you said you wanted to try to be ready, if the legislation went through, to be ready for that at the beginning of the next school year. Did I hear you correctly? [LB78]

WAYNE STELK: No. My intent was not to convey that we are trying to have a new insurance plan in place by the beginning of the next school year. [LB78]

SENATOR CAMPBELL: Oh, Okay. [LB78]

WAYNE STELK: But what I do want to be able to do, for instance, in our recruiting and our hiring is to be able to explain to people what steps we might be taking to resolve the situation. Again, from a recruiting standpoint, if we can let folks know that we're taking steps and working towards some sort of a resolution or that there's light at the end of the tunnel, so to speak, that makes our recruiting efforts more viable. But we do not believe at this point in time we would have a new insurance plan identified, in place by September 1. [LB78]

SENATOR CAMPBELL: So the time period for you to...assuming the legislation passed and so forth, the time period has not been set out? [LB78]

WAYNE STELK: No, it has not. [LB78]

SENATOR CAMPBELL: Okay. Thank you. [LB78]

SENATOR WILLIAMS: Senator Schumacher. [LB78]

SENATOR SCHUMACHER: Thank you, Senator Williams. Just a little bit of follow-up. Your current carrier is Blue Cross? [LB78]

WAYNE STELK: Yes. [LB78]

SENATOR SCHUMACHER: Okay. And up to the point of the controversy with CHI, everything okay? [LB78]

WAYNE STELK: Yes, as far as I know. Uh-huh. [LB78]

SENATOR SCHUMACHER: So basically, unless the Blue Cross-CHI thing goes on forever, there's no reason why it couldn't revert to the way it was before. Is that a fair statement? [LB78]

WAYNE STELK: We're not saying we're leaving no matter what the EHA or Blue Cross and Blue Shield...we don't know what the future holds with the current situation. And we're trying to make...be proactive in our abilities to get something in place for our employees at some point in time down the road that we can take out to our employees and provide a competitive benefit package. Right now, to sit and wait and hope that...some of the newspaper articles that I read have indicated that there's been the possibility that CHI and Blue Cross and Blue Shield may never come together and get back in network. Now I don't know if that's just media reporting or...but we've certainly not received any concrete information that there's going to be a solution to this dilemma in the near future. So I can't, in good conscience and in good faith working with my board of education, working with our group of employees, sit there and look them in the eye and they say, well, what are you doing about our insurance? [LB78]

SENATOR SCHUMACHER: Well, isn't the heart of the controversy that Blue Cross feels that CHI is too expensive compared to a lot of the other hospitals? [LB78]

WAYNE STELK: That's what I've been led to believe. I don't know the specific details. [LB78]

SENATOR SCHUMACHER: Okay. Now, if Blue Cross and CHI work out their differences and you go down this path of research and setting up an alternative provider, that's a lot of overhead that just goes up in smoke if they get back together, wouldn't it be? [LB78]

WAYNE STELK: I'm not sure what you mean by overhead. Would it be a lot of time invested by myself and Mr. Harden? Absolutely. We're certainly willing to do that. [LB78]

SENATOR SCHUMACHER: I would guess just to set up this kind of operation is just a heavy load on your staff and everything else, I would think. It's not an overnight... [LB78]

WAYNE STELK: Certainly, it would be a lot of work. You know? [LB78]

SENATOR SCHUMACHER: And how would it be then that if you have a pool of four or five people in the same predicament, that all our experience in the high cost institution get by any cheaper by...I mean, your policyholders or whoever is paying the bill to the school district, by going down this road would have to pay a big expense in order to come up with the money to pay the higher cost EHA facility? [LB78]

WAYNE STELK: Until we would be able to go out and get bids and those sorts of things, it's my understanding that the cost concern with CHI was strictly related to a couple of Omaha hospitals, that the costs in the Grand Island CHI were not of concern, that they were within the same range of acceptable costs, so. But as I understood it, and I'm not the expert close to negotiations, CHI refused to break out the Omaha hospitals from the outlying hospitals and kept everything under one large group. So I'm not of the belief that the costs in Grand Island would submarine this effort or this project. [LB78]

SENATOR SCHUMACHER: Thank you. [LB78]

SENATOR WILLIAMS: Any further questions? Thank you, Mr. Stelk. [LB78]

WAYNE STELK: Thank you. [LB78]

SENATOR WILLIAMS: Next witness, please step forward. Any other testifiers, pro? Alrighty. We'll move to opponents. Are there any...those that would like to speak in opposition? [LB78]

CRAIG CHRISTIANSEN: (Exhibit 1) For the record, I am Craig Christiansen, C-r-a-i-g C-h-r-i-s-t-i-a-n-s-e-n. Good afternoon, Senator Williams and members of the committee. I'm here today representing the Educators Health Alliance of Nebraska, also known as EHA. I serve as a member of the board of directors and as a member of the executive committee. And I'm testifying today in opposition to LB78. If enacted, LB78 would permit local school districts to enter into their own self-funded pooling agreements. This change would negatively impact the Educators Health Alliance, which is currently the largest insurance pool in the state. The Educators Health Alliance is a voluntary pooling arrangement for Nebraska's public education school districts. It is a fully insured plan for public employers that has successfully operated in Nebraska for four decades. Of Nebraska's 245 K-12 school districts, 242 voluntarily belong to the EHA. So all told, that pool covers more than 77,000 Nebraskans. Our large group affords predictability and stability for all districts. And in Nebraska what is particularly important, it protects small districts from the disastrous effects of having a major health care case in a small individual district. We are community rated in a large pool. The point that was made by earlier testifiers of having the right to do this, I want to make an important point, and I think it is important to note that schools and ESUs can already pool. They can already buy fully insured

third-party products and they have done so successfully for nearly 50 years since our pool was formed in 1968. Our rates for 2015-16 which begin on September 1 will increase by 1.9 percent over the current year. This marks the 13th year of premium rate increases of far less than 10 percent, which is well below national trends. The advocates for bringing down the cost of health care, both in general or in their particular district interests, may point to pooling, but ignore the fact that the EHA is exhibit A in the case of successful insurance pool in Nebraska. We hold powerful leverage with third-party insurers for getting the best pricing, the best coverage. It is, without a doubt, the best deal available. In addition, the risk for the individual participant is on the insurer, not on the individual participant. And this is a major point to be made in case of comparison with self-funded plans. LB78 allows the formation of undercapitalized, self-funded pools. Simply put, this bill will have the opportunity to hurt the large group of EHA by creating relatively smaller groups that will have increased risks in predictability and, therefore, greater cost to participants. The threat to breaking up the EHA insurance pool is quite real and there is no connection, whatsoever, to the creation of self-funding pools and the issue of the CHI controversy. In insurance, size matters. The rule of the large pool or the law of large numbers is a primary principle in insurance. All things being equal, the larger the group the smaller the risk in accurately predicting the amount of incidents of loss or of health cases. This means more accuracy for the insurer and lower costs. We have that currently in the EHA. We believe the changes proposed in LB78 will ultimately make insurance premiums more costly for those employees it intends to help, make it more risky for those employees, and for this reason we ask you to oppose LB78. Thank you. And in addition, I might add that a letter has been distributed which I brought from Superintendent Teahon from Gothenburg, who is also the chair of the Nebraska Council of School Administrators. [LB78]

SENATOR WILLIAMS: Thank you, Mr. Christiansen. Questions for the witness? Seeing none, thank you for your testimony. [LB78]

CRAIG CHRISTIANSEN: Thank you very much. [LB78]

SENATOR WILLIAMS: Chairman Seiler, would you like to take back over? [LB78]

SENATOR SCHEER: Scheer. [LB78]

SENATOR WILLIAMS: What? [LB78]

SENATOR SCHEER: Scheer. [LB78]

SENATOR WILLIAMS: Judiciary has been tough on me. That's an inside joke up here, you don't all have to know that one. [LB78]

SENATOR SCHEER: Welcome. [LB78]

MATT FISHER: (Exhibit 2) Good afternoon, Senator Scheer and the rest of the committee. Thank you for your time this afternoon. I am Matt Fisher, M-a-t-t F-i-s-h-e-r, I'm the superintendent for the Northwest Schools in Grand Island. I'm also currently serving as the NRCSA, the Nebraska Rural Community Schools Association president. And I have distributed a letter from Dr. Jon Habben who is executive director for the NRCSA organization. And I think as you'll see in the letter there from Dr. Habben, the NRCSA organization is opposed to LB78. And I think many of the concerns that Mr. Christiansen just expressed are especially true for the Rural Schools Association. The statement that was made as far as size matters in the insurance business I think is very relevant to those schools that are smaller across the state. And I think that one of the very positive things that the current statute and the EHA pool, which is a by-product of that statute, is the stability that is provided for our rural schools across the state. Obviously, in our situation at Northwest and Grand Island Public and us at the time that they began promoting this bill, discussed us being a part of that pool. And certainly that would be something that we would pursue if we did not have the EHA option. And obviously in our part of the state where we do have the Kearneys and the Hastingses, that we could pool together and create a very large stable pool, it might be doable. Most of my experience has been in western Nebraska where communities are much "farer" spread apart and much lower numbers. And I think that that certainly would increase the difficulty of putting together a viable pool. And so I think that having the EHA being as stable as possible, which is where it's at and it's under the current statute, I think is critical for rural schools. One of the...as we discussed legislative issues with our school board at Northwest this has been a topic of discussion. And one of our board members...many of them are farmers and they have had to deal with the instability of going out and finding their own health insurance and the changes that have currently been going on with the health care across the nation. Our board president this past year saw a jump in his insurance premium of over 25 percent and he certainly expressed his concern of what that would do to our school budget if we were faced with those same kind of increases in terms of premium. And as Mr. Christiansen mentioned, the EHA had a premium increase of less than 2 percent this past year and has been very stable over the years. And so, again, I think that's a very important reason for us keep the current statute in place and not erode the value of that EHA pool. I think in terms of...we're in the same situation that Grand Island Public talked about in terms of our employees not having a local hospital. Again, local is a little bit of a relative term. Since I'm from western Nebraska, we've got three or four hospitals within 20 miles and that would be a luxury out there. But our employees, it's a concern for us and I think it's very unfortunate that these two private businesses have been unable to reach an agreement. And I think it would be very unfortunate if

that dispute caused us to change the legislation which has been very good for schools. Thank you. [LB78]

SENATOR SCHEER: Thank you, Superintendent Fisher. Are there questions? Seeing none, thank you very much. Welcome, Mr. Bourne. [LB78]

PAT BOURNE: Good afternoon. Senator Scheer and members of the committee, my name is Pat Bourne. For the record, that's spelled Pat, P-a-t, and Bourne, B-o-u-r-n-e. I'm a senior vice president for sales and account services at Blue Cross and Blue Shield of Nebraska and I'm here today to testify in opposition to the extension of self-funding for health insurance pools formed for political subdivisions of the state. Coincidently, when I served in the Legislature I sponsored the amendment that adopted the language that LB78 would strike. And I'm here to tell you why that earlier decision by the Legislature was correct and why it should stand. And also for the record, when I adopted that amendment I did not work for Blue Cross and Blue Shield of Nebraska. I worked for a carrier and sold long-term care, but the principles of insurance are sound regardless. Not coincidently, I'm here today to provide information on the relationship between the Educators Health Alliance and Blue Cross and Blue Shield of Nebraska. Blue Cross covers the 77,000 members of the EHA under a fully insured plan, meaning that Blue Cross and Blue Shield of Nebraska is on the risk if losses exceed premiums. While we've had a long and productive relationship, there's nothing that would require the EHA to remain a Blue Cross insured. So while we have a strong interest in protecting our members covered by the EHA we also have an interest in the functioning of a private sector health insurance, so onto LB78. The Nebraska Intergovernmental Risk Management Act is not what allows units of local government to pool their health insurance risk. Local governments can pool health benefits now under existing law if they buy a regulated insurance product. The act doesn't give the ability to use self-funding. They can already do that under a different section of law. What LB78 does is allow local governments to combine pooling with self-funding and get an exemption from many insurance laws in our state. It is the combination of pooling with self-funding and no consumer or very few consumer protection provisions that creates the risk for Nebraskans either as members insured under the policy or the taxpayers who fund those benefits. Pooling and self-funding or, to put another way, assuming risk, is about the simplest way to describe insurance. Insurance is heavily regulated and it should be because people can get hurt without good financial regulation. Insurer rates are regulated, networks are regulated, and maximum levels of administrative costs are also regulated. When an insurer gets into financial trouble unpaid claims are paid by the Nebraska Guaranty Association financed by assessment on Nebraska's insurers, just as we are seeing today here in Nebraska with the bankruptcy of the CoOportunity Health plan. Only a few of the standards apply to pools, like for investments and claim settlements. Under section 44-4315, pools under the act are not an insurer under the laws of the state. They don't offer insurance to insurers supplied to the pools and, most importantly, they are not members of the Guaranty Association. If they run into financial difficulty--and we have seen that

before and not just with CoOportunity--there is no guaranty fund coverage to protect those members and their employers. As to the pooling act itself, it doesn't include the same consumer protections that are required for private sectors who pool and self-fund risk under the MEWA law, the multi employer welfare law. There aren't even the same safeguards there in the statute for single public employers who self-fund on their own when they are still clearly on the hook for the claims. More thought should have been given to those protections when the law was expanded to include health. And if the act is extended to potentially apply to 77,000 Nebraskans, there will be some work to do in that regard. As an insurer, Blue Cross and Blue Shield of Nebraska can tell you there is a strong argument to be made for pooling. Encouraging pooling is one of the key features of most of the health insurance reform ideas that have come before states over the years. Allowing employers to create pools is usually pointed to as the way to improve the predictability of claims and reduce administrative costs. Advocates say that it increases negotiating leverage with the insurer and it does, and I'll tell you that it's true when it's done well. The Educator(s) Health Alliance plan does it well and has for a long time. The EHA is exactly what pooling advocates are describing, but it does it with a thoroughly regulated plan that protects the interests of their members in having strong financial stability. Creating competition for EHA under the underregulated entities reduces the size of the pool so it substantially increases risk to Nebraskans and reduces the leverage the EHA to bear. This will increase the cost of coverage and those costs are paid by the taxpayers. So why put the EHA and its nearly 50 years of success in jeopardy? No one can tell you with any seriousness that there would be lower rates with the same or better coverage. Representing a company with the most thorough claims experience in our state, I'm here to tell you it's not true; rates will not be reduced. While I immensely respect the proponents of the bill, I don't believe that we should put the EHA in jeopardy because of our current dispute with CHI. I share in their frustration that the dispute is not settled, but ask why we would put 50 years of success in jeopardy over a near-term contract dispute. I'm asking that the bill would be indefinitely postponed. [LB78]

SENATOR SCHEER: Thank you, Mr. Bourne. Questions? Senator Williams. [LB78]

SENATOR WILLIAMS: Mr. Bourne, as I understand the EHA today, it's pooled but it is not self-funded. [LB78]

PAT BOURNE: That's correct. [LB78]

SENATOR WILLIAMS: You're taking the risk. Blue Cross Blue Shield is taking the risk, setting an amount of premium, determining from that the underwriting in doing that. [LB78]

PAT BOURNE: Correct. [LB78]

SENATOR WILLIAMS: Are you aware of any situations where there is a pooling arrangement that is also doing the self-insured portion? [LB78]

PAT BOURNE: I'm not aware of any today that are successful. It's been tried, there's been a number of them that have gone bankrupt. But I'm not aware of any of them today that exist. [LB78]

SENATOR WILLIAMS: Okay. [LB78]

SENATOR SCHEER: Other questions? Mr. Bourne, you made the comment that Blue Cross is not one and the same as EHA, so you...Blue Cross has a contract to provide those services for Blue Cross. If this is a dispute, then what is the opt out in that contract? If things are not resolved, how long a time period does your contract serve the EHA or as far as if you can...for whatever reason you can't get along, the opportunity to the EHA to find a different provider? [LB78]

PAT BOURNE: Right. So, the contract renews annually. We negotiate a rate on an annual basis. But there are provisions in the contract that any school district could leave on 30 days' notice, so you could leave. And just for the record, again, Grand Island Public Schools could leave with 30 days' notice. They could self-fund by themselves. They could pool if they created an insured pool or they could stick with the EHA. So, I mean, there are options. [LB78]

SENATOR SCHEER: So your contract with the EHA is only a one-year, rollover contract. Would that be correct? [LB78]

PAT BOURNE: Exactly. [LB78]

SENATOR SCHEER: Okay, thank you. Any other questions? Senator Campbell. [LB78]

SENATOR CAMPBELL: Thank you, Chairman Scheer. Mr. Bourne, the counties' NIRMA is a pool, but it's not self-insured? [LB78]

PAT BOURNE: Okay, so NIRMA is property and casualty insurance, not health insurance. [LB78]

SENATOR CAMPBELL: Not health. [LB78]

PAT BOURNE: And there's a huge difference because at the end of the day, if I may, the difference between the property and casualty and the health is that ultimately the county would pay the claim for the property and casualty claim. But if this pool were to go bankrupt or disband, you as the user of the health care are ultimately responsible for that claim. So if you were insured through Grand Island or a pool that's self-funded and it goes bankrupt, Grand Island doesn't raise taxes or do whatever it takes to pay that claim; that claim is on you. And that's the risk. [LB78]

SENATOR CAMPBELL: Right. Thank you. [LB78]

SENATOR SCHEER: Any other questions? Don't see any. Thank you, Mr. Bourne. [LB78]

PAT BOURNE: Thank you. [LB78]

SENATOR SCHEER: Any other opponents? Seeing none, are there any that wish to speak in a neutral capacity? Seeing none, Senator Gloor. [LB78]

SENATOR GLOOR: Thank you. Good questions. Clearly, the committee was paying attention. A lot of discussion about the pricing. And understand that I believe the Grand Island Schools go into this recognizing the fact that were they to get their way--well, I shouldn't say it that way--were they to have the availability to go in and take a look at pricing, they may come up with a more expensive insurance product than they get through the EHA, but at least they'd be able to use the local medical community. I mean, what's the price of being able to use your local health care providers? I would expect that the utilization of health services through the Grand Island Public Schools this past year will be a stellar record because people aren't able to go in to see their physicians, go into the hospital. I mean, this has caused that degree of people not being able to seek care. It has to affect utilization numbers. Yet, it's not likely to show up in pricing for them. The issue here isn't the cost. The issue here is access. And the opposition for this, never once in the opposition was there some sort of recognition of the fact that as I said in my opening statement, the days of having a statewide network and expecting best pricing...every hospital, every therapist, every physician, the days of having that kind of network are numbered. And the difference of opinion between Blue Cross as an insurer and CHI as a health care provider group are, I think, just the beginning of other sorts of challenges like this that are going to be out there. If nothing else, the EHA needs to be taking a look at the reality of this and deciding what are they going to do the next time this crops up and the time after that. I mean, think of our ability to go down the street and shop at or eat at a McDonald's or a Burger King. You go to the fountains there and you get either a Pepsi product or a Coke product. You don't get both. And the reason is because corporately they sat down and made decisions about which product would offer them the best pricing if they turned all their pumps over, of all their fountains over to one or the other.

And that got them best pricing. They don't offer you both products because they can't give you best pricing. And what's going to happen in our health care industry is, you are going to get best pricing, which also will be defined in part I think as quality outcomes since there's a cost associated from bad care. You're going to find smaller networks that sell themselves as offering best pricing, but it won't include every hospital in a community or every physician in a region. That's where health care is headed in this country and it's not the fault of the Affordable Care Act, it's some of the pressures that are coming to bear on the health care industry and some of the pressures that are coming to bear I think on the insurance industry. That's where the future is headed. The days of the EHA continuing to have a statewide network that includes every hospital and every physician are numbered. And what that means for its pricing, I can't tell you. But what it does mean is, they're going to have to be accommodations to that model. And so far, whatever accommodations may be out there have not been brought forward to help communities like Grand Island, Kearney, Nebraska City, and Schuyler, and others that are sole community provider, places where people don't have a choice to go to. There are other hospitals close to Grand Island and Kearney. Those hospitals refer to Grand Island and Kearney. They are the referral hospitals for critical access. You have a heart attack in Grand Island, you don't go to Central City or St. Paul or Aurora to see the cardiologist because the cardiologists reside in the hospital in Grand Island. Part of the challenge in this process is, it's not as neat and clean as described. So, it's a problem. And if nothing else, hopefully this bill and the discussion about it will raise the red flag to the extent that at least the EHA will start taking a look at its model and realize that it's slowly but surely becoming antiquated. Thank you. And I'd be glad to answer any final questions. [LB78]

SENATOR SCHEER: Questions? I have one, Senator. I apologize I didn't see most of it so if it's been answered, you know. But the concern I would have is putting--in this case we're talking about teachers--so based on this bill, the potential of a teacher going in for whatever type of major surgery, long-term, high-cost procedure, it not being funded well enough. And so it goes into bankruptcy and you now have the individual teacher being held financially responsible for those bills. There's the balancing act as well, the inconvenience of having to drive 30 miles perhaps in this case for those services. And I get it, that that's an inconvenience. But I also look at the inconvenience of someone that was assuming they were going to have health care that was paid for and provided via their contract with the district and at some point in time the possibility of them getting a bill and literally bankrupting the staff member by virtue of that. That's a real...that's a justifiable concern as well. [LB78]

SENATOR GLOOR: I would agree it's a justifiable concern. But, Senator Scheer, in all due respect, you've jumped about ten years down road assuming that...the problem for the Grand Island district right now is, they can't even really sit down and analyze the numbers that would allow them to avoid that kind of mistake. They can't...as they've told me, they've talked to some other districts who have said, yes, we're very interested, but there's no reason to talk to you as

long as the statute is in existence. So what they're looking for is, can we at least sit down and pursue this without the statute that's out there that basically says, no, they can't. And armed with the ability to talk with others and armed with consultants and the opportunity to crunch some numbers, I think they'll make good decisions, hopefully as good of decisions as EHA has made because they have been successful. No argument here that EHA hasn't been successful. My argument is that EHA, in it's all inclusiveness, now has in fact fenced out a number of people that it purported to have covered and provide coverage to, can't access their local medical community. So your concern is well taken, but it would be nice to at least give the district enough opportunity to pull together some numbers and see whether there's...it's even within the realm of possibility. [LB78]

SENATOR SCHEER: Okay. Any final questions? If not, that will close the hearing on LB78. As noted, we'll take a five-minute break and take up the next two bills. So we will reconvene at 2:40. [LB78]

BREAK

SENATOR SCHEER: Thank you all and we are now reconvened and our next bill is LB257. Senator Nordquist. [LB257]

SENATOR NORDQUIST: Great. Thank you, Chairman Scheer, members of the Banking (, Commerce) and Insurance Committee. I'm State Senator Jeremy Nordquist from District 7 in downtown and south Omaha, here today to introduce LB257, a bill dealing with telehealth services. LB257 would require insurers to provide upon request to a policyholder, a certificate holder, or a health care provider a description of the telehealth or telemonitoring services covered under the relevant policy or contract. The purpose of telehealth is to reduce disparities in access to care, enhance physician availability, improve quality of care, reduce health care costs, and create an innovative payment and service model design. To be clear, telehealth is not a specific medical specialty, but rather a larger investment by health care institutions through information technology and the delivery of clinical care. Last session I introduced and passed legislation that included telemonitoring in the definition of telehealth, allowed for the use of store and forward and remote patient monitoring, and eliminated a limitation that we had in Medicaid where you had to be outside of a 30-mile radius for telehealth services to be reimbursed. The bill as it was originally introduced also contained a requirement that private insurers provide parity when it comes to telehealth services, essentially saying if you pay for a service in person, that bill would have required that you make the same payment if that service is provided through telehealth. A number of states do have that policy. At the time that bill faced opposition from the insurance industry, it actually was referenced to the Health Committee. It didn't come before this committee last year because of the Medicaid portions in the bill. So we

removed the parity requirement and with the agreement that we would work on the issue over the interim. And a number of parties came together and in working together the agreement kind of came forward, the issue came forward that providers unfortunately don't always have clarity and sufficient information about what insurers do and do not cover when it comes to telehealth services. So this requirement certainly would help create greater transparency so our health care providers, the hospitals, the doctors, have more clarity on what services would be reimbursed if provided through telehealth services. It's a small step forward, probably not as far as ultimately we need to go to make sure telehealth services are available and reimbursed for statewide. But it is a very good starting point for us. And I'd appreciate the committee's consideration and support of the bill. Thank you. [LB257]

SENATOR SCHEER: Thank you, Senator. Questions? Senator Craighead. [LB257]

SENATOR CRAIGHEAD: Thank you, Chairman Scheer. Senator Nordquist, could this be positively construed as the start of a statewide shared information network for providers throughout the state? [LB257]

SENATOR NORDQUIST: Shared information? Are you thinking like a health information exchange? [LB257]

SENATOR CRAIGHEAD: Example: Someone gets an MRI in Hastings and a month later goes to Kearney to get one done. So that information from the first one could be utilized instead of a second MRI. [LB257]

SENATOR NORDQUIST: Right. So that...those pieces are already...there is already the NeHII system in place that would serve...would help connect electronic medical records in that capacity. This is more just on the reimbursement side. If we had true telehealth parity, like some states do, you would be telling insurance companies, if I go to see a--I guess we just pick mental health--counselor that my insurance would pay for for me to see in person, we would require them to also make the same reimbursement if I saw that person via Skype, essentially. We didn't go that far and we're not going that far with this bill. All we're saying under this bill is that the insurer, if asked, needs to be clear and provide clear documentation to the provider of if that service is covered. So that way, providers know and they'd just have more clarity in that so they're more willing to provide services through telehealth. [LB257]

SENATOR CRAIGHEAD: Thank you. [LB257]

SENATOR NORDQUIST: Yep. [LB257]

SENATOR SCHEER: Senator Williams. [LB257]

SENATOR WILLIAMS: Thank you, Senator Scheer. Senator Nordquist, how would this bill help the rural parts of our state? [LB257]

SENATOR NORDQUIST: Right. Well, certainly we know that telehealth services overall is very much a...the focus on it around the country has really been on reaching out to rural areas to making that connection where, for instance, if you're an individual discharged from a hospital and you need to have...we made in Medicaid...Medicaid now reimburses for remote patient monitoring, for example. If you live 50 miles away, the hospital can now send you home with diagnostic tests that whether it's taking your blood pressure or anything else, that can be transmitted to the hospital rather than you making that drive in. Or if you're a Medicaid patient we often provide transportation for those individuals as well. It obviously saves a lot of money. If it's a physician in Omaha, obviously there's a number of services that can be provided through telehealth services out to all over the state, and a number of people behind me can talk about that which is already going on in Nebraska. But until we get a little more clarity and the providers feel more comfortable with what they can get reimbursed for...because that's been the problem and the limitation on telehealth across the country up till now is that it's been slow to get the reimbursements in place. And now we made a big step last year in the state with making sure Medicaid is reimbursing for these pieces where we haven't put the private parity piece in place, but trying to make providers more comfortable with providing those services and making sure they can get reimbursed for those services will certainly help improve access to those services in rural Nebraska. [LB257]

SENATOR WILLIAMS: Thank you. [LB257]

SENATOR SCHEER: Other questions? Just one, Senator Nordquist. What we're really talking about is, going back to your mental health example, if I'm the counselor or psychologist or psychiatrist, whichever the case might be, what we're really saying is that if I'm going to treat Joe Blow then I call the company and say, I might be treating Joe Blow and policy number. What is the reimbursement? Can you give me...so I don't go into the hole to begin with and then send the bill and then they say it's not covered. [LB257]

SENATOR NORDQUIST: Right. That's the clarity that we need for providers to keep moving it forward. [LB257]

SENATOR SCHEER: Okay. [LB257]

SENATOR NORDQUIST: Thank you. [LB257]

SENATOR SCHEER: Are you staying around or... [LB257]

SENATOR NORDQUIST: Yeah, I'll be here. Yep. [LB257]

SENATOR SCHEER: Okay, thank you. Okay, I would entertain those that are proponents to the legislation. Good afternoon. [LB257]

ANN FROHMAN: Good afternoon, Mr. Chair, members of the committee. My name is Ann Frohman, for the record that's spelled A-n-n F-r-o-h-m-a-n, and I am here to testify in favor of this bill on behalf of the Nebraska Medical Association. We have worked with Senator Nordquist and applaud his efforts here. He has worked diligently on telehealth, telemonitoring and a number of areas. And we recognized last session that there could be some dynamics in place that we think we could find a meeting of the minds with the insurance industry to get to a more palatable response than what was proposed last year for the private sector piece of this. It's there for the Medicaid portion, behavioral health, it started out with children, and so this just is what I call the third bucket. Medicare has telehealth pieces as well. And so the physicians members feel that this would be a very good opportunity to get a comfort level developed so that the information that is out there...once it's out there and you get this game going where we all develop a comfort level, then as Senator Craighead said, we get into the use through NeHII. So this is kind of the front end of all of that...of that approach. And as we develop our telehealth uses, rural is what's driving this. We've had...Senator Gloor, you know, and Senator Campbell, we have spent a lot of time before the Health and Human Services Committee trying to find a way to get the delivery of health care to move forward in the state, to move forward in the rural areas to recognize and find ways to fill the gaps of our providers that are retiring. And we have those concerns and so we spend a lot of time in dialogue on how do we do this and do it right? And we know that this is a start, as Senator Nordquist said, but we think it's a good approach to open the door and get everybody comfortable with it. It's law light, a light touch point in many respects, but we're dealing with technology. And with technology, you don't want to spend too much time trying to craft regs because it's a moving target and we recognize that. So we didn't think it was a matter of parking this in an agency to do something. You know, we think this is clean and would work well for everybody, all the stakeholders involved. [LB257]

SENATOR SCHEER: Thank you, Ms. Frohman. Senator Gloor. [LB257]

SENATOR GLOOR: Thank you, Chairman Scheer. Ann, had there been any...well, remind me. Part of the challenge with telehealth is, you've got a person on the sending end and a person on the receiving end and only one of them traditionally gets paid. To get involved in both getting a

piece of the action gets into the fee splitting prohibitions that we've got. Is that still as big an issue or are there inroads that are slowing being made on recognizing telehealth requires looking at things a little different from a reimbursement standpoint? [LB257]

ANN FROHMAN: Yes, I think they couch it in the phrase of transmission costs and trying to wrap a process around that. And currently I know I think Medicare has been dealing with that. Medicaid, I think they left...maybe it wasn't Medicaid, maybe it was Child Behavioral Health. They left that in the Department of Health and Human Services here and I'm not sure if...I know they drafted a reg. I'm not sure it was ever enacted, but I think they're getting there with it. I don't think it's quite an issue that it was, but I can't say for certain that it's been resolved entirely. [LB257]

SENATOR GLOOR: Okay. Thank you. [LB257]

SENATOR SCHEER: Thank you, Senator Gloor. Any other questions? Seeing none, thank you very much. [LB257]

ANN FROHMAN: Thank you. [LB257]

SENATOR SCHEER: Any other proponents? Good afternoon. [LB257]

MANDI CONSTANTINE: (Exhibits, 1, 2, and 3) Good afternoon. I'm the person who had the coughing fit in the back so I'm going to have to have my bottle of water up here. Chairman Scheer and members of the Banking, Commerce and Insurance Committee, I'm Mandi Constantine, that's M-a-n-d-i C-o-n-s-t-a-n-t-i-n-e, for the record. I'm the executive director of Telehealth for Nebraska Medicine in Omaha, Nebraska. I'd like to thank you for the opportunity to present information regarding reimbursement for telemedicine and share where other states are headed in efforts to update their legislation on coverage of telehealth services. I'm here today to testify in a supporting position for this bill. Telehealth is a means of communication between patients and their health care providers, using telecommunication technology to provide medical services and education to patients when the care provider and the patient are in separate locations. Today with the help of telehealth tools like remote patient monitoring, doctors can monitor and communicate with patients and keep updated with all their health information on a daily basis. Telehealth can also be used in urban areas in situations you may not have considered until a few months ago, when Nebraska Medicine received our first Ebola patients. Just as we used telehealth in those situations, if infectious disease broke out in rural Nebraska, physicians throughout the state could use telehealth technologies to consult with physicians at UNMC, the CDC, and around the world. The field of telehealth is growing at a rapid pace. Two months ago PR Newswire reported: The worldwide telehealth industry is expected to grow at a rate of almost

19 percent by 2019, with a telehome segment experiencing the fastest growth at an annual growth rate of almost 22.5 percent by 2016. Research studies since the 1980s have demonstrated that telehealth services provide comparable care to in-person visits, improved costs, and result in high patient satisfaction. However, reimbursement is continually noted as a significant barrier to the widespread adoption of telehealth by such organizations as the National Rural Health Association, the American Telemedicine Association, and HRSA. Today not all telehealth costs are reimbursed and there is no single widely accepted standard for private payers. Some insurance companies value the benefits of telehealth and will reimburse a wide variety of services, while others have yet to develop comprehensive reimbursement policies and often require prior approval for telehealth. The November 14 issue of Medical Economics reported 40 percent of clinicians surveyed stated their practices had not been reimbursed for telemedicine services. State legislatures have made telemedicine a priority for this year. In the American Telemedicine Association handout that I've provided, committee members will note that as of February 6, 28 states have introduced telehealth legislation ranging from defining practice standards to establishing home telehealth payment reform. And six states have introduced telehealth parity legislation. Since 2011, 22 states and the District of Columbia have passed legislation requiring private insurance plans to cover telehealth services the same as an in-person visit. Although private payers are starting to cover telehealth services, difficulty getting reimbursed through insurance companies hinders providers from adopting telehealth. The proposed legislation in LB257 to require "insurancers" to provide policyholders, certificate holders, or health care providers a description of the telehealth and telemonitoring services covered is a step forward in Nebraska's attempt to remove barriers to telehealth reimbursement and to aid in the adoption of telehealth throughout our state. For insurers to provide a description of covered telehealth and telemonitoring service would not be a difficult task. The Department of Health and Human Services Centers for Medicare and Medicaid Services publish a telehealth service Rural Health (Clinic) Fact Sheet series every year that includes two pages on covered services, billing, and reimbursement. I've provided a copy of this to the committee members for their review and that's on page 3 and page 4 of the purple handout. In summation, LB257 appears to be in step with recent legislative changes and current proposals in many other states seeking to make telehealth much more viable as a tool in the health care delivery system. Thank you for this opportunity and I'll answer any questions you may have. [LB257]

SENATOR SCHEER: Thank you. Questions? Senator Gloor. [LB257]

SENATOR GLOOR: Thank you, Chairman Scheer. Dr. Constantine, would you take a shot at answering my question to Ms. Frohman about this issue of fees and how we get fees paid on both ends of the telehealth? [LB257]

MANDI CONSTANTINE: Medicare reimburses what they call an originating site fee. It's about $24.83. And that goes to the site where the patient is originated from. If a patient has Medicare

that has a telehealth visit, you can actually file for reimbursement for that fee and it's included in that purple handout that I gave you. The state does not reimburse, Medicaid does not reimburse for that fee at this time. And different insurers either reimburse or don't reimburse. [LB257]

SENATOR GLOOR: But the full fee...let's say I'm a family practitioner located in community A and I want to consult with an ENT that's in community B. So the family practitioner would get the $24 and the full fee for whatever the negotiated... [LB257]

MANDI CONSTANTINE: The pro fee will go to the consultant. [LB257]

SENATOR GLOOR: ...fee was...yeah, the clinical fee goes to the consultant. [LB257]

MANDI CONSTANTINE: Yes, sir. [LB257]

SENATOR GLOOR: Okay. Thank you. [LB257]

MANDI CONSTANTINE: You're welcome. [LB257]

SENATOR SCHEER: Senator Williams. [LB257]

SENATOR WILLIAMS: Thank you, Senator Scheer. Ms. Constantine, we're talking about the money end of this right now. Switch gears for just a second. The availability of providing these services across our state is there generally, right? [LB257]

MANDI CONSTANTINE: Yes, sir. [LB257]

SENATOR WILLIAMS: So we have that. It's just figuring out how we handle the money. Would it be a fair statement to say, if we can figure that out, we're actually going to spend less money? [LB257]

MANDI CONSTANTINE: I would say there's actually two things. It's the reimbursement piece and the educating people on how to get reimbursed and what services are covered. So when you can cover those two things then, yes, I think that you will. I think this state spends over $4 million a year in transporting people around the state for routine medical care. And I think that's money that you could probably put a portion of that to better use somewhere else. [LB257]

SENATOR WILLIAMS: Thank you. [LB257]

MANDI CONSTANTINE: You're welcome. [LB257]

SENATOR SCHEER: Other questions? Thank you, so much for (inaudible.) [LB257]

MANDI CONSTANTINE: You're welcome. [LB257]

SENATOR SCHEER: Any other proponents? Welcome. [LB257]

JOHN LINDSAY: Senator Scheer and members of the committee, I was the other person coughing in the back of the room. My name is John Lindsay, L-i-n-d-s-a-y, appearing as registered lobbyist on behalf of Blue Cross Blue Shield. Eric Dunning was going to testify, but he had to catch a plane and he had to get up to the airport in Omaha. We are appearing in support of LB257. Last year was a different approach. We were opposed to that because it would have mandated coverage. Blue Cross had the opportunity to work with Senator Nordquist and his office and the Nebraska Medical Association heard that the providers...we needed to eliminate any confusion on the part of providers about what exactly is covered. And this approach appears to be a fair mechanism for doing that, both fair to the providers and fair to our members. So we are in full support of the bill. [LB257]

SENATOR SCHEER: (Exhibits 4 and 5) Thank you, Mr. Lindsay. Any questions? Seeing none, thank you very much. Any other proponents? If not, I would note that we have two letters of support from the Nebraska Hospital Association and The Nebraska Board of Medicine and Surgery. We would now open it to those that would be opponents to the bill. Seeing none, are there any that wish to speak in a neutral capacity? Seeing none, Senator Nordquist. Senator Nordquist waives closing, so that will end the hearing on LB257. We will now move to LB553. Senator Gloor. [LB553]

SENATOR GLOOR: Chairman Scheer and members of the Banking, Commerce and Insurance Committee, thank you. My name is Mike Gloor, G-l-o-o-r. This is my third trip with a different reiteration of the bill I brought here twice before. This committee advanced the bill twice before and it was approved by the Legislature twice before, but we continue to need to tweak this legislation. It's a bill to stop a practice that dentists were starting to see from prepaid dental plans. The problem practice was created when dental plans started telling dentists they had to limit charges on services that were not covered at all under the contract with the dentists. So we thought we'd prohibited this practice in statute, however, our earlier bills did not stop the practice in its entirety. So we've come back with a further tweak to see if we can't further define the parameters in this issue. LB553 defines when dental services are considered to be a covered service by a policy, certificate, contract agreement, or a plan as a service for which full reimbursement is provided. Services for which full reimbursement is not provided would be a

noncovered service. We hope this new definition will stop prepaid dental plans from telling dentists they can only charge a certain amount for services that were never intended to be covered and are not covered under the contract. In other words, the services are covered, however, the dentists are being told, you're limited to the fee schedule that we provide. LB553 also states that an alternative benefit is allowed for noncovered services and that a dentist may bill for the difference between their charge and the corresponding reimbursement or alternate benefit. An example would be, when a patient needs a crown and is considering to have the crown made of gold or porcelain. His decision is often made when a plan says, we will only pay for the less expensive crown made of gold. If a patient then determines they want a porcelain crown instead, the dentist can provide that porcelain crown and bill the patient for the difference between the reimbursement they got from the insured for the gold crown and the cost of the porcelain one. Again, this committee has heard this bill twice in the past and, hopefully, the third time is a charm. I'll be glad to answer any questions about the bill. [LB553]

SENATOR SCHEER: Any questions? Clarification when you're talking about services that aren't provided. So if I go into the dentist and I have a filling, that's a covered procedure and they're going to reimburse the dentist for $150. And I need a bridge, for example, and that may not be covered under the policy. But under the fee schedule it says, if it were, you'd be reimbursed for $500. They're saying, okay, but you can only charge Jim $500 for that because it's on the fee schedule, but it wasn't ever intended to be covered. Is that... [LB553]

SENATOR GLOOR: Yeah. It was never part of your plan, but...it's piggybacking. [LB553]

SENATOR SCHEER: Okay. [LB553]

SENATOR GLOOR: At least my definition of it is a nonlegal term, piggybacking. [LB553]

SENATOR SCHEER: Okay. Anything else? Thank you. [LB553]

SENATOR GLOOR: Thank you. [LB553]

SENATOR SCHEER: Are there proponents for the bill? Good afternoon. [LB553]

DAVID O'DOHERTY: (Exhibits 1, 2, and 3) Good afternoon, Chairman Scheer and members of the committee. My name is David O'Doherty, O-'-D-o-h-e-r-t-y, I'm the executive director of the Nebraska Dental Association which represents about 75 percent of dentists in the state. We'd like to thank Senator Gloor for introducing LB553, regarding an issue we thought we'd addressed two years ago with LB810. But after LB810 passed, we started seeing two scenarios appearing.

And I'm passing out actually three handouts. The first one is what you heard about before, it shows a picture of a crown. And the plan will cover a basic crown, basically metal. But many patients don't want to see a big chunk of metal in the back of their mouth so they opt for the porcelain crown. But the plan doesn't cover the porcelain crown. And behind this sheet--when you get it--you'll see examples of three EOBs that will clearly say under the notes, the plan does not cover any porcelain, but we are providing an alternate benefit, which is the price of the metal crown. So that's...clearly the EOB is admitting that it's not a covered service. And what this bill is trying to address is that sure, it's great the insured gets a benefit, but it's not the full benefit. Basically, they're getting a free upgrade from a basic crown to a much more expensive porcelain crown. The second handout are three examples that I found in dental benefit plan books that addresses the alternate benefit. And it basically says, you and your dentist may choose for a more expensive treatment, but you will be responsible to pay the difference, which is not surprising because if you're getting a superior product you should pay a higher fee and not get it for the base price. So that's what paragraph 3 in the bill is attempting to do. The second handout...I'm going fast because I'm just getting here. I'll try to slow down so you can see that...so the sheet that has the crown on the front, behind that sheet has three examples of EOBs where it says the plan doesn't cover that particular procedure, but we are providing an alternate benefit. The second handout on the top of it has alternate benefits highlighted. And those are three examples from different dental plan benefit booklets that explains how the alternate benefit would work, that sure, your dentist and you may decide on a more expensive procedure, but you're going to be responsible for the difference in price. The final handout is the second example that we've been running into. It shows--I'm sorry, it's the Delta. It's actually from a Delta benefit handbook--it runs into...it talks about benefits and frequency limitations. That's on the top righthand side and that page shows all of the things that are not covered under that particular plan. And on the bottom of that sheet, paragraph 25 described this pretty clearly. And it's the best I've ever found. You are not covered for any service that otherwise would have qualified as a covered service, but which Delta does not reimburse to some extent. That usually shows up in frequency limitations like two cleanings a year, someone comes in for a third. Or if there's a maximum amount of benefit to the plan, $1,000, $1,500, or $2,000. Once you've hit that limit, the insurance company and the company are no longer contributing to your benefit. So our thought is, if they're out of the game, then why is the dentist still in the game providing discount if the insurance company is providing absolutely no benefit to the patient? So those are the two examples that have come up...primary examples that have come up in the last two years. We recognize that a lot of states have adopted...it's called NCOIL model language. But we've looked at that language and it does not address either of these situations appropriately. So we've looked at all of the statutes that have been changed in the last three or four years and none of them really address this situation, oddly enough. So we really didn't have much to copy from. So we are still...this is still an evolving area, in Nebraska anyway, that the alternate benefit and the frequency limitations, annual maximums, are the two areas that still we think violate the noncovered services statute as passed last year. I'd be happy to answer any questions. [LB553]

SENATOR SCHEER: Any questions? Senator Williams. [LB553]

SENATOR WILLIAMS: Senator Scheer. Just to make that clear then, the legislation as drafted right now covers all of those circumstances, all of the ones that you've talked about? [LB553]

DAVID O'DOHERTY: As it currently exists in statute or the bill? [LB553]

SENATOR WILLIAMS: The bill. [LB553]

DAVID O'DOHERTY: The bill, we believe. There's going to be...in paragraph 2 we had a concern...was it raised in line 17 where it says, service for which full reimbursement is actually provided. One of the insurers was concerned that that meant full reimbursement came from the insurer, when oftentimes it's a combination of 20 percent from the patient, 80 percent from the insurer. So we're working on language to help clarify that. But we believe... [LB553]

SENATOR WILLIAMS: So we may see an amendment on... [LB553]

DAVID O'DOHERTY: You may see an amendment to paragraph 2 that just clarifies that it's still full reimbursement, but it might come from two different spots. [LB553]

SENATOR WILLIAMS: Okay, thank you. [LB553]

SENATOR SCHEER: Any other questions? Seeing none, thank you very much. [LB553]

DAVID O'DOHERTY: Thank you very much. [LB553]

SENATOR SCHEER: Other proponents? Seeing none, are there any opponents to LB553? Seeing none...oh, excuse me. A little quick at the switch, sorry about that. Welcome back. [LB553]

ANN FROHMAN: (Exhibit 4) Good afternoon again. My name is Ann Frohman, for the record that's spelled A-n-n F-r-o-h-m-a-n, and I'm here to testify in opposition to LB553 on behalf of Ameritas Insurance Corp. Ameritas, as you may know, is a large employer and insurer of dental plans both in the state of Nebraska and in the nation. They work with over 225,000, approximately, employers in the state of Nebraska providing dental plans and services to Nebraskans. The primary concern that Ameritas has with respect to this bill is that it doesn't necessarily provide much of anything other than confusion, in our opinion. First of all, the

definition of covered service that's currently in place provides a recognized definition that is workable in the insurance industry context for the purposes of administration of claims. But it does not behoove us to change that definition to pick up something that's unique and not recognized nationally. It's not recognized in insurance language. Covered service is a term of art and when you take it and say covered service now means something other than what an ordinary person would say is a covered service, you really have created a lot of confusion. So there's a concern there. Our second concern is, it would be unique to Nebraska, it would be administratively burdensome for the insurance company. And then when you have those sorts of issues, when you're talking IT and you're talking technical changes. But the real concern we have with this bill today is that it is fairly anticonsumer. And if you spend time looking at it--and I didn't catch it in the beginning when I was going through all of the bills as we were looking at them--it has a scenario that essentially says this: If a dental plan such as Ameritas is going to contract with a provider of dental services--and they negotiate these contracts--and in that negotiation the insurance plan provides access to their employers and their groups, there's a lot of flow of business that comes in. In exchange for that the provider agrees to negotiate on the rates and on what the coverages are. So what this bill does is says this: Well, we want to change the definition of covered service such that, with respect to let's say a crown, silver crown versus a porcelain, we would like to be able to charge not what we have agreed to in the contract, but whatever we would like to charge. And so what we have provided you is a copy of a letter that shows, for instance, if an enrollee wants to have a porcelain crown and chooses to do so as an option, what you're looking at is an increase to the consumer, significantly. Why does Ameritas care about that? Well, they care about that because they're in the business of trying to not simply provide dental coverage, but to control costs. And, in essence, what this does is circumvent that such that the individual will be paying substantially out of pocket more than they would have paid otherwise. And that's a reflection on everybody because then the enrollee will call up the insurance company and say, well, why aren't you paying more. And then, well, in fact, we had negotiated our rates and this is a statutory change around that so that you are paying more. You, the consumer, you know. So that is really what we think is happening here. And attached to the letter is some recommended language. It is the NCOIL language. It is in 30 states. We're fine with what the law says now, but if you felt a need to change the definition of covered services, we would suggest going with a uniform definition. I think it doesn't get the proponents where they need to be, but it does put some uniformity in there. [LB553]

SENATOR SCHEER: Any questions? Senator Craighead. [LB553]

SENATOR CRAIGHEAD: Thank you, Mr. Chair. Hi, Ms. Frohman. Were you speaking in opposition or neutral today on this? [LB553]

ANN FROHMAN: Opposition. [LB553]

SENATOR CRAIGHEAD: Opposition? Okay. I have a question. Is the term covered service different for dentists versus physicians? [LB553]

ANN FROHMAN: I would say, no. Under this bill, yes. [LB553]

SENATOR CRAIGHEAD: Okay. Thank you. [LB553]

SENATOR SCHEER: Real quick, when you or when Ameritas contracts--and you may or may not be able to answer this, I understand because you're representing them today--but would they negotiate with an association, for example either Nebraska or Iowa or Kansas Dental Association for the contract to provide these services or are these services contracted on an individual either clinic or dentist? [LB553]

ANN FROHMAN: It's not association based as far as I know. It's based upon the clinics within the group of dentists. [LB553]

SENATOR SCHEER: So any dentist that signs the contract, literally is agreeing to do whatever is in that contract. So we're changing...rather than changing contract language, we're changing statute language. Is that a fair assessment? [LB553]

ANN FROHMAN: They can negotiate now, if that's what you're... [LB553]

SENATOR SCHEER: Yeah, I mean, they have the capacity to change the contract. [LB553]

ANN FROHMAN: Yes. Yes, it is a negotiated contract is what it is. And then there's also the option is if you don't...if you're not interested, you can also go outside of a contract. You know, there are insurance carriers--one that I used to work for--that offers nonnetwork, nonemployer-based opportunities for coverage. So that's there as well. [LB553]

SENATOR SCHEER: Okay. Thank you. Any other questions? Seeing none, thank you very much. Any other opponents? Good afternoon. [LB553]

GALEN ULLSTROM: (Exhibit 5) Good afternoon, Chairman Scheer, members of the Banking, Commerce and Insurance Committee, my name is Galen Ullstrom, that's G-a-l-e-n U-l-l-s-t-r-o-m. I'm senior vice president and registered lobbyist for Mutual of Omaha Insurance Company appearing today in opposition to LB553. Senator Gloor mentioned that this bill or parts of the bill were up, I think, once in 2010 and once in 2012. We did not appear against those bills at that

time because they basically provided that if a service was not covered, an insurer could not limit the charge that a provider makes for that service. And we took that to mean the general definition of a noncovered service, which is something that is excluded from coverage under the policy. As stated by Ms. Frohman, this language--specifically on line 16 and 17 of the green copy--would say it's a noncovered service if full reimbursement is not made on a per claim basis. So we would say that that would prohibit us from applying deductibles, coinsurance, copays, or other limitations. Virtually, no service is covered at 100 percent. And so if this language is as is, it would be a noncovered service if we paid 80 percent of the claim, which would then allow under this bill the provider to not follow the bill charges and do whatever charge you wanted. I understand from Mr. O'Doherty that they might be changing this language to talk about copays and deductibles, but it still would not address what we also have in our policy, which are service limitations. He actually mentioned them. For example, if you get two routine visits a year, two fluoride treatments, four bitewing x-rays, if you go for a third, they're now--the provider in a provider situation, preferred provider--is bound to charge that regular charge, the charge they've agreed to. If this wasn't there, two times you'd get billed one thing. For the third service, not covered by the plan, you could get charged anything that the provider wanted to charge; the consumer would. Now we would not pay any more, but that would be a bill to the consumer and we think that's not right. The same thing would apply if you have an annual limitation in total coverage. A lot of policies, and ours included, have an annual limitation of $2,000 a year. That's based to keep the cost down. This bill would say, okay, you're subject to those charges for the first $2,000. But once the $2,000 ends up and the insurance company no longer pays, that's a noncovered charge and we can charge anything we want. And I think that certainly is not in the consumer's best interest, the way we look at it, and think it would go a long way to changing things. We think the NCOIL model, which is what I have also passed out, this amendment would address those situations. And we think it is uniform. And it does not provide the relief that Mr. O'Doherty wants, but it provides a uniform definition, if we need one in Nebraska, of what a noncovered service is. So it's a concern. Again, it's not...this is one of those unique things that by the passage of this green copy bill, we are not paying more as a company, but the consumer is paying more. And if you look on the medical side, as you know you get an explanation of benefits when you submit a claim. The first column usually says "bill charge." The second column usually says either "adjusted charge" or "allowable charge" and there can be a significant difference between the bill charge and the allowable charge. And then your copays and whatever else are taken off the allowable charge. On the dental side, it's not as extreme. It may be only a 20 percent discount that's negotiated. On the medical side, it could be 50 percent or 60 percent difference between the bill charge and the other charge. And so it could have a significant ramification if this definition of covered service was put in statute, in our estimation, so. With that, I'd be glad to answer any questions. [LB553]

SENATOR SCHEER: Thank you. Senator Williams. [LB553]

SENATOR WILLIAMS: Thank you, Senator Scheer. Galen, if we...under the NCOIL language, does that take care of the copay and deductible issue? [LB553]

GALEN ULLSTROM: It does. It takes...plus it also takes care of the waiting, the annual, lifetime, and the frequency limitations because it's specifically pointed out. It does. [LB553]

SENATOR WILLIAMS: Thank you. [LB553]

SENATOR SCHEER: Any questions? Just one for myself, anyhow. What is a...give me an example of a noncovered procedure. I mean, would dentures be a noncovered... [LB553]

GALEN ULLSTROM: Dentures can be one or replacement of dentures or breaking of dentures, correcting dentures. There can be some on... [LB553]

SENATOR SCHEER: That's okay. We'll go with, I'm going in and getting dentures. [LB553]

GALEN ULLSTROM: Right. [LB553]

SENATOR SCHEER: Regardless if it's the first thing I do during the year, I've got to get dentures. Now is that on your registered fee list even though it's not covered? [LB553]

GALEN ULLSTROM: No, that would be an excluded service under our plan and, therefore, it...by the original law as passed two years ago, we could not put a limitation on that and they could bill anything they wanted. [LB553]

SENATOR SCHEER: Okay. So if it's something that you are not going to have the potential to pay anything, you cannot determine the price that the client would be purchasing. Okay. [LB553]

GALEN ULLSTROM: Correct. That's correct, per the existing law. Yeah, that's correct. [LB553]

SENATOR SCHEER: Okay. Okay, thank you. Seeing nothing else, thank you very much. [LB553]

GALEN ULLSTROM: Thank you. [LB553]

SENATOR SCHEER: Welcome back. [LB553]

JOHN LINDSAY: Thank you, Senator Scheer and members of the committee. For the record, my name is John Lindsay, L-i-n-d-s-a-y, appearing as a registered lobbyist on behalf of Blue Cross Blue Shield. Rather than being redundant and repetitive, I would just concur with what the last two witnesses have talked about. We also did not object to the last two renditions of this...the last two times it was introduced. We do object, though, to the same paragraph. Our concerns are resolved with the same amendment, with the NCOIL amendment. [LB553]

SENATOR SCHEER: (Exhibit 6) Okay. Thank you. Any questions? Seeing none, thank you, John. Any other opponents? Seeing none, is there anyone in a neutral capacity? Seeing none, Senator Gloor...waives closing. So that will end...well, wait a minute. I have one letter of opposition from the National Association of Dental Plans, and with that, that will end the hearing on LB553. Thank you all for coming. [LB553]