Business and Labor Committee
March 06, 2017

[LB147 LB319 LB408 LB609]

The Committee on Business and Labor met at 1:30 p.m. on Monday, March 6, 2017, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB609, LB408, LB319, and LB147. Senators present: Joni Albrecht, Chairperson; Sue Crawford, Vice Chairperson; Ernie Chambers; Steve Halloran; Matt Hansen; Sara Howard; and John Lowe. Senators absent: None.

SENATOR ALBRECHT: Good afternoon. Can everybody hear me okay? Yes? My name is Joni Albrecht. I'm the Chairman of Business and Labor and...Business and Labor. I'm not Business and Labor. Yes, I am. Business and Labor Committee. Sorry about that. I have committee members to introduce to you today. First, we'll start with Senator Hansen, if you'll just introduce yourself, please.

SENATOR HANSEN: Yeah, Matt Hansen, District 26, northeast Lincoln.

SENATOR HALLORAN: Steve Halloran, District 33, Adams County and southern and western Hall County.

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

MEGHAN CHAFFEE: Meghan Chaffee, committee counsel.

SENATOR CRAWFORD: Senator Sue Crawford from LD45 which is eastern Sarpy County, eastern Bellevue, and Offutt.

SENATOR LOWE: John Lowe, Legislative District 37 which is the southeastern part of Buffalo County.

SENATOR CHAMBERS: Ernie Chambers, District 11, Omaha.

SENATOR ALBRECHT: Thank you. And we have...to my left we have Beverly Neel is our committee clerk. And where are my pages? They're hiding. Oh, there's one. Okay. Is Lee-Ann over there too? No? Oh, she'll be here. Okay. Well, we have Lee-Ann Sims who's a sophomore at UNL studying political science and global studies. And our other page is Toni Caudillo who is a sophomore at UNL studying elementary education. Sorry. I better get back with my stuff here. Okay, a few housing items to take care of, please turn off any cell phones. Senators, note of

course that the microphones are sensitive and are unable...are able to pick up side conversations. Testifiers should have the appropriate number of copies and handouts with you and ready for distribution. The Business and Labor Committee requires ten copies. Each witness appearing before the committee must sign in using the forms provided at the entrance of the hearing room. Sign in only if you're going to testify. Your form must be given to the page before you begin presenting your testimony. Each testifier will be allotted five minutes before the committee. That might change once we get started here because I need to find out how many we're going to have talking today. We use a light system: Green indicates that you may begin, yellow indicates that you're nearing the end of your time, and red indicates it's time for you to end the testimony. Please begin your testimony by stating your name clearly into the microphone and then please spell your first and last name to ensure accuracy for the record. Note that the committee members may need to leave in the middle of the hearing as they might have a bill to introduce in another committee, so do not be offended if the senators come and go. Today's agenda, I believe you saw it when you walked in, but we'll be going in the order of LB609, LB408, LB319, and LB147. We will have the introducers make initial statements, followed by the proponents, then opponents, and those providing neutral testimony. Closing remarks will be presented by the introducing senator. So up first we have Senator Lou Ann Linehan introducing LB609. And I should ask real quick for a show of hands testifying on LB609. It will be three minutes. I have four others with several others, so we'll have three minutes of testimony after this. Lou Ann...I'm sorry, Senator Linehan. [LB609]

SENATOR LINEHAN: (Exhibits 1 and 2) Good afternoon. Chairman Albrecht, members of the Business and Labor Committee, my name is Lou Ann Linehan, L-o-u A-n-n L-i-n-e-h-a-n. I'm the senator from Legislative District 39 and here today to introduce LB609. LB609 which would create a workers' compensation Medicare plus medical fee scheduled for outpatient hospital and ambulatory surgical center services, similar to fee schedule applicable to inpatient hospital and inpatient hospital trauma services. I was approached by representatives of the Nebraskans for Workers' Compensation Equity and Fairness earlier this session who expressed concern over the matter in which reimbursement for outpatient and ambulatory surgical center services related to workers' compensation cases is determined. I was informed the medical cost component of total workers' compensation costs in Nebraska was high compared to other states in our region and to the nation as a whole. I also learned that existing workers' compensation medical fee schedules for outpatient hospitals and ambulatory surgical centers allow these facilities to be reimbursed on a fees, less a percentage discount basis with no clear understanding of what the fees are. Until 2008, inpatient hospitals were reimbursed in workers' compensation cases on the same fees less a percentage discount basis. At that time, the Legislature adopted a Medicare plus system of reimbursement for inpatient hospital services and four years later implemented the system for inpatient hospital trauma services. The Medicare plus system of reimbursement has controlled costs for inpatient hospital and inpatient hospital trauma services and I believe the same reimbursement system should be extended to outpatient hospital and ambulatory surgical center

services. I've handed out a chart that illustrates the problem that exists in our current system. In the first example, charges for an emergency room visit at eight Omaha area hospitals vary from 77 percent above Medicare to 385 percent above Medicare. The second example reflects the charges for a back injection at three of Omaha area ambulatory surgical centers with the charges ranging from a low of 100 percent above Medicare to a high of Medicare plus 306 percent. I have spoken to hospital representatives since introducing LB609 and they have suggested that it would severely harm their operations. I found I was confused by that because the bill as you will tell...as you can see doesn't determine the percentage of the markup above Medicare reimbursement rate that is to apply. I purposely left the provisions of the bill blank because I do not want to presuppose what the appropriate level of reimbursement should be. In closing, under the current system the reimbursement levels for outpatient hospital ambulatory surgical centers are on the rise. Employers have no way to predict the level of reimbursement that will apply in a particular case, cannot direct whether their employees utilize a facility that imposes low charges or high charges, and are at the mercy of a system that allows the facility to determine and increase its level of reimbursement by simply increasing its charges. I would encourage the committee to act favorably on LB609. And while I would be glad to address any questions of the committee, there are witnesses who will follow me that are better able to answer any technical questions. Thank you. [LB609]

SENATOR ALBRECHT: Thank you very much. Do we have any questions from the committee? Senator Hansen. [LB609]

SENATOR HANSEN: Thank you, Senator Albrecht, and thank you, Senator Linehan, for coming before us today. I guess my question stems from kind of a fundamental policy question of...and I'm not an HHS Committee member. Medicaid, Medicare stuff is not necessarily my forte. But if the problem is that healthcare costs in the state of Nebraska are rising, why would we just for this one group of employees limit the choice of providers and the cost to providers? [LB609]

SENATOR LINEHAN: Okay, so I'm not the expert, but I'm going to take a stab at it because once in my life many, many years ago I did sell insurance and I did work on these issues for a number of years. Most if not...not all. I can't say that. But many, many charges at a hospital as paid by insurance companies is based on Medicare. So if Medicare pays $100, Lincoln National Life may pay $140. Blue Cross Blue Shield, they're charges are based on negotiations between the hospitals and the insurance companies and they're frequently based on Medicare charges. So it gives somebody the idea of the risk. When you don't know what your charges are going to be it's very hard to figure out what the risk is going to be and then you can't fund against your risk. [LB609]

SENATOR HANSEN: Okay. So would this bill allow that than for workers' compensation carriers to negotiate rates? [LB609]

SENATOR LINEHAN: Right, that's exactly...that's why it's...okay, it would allow for a rate to be set. So if you have an employee who breaks their arm and they get services, what is that going to cost? So there's a chart of fees that everybody knows ahead of time what the costs are going to be. That's the way I understand it. And someone behind me may correct me. [LB609]

SENATOR HANSEN: Sure. Absolutely. Thank you. [LB609]

SENATOR LINEHAN: You're welcome. [LB609]

SENATOR ALBRECHT: Any other questions? Senator Howard...Crawford. You two, I do this to you all the time. Sorry. [LB609]

SENATOR CRAWFORD: Thank you, Chairwoman, and thank you, Senator Linehan. I have a...one of my questions in just looking at this and thinking about the policy logic of the approach is that it looks like that we're basing...we're going to...if I understand it correctly we'd be basing what we're paying based on the understanding of what Medicare pays plus some adjust...so we're thinking about what we should be paying something similar to what Medicare pays for some of these same procedures. [LB609]

SENATOR LINEHAN: Well, generally speaking I think mostly...generally everybody pays more than Medicare pays. I shouldn't say everybody. I don't have exact figures. But when an insurance company negotiates with a hospital or doctor's office, it's Medicare plus. So it could be Medicare...and if you look at the...they kind of tried to show you on the chart that I handed out--hopefully I have a copy of it here--what the Medicare...what Medicare pays for a certain procedure and then what the charge was. So if you're...very rarely...well, I shouldn't say rarely, but it's not the norm for somebody to walk in and need a hospital's services or a doctor's services and pay cash out of their pocket. There's usually some kind of insurance involved. And even if it's you pay the $1,000 deductible, it's added up towards what your insurance company is going to pay. And then when the insurance company starts paying, it pays a fee according to what pre-negotiated cost so everybody knows going in what your expenses are going to be so you can actually through...and I am not an actuary, but know if you have 100 people employed what the risks are they're going to get hurt or what the risk of them going to have cancer or heart attack. And then you insure yourselves up to what you think that risk is going to be. It's what your premiums are based on. You have some...it's a matter of figuring out what the costs are so you can figure out what you have to pay for premiums. [LB609]

SENATOR CRAWFORD: Right, so the base is that and then we're...my concern is that we make...and I'm trying to find, you said that part of what the markup would be... [LB609]

SENATOR LINEHAN: There's not a number in there because... [LB609]

SENATOR CRAWFORD: Oh, okay. [LB609]

SENATOR LINEHAN: ...I'm hopeful that workers' comp and the hospitals will figure out what the appropriate fee is... [LB609]

SENATOR CRAWFORD: What the appropriate markup, yeah. [LB609]

SENATOR LINEHAN: ...because they know more about...yes. And I do, you know...everybody deserves to get paid for the services they provide. So they do...it wouldn't be Medicare. It would be Medicare plus. [LB609]

SENATOR CRAWFORD: Okay. So a concern would be that population would be very different than a younger working population in terms of costs or what that might look like in terms of the kinds of...and so my concern is that we wouldn't base our payment on something that makes sense for an elderly population for a program that we have in our state that's younger workers. So the other people following might also help understand that issue. [LB609]

SENATOR LINEHAN: Well, I think the younger...the cost is going to be dependent upon how many people actually use it. So it's a matter of how many people get hurt, because it's workers' comp, at work. And hopefully everybody is working to make sure as few as possible to zero get hurt on the job. That saves everybody money. But they should through experience be able to figure out how many people may get hurt and what...so they know the number they should by experience know what the number is probably going to be. So what they're looking for here is the cost to put against that number. And right now there's not a cost, a for sure cost, that they can calculate it on. [LB609]

SENATOR CRAWFORD: Right, and this is wanting to establish a rate. [LB609]

SENATOR LINEHAN: A cost, not the rates. What I understand...I'm probably digging myself a very deep hole here. The way I understand it, it's the cost. We're trying to figure out the cost. [LB609]

SENATOR CRAWFORD: For the health procedure. [LB609]

SENATOR LINEHAN: Yes. [LB609]

SENATOR CRAWFORD: That would need to be paid. [LB609]

SENATOR LINEHAN: That would need to be paid by workers' comp. [LB609]

SENATOR CRAWFORD: And tagging that, the base tag for that's going to be the Medicare rate. [LB609]

SENATOR LINEHAN: Right. [LB609]

SENATOR CRAWFORD: But it's going to be more than that, and that's going to be some of the conversation is, how much more? [LB609]

SENATOR LINEHAN: How much more. [LB609]

SENATOR CRAWFORD: Thank you. [LB609]

SENATOR LINEHAN: Thank you. [LB609]

SENATOR ALBRECHT: Any other questions? Senator Chambers. [LB609]

SENATOR CHAMBERS: I listen to you young folks talk about us old folks as though we're not here. (Laughter) But as I listen to this, it probably would be cheaper if we would just go ahead and die, more or less, shouldn't hang around lingering. [LB609]

SENATOR LINEHAN: If they're healthy, if they're a healthy elderly person that's great. [LB609]

SENATOR CHAMBERS: Okay. Thank you. [LB609]

SENATOR LINEHAN: You're welcome. [LB609]

SENATOR ALBRECHT: Any other questions? Senator Howard. [LB609]

SENATOR HOWARD: Thank you, Senator Albrecht. Oh, you got it right. Solid start. Thank you, Senator Linehan, for bringing this bill to us. I wanted to clarify, so your aim is to address the cost issue. It's not to address whether or not...so for instance, Medicare really depends on the location of the service--so a hospital versus an ambulatory care center versus an outpatient facility. Your aim is for the cost of the service regardless of the location? [LB609]

SENATOR LINEHAN: No, no. They would cost...my aim is to have a cost that is known. [LB609]

SENATOR HOWARD: Okay. [LB609]

SENATOR LINEHAN: So if you're a businessperson, and all of us have some kind of just in our own normal lives, it's so you know what your cost is going to be or to the best of your ability. So when they figure out what our insurance rates are here they have an idea what their costs are going to be and then we all divide it up equally and pay for those costs, so that those are based on certain things. If we have Blue Cross Blue Shield, they know how much they're going to pay. If I have a heart attack and I'm have to go to the emergency room and they have to put in a stint, Blue Cross Blue Shield, if I go to Methodist they know what they're going to pay Methodist. And most of our procedures are...most of the hospital business is done that way. Workers' comp is not...this part has not gotten to that where they know ahead of time what the costs are going to be. It's not to limit anybody's ability to get coverage. [LB609]

SENATOR HOWARD: No, more I'm trying to reach into, so for instance...I'm trying to think of something. If I go to the emergency room for something that could have been handled in a primary care office it will be more expensive in the emergency room because of the location of the service. Is there an issue here with that? [LB609]

SENATOR LINEHAN: I don't think so but I will leave that to somebody behind me because I would assume if you get hurt on the job, you know, hopefully what happens and I would assume this happens, you go to the place that is most likely will take care of you. And if it's hurt on the job it probably would be an emergency, but maybe not. [LB609]

SENATOR HOWARD: I think maybe for your ongoing services. More I'm trying to think of the outpatient and I'll ask a testifier behind you... [LB609]

SENATOR LINEHAN: Thank you. [LB609]

SENATOR HOWARD: ...but it's the outpatient, the rate for the service, and the location for the service. And I think it's a location issue that we might run into, not the rate. If we're trying to set the rate, that's perfect as long as there are no issues with the location of where there's service. [LB609]

SENATOR LINEHAN: No one spoke to me about location issues. [LB609]

SENATOR HOWARD: Perfect. Thank you. [LB609]

SENATOR LINEHAN: I don't think we're talking about that. [LB609]

SENATOR HOWARD: Okay. Great. Thank you. [LB609]

SENATOR LINEHAN: Thank you. [LB609]

SENATOR ALBRECHT: Senator Halloran. [LB609]

SENATOR HALLORAN: Thank you, Chairman. Thank you, Senator Linehan. I see you...and I'm trying to add a little bit of levity to the issue a little bit. But I see that you conveniently left out the names of the hospitals. [LB609]

SENATOR LINEHAN: Yes. [LB609]

SENATOR HALLORAN: I wonder if you'd share that with me privately so I know where to go. (Laughter) [LB609]

SENATOR LINEHAN: We'll see. [LB609]

SENATOR ALBRECHT: Any other questions? I have just one. Are we talking about more the metropolitan areas? Are you also talking...it shows 51 beds, licensed beds in Section 1. [LB609]

SENATOR LINEHAN: It is more the metropolitan areas if I recall right. And again, people behind me will know better. But hospitals with 50 licensed... [LB609]

SENATOR ALBRECHT: Fifty-one licensed beds. [LB609]

SENATOR LINEHAN: There's three tiers. And the one...we're only talking about tier one and tier two. I can read them to me if you want. Tier one is hospitals and licensed ambulatory surgical centers "located in or within fifteen miles of a Nebraska city of the metropolitan class or primary class" and all hospitals and ambulatory centers located outside the boundaries of the state Nebraska shall be tier one facilities. The fee under the schedule for tier one shall be...and then tier two: hospitals with 51 or more licensed beds and not classified under tier one and a licensed ambulatory surgical centers located in or within 15 miles of a Nebraska city of the first class shall be tier two facilities. And the hospitals with 50 licensed beds or less not classified under tier one, all critical access hospitals, licensed ambulatory surgical centers not classified under tier one or two shall be tier three and they are not included in this, tier three. So I think...does that answer your question? [LB609]

SENATOR ALBRECHT: Yes. Thank you. Will you be sticking around for close? [LB609]

SENATOR LINEHAN: I'm actually going to duck out and then may come back. It depends on what's happening in Education Committee. [LB609]

SENATOR ALBRECHT: Very good. Thank you very much for your testimony. [LB609]

SENATOR LINEHAN: Thank you very much. [LB609]

SENATOR ALBRECHT: So we shall start now with the proponents, anyone wishing to speak to LB609. And again, we'll go three minutes. [LB609]

ROBERT HALLSTROM: (Exhibit 3) Chairman Albrecht, members of the committee, my name is Robert J. Hallstrom, H-a-l-l-s-t-r-o-m. I appear before you today on behalf of both the Nebraskans for Workers' Compensation Equity and Fairness and the National Federation of Independent Business in support of LB609. I've also been authorized to sign in on behalf of the Nebraska Trucking Association. Given the limited time period that we have, what I will do is summarize my testimony. I've covered a great deal of ground in my written comments. Senator Linehan has talked on what the bill does, which is to establish a Medicare plus fee schedule for outpatient hospital and ambulatory surgical centers similar to that which already exists for inpatient hospital and inpatient hospital trauma services. The problem that our members have identified is we have a "bill what you will, less a percentage discount" system that's in place which was the same system that applied for inpatient at inpatient hospital trauma services before about eight years ago when we went to a Medicare plus system for both of those settings. The Medicare plus for inpatient hospitals under law is set at Medicare plus 50, or a 150 percent, and 160 percent is for inpatient hospital trauma services. On page 2 of my testimony are the distinguishing factors between tier one, tier two, and tier three hospitals and ambulatory surgical

centers. Like the inpatient hospital and inpatient hospital trauma law, we are trying to apply this to the tier one and tier two facilities. With regard to the problems that we face in Nebraska, as Yogi Berra would suggest, it's deja vu all over again. When we first went down the path of inpatient, trying to do something different on inpatient services, we were looking at the same bill--charges less a percentage discount. We had data at that time that showed that comparable services in the same hospital setting for a work comp and a non-work comp procedure were sometimes two to three to four times higher if you happen to have a work-related injury. And that was kind of the discrepancy that we were hoping to address there and would like to similarly do that in this particular area. I have charts attached to my testimony that show that Nebraska has a disproportionate or comparatively high percentage of its cost on the medical cost component side of total benefits running 5-8 percent above the regional and nationwide averages in those various categories, including having a higher percentage in the outpatient hospital and ambulatory surgical center areas. On page 5 of my testimony I've indicated from some studies that I've noted that the bill charges reimbursement system that we have in Nebraska is not effective at controlling cost and that states like Nebraska that base it on bill charges less a percentage discount are experiencing the fastest or the highest growth rates in their outpatient hospital and ambulatory surgical center areas. I'd also...and Senator Linehan had in her testimony if you'd turn to page 8 of my comments, we show the vast variation that currently exists, the ability where the provider is setting the bill charges. I've shown eight separate emergency rooms in the area, Omaha area, that range from 180 percent of Medicare up to 384 percent. Similarly not to leave ASCs out of the mix, we show a back injection procedure for three ASCs in the Omaha area that range from 100 percent above Medicare to...100 percent of Medicare to 306 percent above Medicare. So those markups are significant, they vary significantly, and they're a direct result of not having a system, as Senator Linehan pointed out, to give us anything that lets us know what the ultimate cost is going to be. And that's basically what we think the Medicare plus. I've noted a number of states that have already adopted this type of approach that have seen their cost factors reduced by going to a Medicare plus. Again, we didn't want to come into this setting presupposing what Medicare plus ought to be, but from the data that we've received we believe that currently hospitals and ambulatory surgical centers are probably being reimbursed above 200 percent, probably in the 225 to 235 percent range above Medicare and would like to see something done effectively. In closing, what I'd suggest is please don't be frightened by the complexity of this issue. We've been down this path before and it was just as complex when we took on the inpatient hospital and the inpatient hospital trauma setting. And don't be alarmed by the level of concern that the hospitals and ambulatory surgical centers are going to provide for you today. I can tell you back in 2007 or '08 when we first started down the inpatient hospital that they were more alarmed because we were asking them initially to set it at the same rate as their lowest cost healthcare reimbursement and we worked it out. So, be happy to address any questions. [LB609]

SENATOR ALBRECHT: Thank you very much for your testimony. Anyone have a question for Mr. Hallstrom? Senator Hansen. [LB609]

SENATOR HANSEN: Thank you, Chair Albrecht. Mr. Hallstrom, thank you for coming. I guess my question kind of stems from kind of we're talking about the cost of healthcare in Nebraska is the I guess the fundamental issue here. And, you know, with the terms of different prices in terms of different hospitals, different surgical centers isn't it possible that they would all have different costs of input to give them the different amounts? [LB609]

ROBERT HALLSTROM: That could be a factor, Senator. And I will note given the complexity of this issue we have utilized some folks that have been through this practice before that are from a company primarily based out of Minnesota, SFM Mutual, who will be coming up for technical questions in a neutral capacity. But what we're looking at in this particular area, Senator, is I think it may be fair and some people can certainly question this but I think in general what I've heard over the years is when you look at the issues of reimbursement for hospitals in particular that if you look at Medicaid they're probably going to suggest, and perhaps rightfully, so that they're being reimbursed below their cost in that particular area. Medicare is maybe a little bit below cost, perhaps closer to breakeven. They have some pretty good leverage from some of the health insurance companies that maybe they have some profit on but it's ratcheted down. This is an area where there's really not much control over the ultimate costs that are paid by the employer and we're not certain that it ought to be foisted for that to be more of a percentage profit center, if you will, than the other ones. But with regard to the cost differentiations, there may be some factor. I just can't see that they're that great to see the differentiations that are in my testimony chart. [LB609]

SENATOR HANSEN: Sure. Well, I guess I'm just kind of trying to figure out, take a more holistic approach. I appreciate what you said--some of it is more technical concerns coming up. But it seems to me so that we're...and you're representing the Federation of Independent Businesses among others. It seems to me here that we're kind of asking one group of businesses in order to control their costs or trying to set a price ceiling on another group of business. And that just...I'm just trying to figure out how that process kind of works between the two. [LB609]

ROBERT HALLSTROM: Well, I mean it's something that is not unique to Nebraska if we were to adopt it, Senator. I think there's been somewhere in the neighborhood of 20 to 25 states with both this type of fee structure reimbursement to bring some certainty into the setting. And it's designed again without presupposing the percentage that ought to apply in Nebraska. I think that's something that over time we'll be able to hopefully work out with the parties that are going to come up on the other side of the issue today. [LB609]

SENATOR HANSEN: Sure, no, and I appreciate the...actually the very explicit we're willing to negotiate the percentage if the idea moves forward. But I'm just I guess focusing on the main framework of this, because you talk about, you know, we want certainty in cost, you know, in order presumably to control the cost of the businesses that you represent. But I'm thinking if...I assume a lot of ambulatory surgical centers are small, independently owned businesses, are they not? [LB609]

ROBERT HALLSTROM: I would imagine some of them are. [LB609]

SENATOR HANSEN: And so I'm trying to figure out how that...if we're looking out for businesses, just the one side, by harming other business interests potentially. I'm trying to balance that. [LB609]

ROBERT HALLSTROM: Well, and, Senator, I don't know that we've got the same small, independent business owner type situations. I assume the ASCs are actually owned either by hospitals or a group of physicians, something of that nature might be a little bit different than the traditional small business, main street business. [LB609]

SENATOR HANSEN: Okay. Well, I'm sure they'll come up and give their side, so. [LB609]

ROBERT HALLSTROM: And they certainly can and will. [LB609]

SENATOR HANSEN: So we'll go from there. Thank you. [LB609]

ROBERT HALLSTROM: Thank you. [LB609]

SENATOR ALBRECHT: Thank you, Senator Hansen. Any other questions? Seeing none, thank you. [LB609]

ROBERT HALLSTROM: Thank you. [LB609]

SENATOR ALBRECHT: Good afternoon. [LB609]

ROBERT BALL: (Exhibit 4) Senator Albrecht, members of the committee, thank you. My name is Robert Ball, R-o-b-e-r-t B-a-l-l. I'm the medical administrator at Hormel Foods in Fremont, Nebraska, and I'm here in support of LB609. Our exhibits are being handed out to you and in the essence of time I'm hoping that some of those exhibits will able to answer some of the questions

that you've been asking as well. The first example that I have provided which we have marked exhibit 1 provides some typical examples that are illustrative of the application of that fee schedule to inpatient hospital services. As you can see, the applicable fee schedule results in an approximate 50 percent reduction in those charges. We believe that the fee schedule as it is currently applied to inpatient hospital services provides predictability and consistency in what employers are required to pay for similar services regardless of what facility renders them. However, in our experience with outpatient hospital services rendered by ambulatory surgical centers, it has been less consistent. Under the present fee schedule for outpatients services, the employer is required to pay a percentage of the bill charges. This means depending on what facility renders those services, the fees charges are only subject anywhere from a 4 percent to a 15 percent discount of the bill charges. Because the bill charges are...they vary widely from facility to facility, there's a lack of consistency in those bill charges as well as the amount the employer is required to pay, illustrative of exhibit 2 which are some examples of bills and fee audits from the outpatient services. In those two examples you will see that these charges are subject to a much lower discount. The first example is a rotator cuff surgery and the original charges for which were $12,620.78 which were reduced to $9,931. And the reduction was only...excuse me, and the second bill is for an outpatient discectomy procedure and the original charges for which were $14,667 and the reduction was only approximately $2,200 resulting in approximately $12,500 being owed on that bill. Comparing the examples in exhibit 1 to the examples in exhibit 2, the difference that result from the differing fees schedules applicable to inpatient and outpatient services is definitely quite apparent that it's different. Additionally, we see a wide variation of how facilities charge for similar procedures. Example 3 is illustrative of a common billing practice that we see which is multiple charges for similar procedures all performed at the same time with the same facilities. The patient in question has bilateral wrist and finger surgeries. The left-sided surgery was performed first consisting of a left carpal tunnel release and a left trigger finger release. While there were two procedures performed during the operation--they were performed at the same time in the same OR--it would not appear have the...have resulted in the use of the facility being greater or different. However, Hormel was charged $1,400 for the carpal tunnel surgery an additional $1,600 for the trigger finger for the use of the OR, same OR in that facility. The patient then had a right-sided surgery which involved right carpal tunnel release and right release of three trigger fingers. As you can see from the billing, Hormel was charged almost $1,400 for the carpal tunnel release and an $1,600 per finger for the trigger finger procedures. And again, these were all performed in the same OR that would not seem to require any additional use of the facility at that time. The total charges for the left-sided surgery was almost $3,000 and the right-sided surgery was billed for a total of over $6,000. It does not appear that there would be any great difference in the use of those ORs for those similar procedures, but the variation in the billing is considerable. The fourth example of exhibit 4 is that of a patient who underwent a right surgery, shoulder surgery that required the use of a surgical anchor. The invoice from the manufacturer showed the cost of anchor was approximately $300. However, the surgical center billed Hormel $1,300 for the surgical anchor.

Additionally, that bill illustrates additional charges for two procedures that were part of the same arthroscopy and would not appear to require the use of the facility to be any greater if only one process was performed during that surgery. The fifth example...fifth exhibit shows the inconsistency in the amounts an employer is required to pay for similar procedures based upon which facility the procedure is performed. The procedures involved in exhibit 5 involve charges for rotator cuff surgeries that were similar in nature. Both procedures were performed at tier one facilities which are paid at 92.5 percent of the bill charges. However, the procedure dated September 18, 2014, was performed at a hospital while the procedure on February 20, 2015, was performed in an outpatient surgery center. There is some variation in total charges between the two, some of which is due to the September 18 procedure including anesthesia services as well, whereas the 2-20 procedure does not. However, nonetheless, when the application of that fee schedule is examined, the difference between the two become apparent. The total charges of September 18, 2014, procedure was approximately $27,500 and were reduced pursuant to the fee schedule to approximately $22,600. However, the reduction in the billing for the 2-20-15 procedure was much greater, reducing the bill from approximately $21,000 to approximately $12,000. The reason for this is simply because the procedure that was performed at the hospital is not subject to an additional 50 percent reduction on the additional surgical procedure that was performed during the same operation. Thus you can see that there were additional reductions in the 2-20-15 procedure that were not applicable to the September 18 procedure simply because the additional 50 percent reduction does not apply to procedures performed at a hospital. This is a result...this result is inconsistent amounts being paid to the facility simply based on what type of facility it is. Lastly, another thing we commonly see in great variations is billing of the MRIs. Illustrative of this is exhibit 6. These are billings of shoulder MRIs would show a great variation between charges charged by the facilities. The amounts charged for the similar MRIs are $2,250 at a hospital, $650 at a medical provider facility, and $1,600 at an imaging center. The charges for the same service at the hospital is almost four times more than the same procedure performed at the medical providers facility. This illustrates the great variation we see in billing practices among the different facilities. We believe that in applying the Medicare plus fee schedule for outpatient procedures would provide, number one, consistency to Nebraska employers as to the amounts to be paid by similar procedures for their work injury patients. We also believe that applying the fee schedule would provide consistency among the facilities and would help to eliminate the wide variations on what various facilities are paid for similar services. We believe that the bill under consideration will alleviate these billing issues and ask for your consideration. [LB609]

SENATOR ALBRECHT: Thank you. [LB609]

ROBERT BALL: And those examples or exhibits that I've given you, hopefully they'll answer some of your questions as well. [LB609]

SENATOR ALBRECHT: Appreciate that. Questions from the committee? Senator Howard. [LB609]

SENATOR HOWARD: Thank you, Senator Albrecht. Thank you, Mr. Ball, for visiting with us today. This is actually more of a comment. Unfortunately, the blacking out of people's names was not done very successfully on these documents. And so if I might make a suggestion that you take them back so that you don't have any HIPAA liability... [LB609]

ROBERT BALL: Sure. [LB609]

SENATOR HOWARD: ...at the end of your testimony. [LB609]

ROBERT BALL: Yes, ma'am. [LB609]

SENATOR HOWARD: Thank you. [LB609]

ROBERT BALL: Thank you. [LB609]

SENATOR ALBRECHT: Any other questions, any others? Seeing none, we can certainly hand these back in if you don't mind. [LB609]

ROBERT BALL: Yes, ma'am. Thank you. [LB609]

SENATOR ALBRECHT: Next proponent. [LB609]

KORBY GILBERTSON: Good afternoon, Chairman Albrecht, members of the committee. For the record, my name is Korby Gilbertson; it's spelled K-o-r-b-y G-i-l-b-e-r-t-s-o-n, appearing today as a registered lobbyist on behalf of the Property Casualty Insurers Association of America, or the PCI which has carriers that cover about...a little under 50 percent of the workers' compensation coverage in the state of Nebraska. I guess my job today is to talk about ten years ago and why anyone would want to go through this again is beyond me because I think we lived through it once and aged me probably a good ten extra years. But I think Senator Hansen brings up a great issue in your comments on why do we want to treat this one little group of facilities different than other groups? Well, they really...there weren't very many of them back ten years ago when we did the original fee schedule for inpatient hospital services. So this is kind of the last group that's not covered by a fee schedule. So that's why we're talking about this. Hospital inpatient process...inpatient already has to have it. There's already a physician's fee schedule. So

this is kind of the last group that is not covered by a fee schedule. The concern lies when you have employers and I represent a number of self-insured employers that have seen an uptick in workers' compensation cases being shifted over to ambulatory surgical centers or outpatient surgical centers because they do not have to comply with the fee schedule. And so from that standpoint our...we maintain that it needs to be looked at and something that needs to be addressed now. It hasn't been addressed thus far and it took us a couple years to get the other fee schedule done. I don't anticipate that it will take any less time to work something out on this issue. But we maintain that something does need to be done, because when you look at workers' compensation costs we have had a reduction in the number of overall injuries. You have a reduction in the severity of injuries in Nebraska. We have actually pretty good rates in Nebraska that have maintained or even gone down. The one thing that continues to increase in Nebraska are the medical costs. And so this should be addressed by the Legislature. And obviously I think when we did it ten years we held numerous meetings during the interim for two years between two different sessions discussing what would work best because we didn't want to put anybody out of business. At the time when we did the original bill, we were told we would be closing hospitals. Outstate hospitals were going to go belly up because if they had to comply with the fee schedule. That's why you'll see differences in the level of fees for different hospitals and then some hospitals that are exempt from it. I don't anticipate that being any different during these discussions. The issue that I've heard someone else bring up is, why would you use Medicare because it's used for elderly people and it shouldn't apply to this because this is workers' compensation? It is just a basis for setting a fee because there are clear fees set for this. If you look at Section 48-120.04 that is where the fee schedule is established for inpatient hospital services. That's not in the bill. So it's another one of the...and we had a bill I know last week that we talked about. There are issues in...when we talk about the overall fees schedules, there are others covered in other sections of law. So when we look at that we need to look at all of this together, not just at LB609 sitting here in front of us. [LB609]

SENATOR ALBRECHT: What was that number again? [LB609]

KORBY GILBERTSON: It's Section 48-120.04. [LB609]

SENATOR ALBRECHT: Thank you. [LB609]

KORBY GILBERTSON: And that's the hospital...the inpatient fee schedule language. And so that's why...we're looking for a basis to set the fees at, not just trying to pick something out of the air but that...it works for the other fee schedule so that's why it's used in this one also. I'd be happy to try to answer any questions. [LB609]

SENATOR ALBRECHT: Thank you. Do we have any questions? Yes, Senator Crawford. [LB609]

SENATOR CRAWFORD: Thank you. Thank you, Chairwoman Albrecht, and thank you, Ms. Gilbertson, for giving us a little historical perspective on how this compares to other efforts. So I'm glad to hear the good news about workers' comp rates being under control and other costs being under control. Now you noted then that medical costs had increased in Nebraska. So I wonder if you could tell us what rate or what percent medical costs for workers' comp had increased in Nebraska and if we have a rate for this one set of costs that we're talking about related to this bill. [LB609]

KORBY GILBERTSON: And I'm not sure if the court is going to testify on this piece of legislation or not. They only just recently began starting to track information like this. Another organization, National Council on Compensation Insurance, tracks things. And they don't track exactly the information in this because it's never been required to be tracked. But they do do anecdotal studies every year of looking at overall medical costs compared to the severity and number of injuries and I will happily get you their last report. I don't want to give you any false data right now, but I will get a copy of that over to you. [LB609]

SENATOR CRAWFORD: Thank you. [LB609]

SENATOR ALBRECHT: Thank you, Senator Crawford. Any other questions? Seeing none, thank you for coming. [LB609]

KORBY GILBERTSON: Thank you. [LB609]

SENATOR ALBRECHT: Do we have any other proponents wishing to speak? [LB609]

TAD FRAIZER: Good afternoon, Senator Albrecht, members of the committee. My name is Tad Fraizer; that's T-a-d F-r-a-i-z-e-r, representing the American Insurance Association, a national trade association of property and casualty firms that includes worker comp writers. In the interest of both time and temperature, I will simply echo the remarks of the previous testifiers. This policy is already in place for inpatient facilities. It would seem logical to pull in outpatient and ambulatory facilities under the same basically Medicare-based basis that is currently in use. And I would try to answer any questions you might have. [LB609]

SENATOR ALBRECHT: Great. Thank you. Any questions? Seeing none, thank you for your testimony. Any other proponents wishing to speak? Any other proponents? Seeing none, we'll start with the opponents. [LB609]

DENNIS BOZARTH: Senator Albrecht, members of the committee, thank you for allowing me to testify today against this bill. My name is Dennis Bozarth, D-e-n-n-i-s B-o-z-a-r-t-h. I'm an orthopedic surgeon. I've been in Lincoln for almost 29 years. I'm a partner in Lincoln Orthopedic Center here in town. My practice primarily involves care and treatment of injured workers. Workers' compensation arose out of industrialized America in the early 1900s. Workers were getting seriously injured in factories. They were fired for incompetence. Employers were sued for negligence and awards could bankrupt businesses leaving the injured worker still without care or financial help and without a job. A compromise was made back then which was a no-fault system that would provide care for the injured worker in exchange for the worker to forfeit their right to sue for civil damages. Workmen's compensation is not a health insurance. It is an insurance to cover specific injuries, illnesses, or exposures and their treatment and to compensate for financial loss and try to return the worker to his or her life and job as best we are able. It is case specific to the injury goal...and the goal is to restore the employee to as close to preinjury status as we can. LB609 seeks to change compensation for outpatient surgery care to more of a Medicare-based system with an unknown conversion factor to be determined. Medicare, as we have talked about, is a generalized healthcare system for large populations, primarily older Americans, which I am now become, and deals with problems of aging and chronic conditions. The diagnosis of these conditions can overlap with workmen's compensation, for example, rotator cuff tears, but tends to be a system to treat large numbers of individuals with similar pathology, the goals of controlling or treating chronic conditions for as long as possible. The ideal physician for a workers' compensation is one that is willing to accept patients that are covered by workmen's compensation, employ best practices to provide high-quality care, and respect and fulfill the extra responsibilities that the compensation system places on us and creates and also to provide better overall outcomes at comparatively better cost. The best way to treat a workmen's comp injury is timely and efficient care. Outpatient ambulatory centers are able to be more flexible with schedules and adapt to unplanned events making unplanned care available. Large hospital systems are designed for care of full, prearranged surgery schedules with limited flexibility. For example, I schedule my total joint replacements that I do weeks or months in advance. I recently took care of an individual who was injured in a municipality here in Nebraska. This person was seen in the emergency room the day before, came to my office at 11:00 in the morning the next day, taken to the outpatient surgery at 11:50, had surgery at 1:00 p.m., and was dismissed at 3:00 that afternoon. Surgery centers overall are most cost effective and have less complications. Workmen's compensation is a complex system that deals with many stakeholders. At every patient visit, employers' work status...we need to address work status, we need to make copies for insurance companies, request plan updates, we talk to case manager and attorneys. Some studies estimate that in our office that it takes 1.8 times more work for a

physician to treat an injured workmen's compensation. I am a physician but also a business owner and an employer with over 100 employees. I am concerned how this plan will affect reimbursements in an already complicated system. As a surgeon and an owner of a surgical center, this questionable factor may cause physicians to rethink involvement with workmen's compensation and could lead to a decrease in access for care. [LB609]

SENATOR ALBRECHT: Thank you, Mr. Bozarth, for your testimony. Do we have any questions? Senator Chambers. [LB609]

SENATOR CHAMBERS: You mean to tell me that this system can create problems for physicians also? [LB609]

DENNIS BOZARTH: Oh, yes. [LB609]

SENATOR CHAMBERS: Physician, heal thyself. (Laughter) [LB609]

SENATOR ALBRECHT: Any other questions? Seeing none, thank you for your testimony. Any other opponents? Hi there. [LB609]

TRACY HOEFT-HOFFMAN: Good afternoon, Senator Albrecht and committee. I am Tracy Hoeft-Hoeffman. I am from Heartland Surgery Center in Kearney. [LB609]

SENATOR ALBRECHT: And can you spell your name, please. [LB609]

TRACY HOEFT-HOFFMAN: T-r-a-c-y, last name H-o-e-f-t-H-o-f-f-m-a-n. I'm the administrator at Heartland Surgery Center in Kearney which we are an affiliate of CHI Health, Good Samaritan. I live in Senator Lowe's district, actually for only about three months now though. Our center does 60 percent orthopedic cases. I know Senator Lowe has heard from some of my orthopedic surgeons at this point. And 15 percent of that 60 percent of cases are worker comp for us. So we are a pretty big provider in central Nebraska for work comp. We, the center and the surgeons we work with, try to fast track those workers in, as Dr. Bozarth alluded to, to get them in timely, get them back out of surgery and back to work as timely as possible. Like, reading the bill and its proposal, the expensive nature of orthopedic procedures because often they do involve implants, which by the way, Medicare doesn't allow reimbursement for implants so we would be losing money just based on implant alone. We would also...it is extensive paperwork. Every case we do with work comp is preapproved, preauthorized by that worker comp company. So we don't just randomly do them. We try to expedite that information, get that to them so we can fast-track those patients through our system and get them back to work. If less

surgeons are performing work comp cases, meaning less surgery centers would since they bring their cases to us, that limits patient choice, patient access, and certainly the ability to get patients back timely. As Dr. Bozarth said, to get scheduled at a hospital, you wait longer to get that patient on a schedule than at a surgery center. As an employer, this concerns me because I have employees, not as routinely as Hormel by any means, but I have employees that get injured on the job, too, and I want them to see the best surgeons. And if this bill limits the amount of surgeons, orthopedic surgeons, or others seeing patients that is a detriment to me as an employer as well because I want my employees seeing the best because I want them back to work as quickly as possible. Reimbursement changes lead to shifting of site services based on a financial reason, nothing to do with clinical care because certainly as an ambulatory surgery center administrator and partial ownership by a hospital, we want that patient's care done at the most cost effective place. We have usually more cost effective care than a hospital and certainly less risk of infection for that patient as well as the ability, again, to get them on the schedule timely. The shift, we don't want to shift that care to a higher cost level than a surgery center. We want to keep care at the most cost effective spot for that patient, which typically is the surgery center. It sets up...this bill sets up complex reimbursement, and trust me, I have an MBA so I can figure out complex. But I'd rather not have to have my staff spending the time to figure out complex reimbursement in order for us to get paid for doing these procedures. Also, if this bill changes our reimbursement we would be looking at...we have 50 employees. We would be looking at having to lay some of them off. And in Kearney, there are some other healthcare jobs but we kind of have the luxury at a surgery center of better hours for them. So they don't want to go back and work at our counterparts called hospitals in particular, even though we are representing the hospital as well...or the Hospital Association. I know Dr. Lowe...Senator Lowe heard from some of my doctors, in particular Heber Crockett. And I'd like to close with the e-mail he sent to Senator Lowe. Dear John, I'm writing you to urge you to vote against LB609. A large part of my practice is composed of workers' compensation cases. I am specifically referred several cases that are coming for a second or third opinion. The amount of paperwork and interaction between the employer as well as the work comp case manager is daunting. In fact, one of my partners Nick Mansuetta--he's a hand surgeon in Kearney--has stopped taking workers' compensation patients because of all the extra paperwork and hassle. It would be hard for many of us to continue to see workers' compensation patients if the rates were cuts as proposed. I'm hopeful that workers' compensation will remain a strong program in the state. It allows for extra time spent on the paperwork and for the extra interactions with separate entities. Also, I'm sure you are aware workers' compensation patients at times can be motivated to not get better because the secondary gain issues. This takes tremendous amount of workaround and counsel and plan to ensure that patients remain motivated throughout that process. It's my understanding that Nebraska pays reasonable rates for its workers' compensation insurance. I feel these laws which govern the workers' compensation in the state are fair to both the worker and the employer. And he, again, is one of our owners. I always try to walk the line and treat both of these entities fairly.

I try to expedite care of work comp patients so that they may return them to work as soon as possible. Thank you. [LB609]

SENATOR ALBRECHT: Very good. Thank you for your testimony. Do we have any questions? Senator Crawford. [LB609]

SENATOR CRAWFORD: Thank you, Chairwoman Albrecht, and thank you for your testimony. So I was trying to read what we do for inpatient and it looks like basing it off diagnostic related groups and this is outpatient surgical center so it's a different set of standards. So you mentioned your concern about implants. And I wondered if you would just explain that a bit about when you say Medicare doesn't allow implants, what you mean by that, whether they're a related value (inaudible). [LB609]

TRACY HOEFT-HOFFMAN: They don't allow reimbursement for implant. [LB609]

SENATOR CRAWFORD: At all. [LB609]

TRACY HOEFT-HOFFMAN: At all. When I do a Medicare shoulder, for example, rotator cuff which we do them on Medicare as well as work comp as well as commercial insured patients because we have so much orthopedics, Medicare does not allow reimbursement for that implant. As the person running the day-to-day operations of the Surgery Center, I am negotiating with every vendor to get those prices down so that I can put the best implants in for the patients. Again, a different group with Medicare, they're usually a little bit older, not that they're all not working, like Senator Chambers or Dr. Bozarth. But they're typically not needing to get back to full functionality at their job where workers' comp does. So you certainly don't want to be putting in a lesser because there's this range of implants, here and here, for the same implant cost, like cost here and cost here, quality doesn't always come with this cost that's less than this cost that's more. Certainly for work comp and wanting to get the patient back to work, we want to put in the most effective implant possible to get them as close to their original functionality as possible. But currently Medicare does not...they say it's captured in their reimbursement for that procedure. But having to pay the implant bills out of my center, it's not. I typically lose money if it's more than one implant we put in on a Medicare patient. [LB609]

SENATOR CRAWFORD: Is there any other example like that that we should consider as we're thinking about what we would need to consider in terms of the comparison between Medicare and...? [LB609]

TRACY HOEFT-HOFFMAN: Right. I think certainly my center and I believe some of my counterparts in the state of Nebraska, we will negotiate with workers' comp managed care companies to get their rate more reasonable. My center is very transparent. If you go to our Web site, our top 25 five procedure costs are on there. Not every center is quite there yet. I understand that. A lot of...of course my top 25, a lot of those procedures are going to be orthopedics obviously. So they're out there for their work comp insurers to see. They can call and negotiate a contract with us at any point or even a case-by-case, if need be, discount. That is probably a managed care approach in my opinion as an ambulatory surgery center administrator would be a better approach than a true fee schedule based, especially off a Medicare fee schedule, even if it's a percent marked up. [LB609]

SENATOR CRAWFORD: Thank you. [LB609]

SENATOR ALBRECHT: Any other questions? Senator Halloran. [LB609]

SENATOR HALLORAN: Thank you, Chairwoman. Thank you for your testimony. A little bit curious, in pursuit of a better bill--this one's obviously not satisfactory to some people and it's very satisfactory to others--what would you suggest would be a better, maybe a more proficient methodology if this doesn't satisfy you on how to create a means of being...having more a predictable cost structure for businesses to be able to pursue finding. I know you mentioned you had some listing of procedural cost. [LB609]

TRACY HOEFT-HOFFMAN: Right, we have some transparency. [LB609]

SENATOR HALLORAN: What percentage of those listings are...would you say is a percentage of your total operation of procedures? [LB609]

TRACY HOEFT-HOFFMAN: We list our top 25 percent of our procedures. And with 60 percent being ortho you can guess most of my list is ortho. But I will always disclose to a patient or an insurance...a work comp case manager, we'll always disclose our fee schedule to them for that procedure to them for that procedure. The problem then lies that once you get in there, you don't always know for sure everything you're going to do for that patient until you're actually in that surgery. So if I say, okay, we're are only going to do this CPT...we bill by CPT codes in the ASC world rather than DRGs as you referred to. So we try to do the most limited we can but yet we want to do what's absolutely best for that patient. We can't always guess the number of implants a surgeon is going to use and that's...most of them are good and use the very minimal that they need to. But you can't always out guess until you're in that surgery. I don't know the right answer for you on what would be a better plan. I just know this plan for the size of my center and we do 500 cases a month on average with 60 percent of it being orthopedics and 15 percent of that

being work comp is not a good position for our center. And I think Senator Hansen talked about us being a small business, which we are with 50 employees. We are 20 percent owned by Good Samaritan. And they come to the table, but guess what, they don't bring their checkbooks to the table with them. [LB609]

SENATOR HALLORAN: Would you have any suggestion for a friendly amendment to any part of this process? [LB609]

TRACY HOEFT-HOFFMAN: I don't know about an amendment. I think probably further discussions outside of a committee need to occur before this bill goes any further. [LB609]

SENATOR HALLORAN: Okay. [LB609]

TRACY HOEFT-HOFFMAN: And I lived in your district for a few years too. [LB609]

SENATOR HALLORAN: Well, I'm sorry you left. [LB609]

TRACY HOEFT-HOFFMAN: I'm coming back to central Nebraska. [LB609]

SENATOR ALBRECHT: Thank you. Just a quick question for you, your center does over 500 per... [LB609]

TRACY HOEFT-HOFFMAN: We do. We average 500 cases a month. [LB609]

SENATOR ALBRECHT: And do they spend the night? [LB609]

TRACY HOEFT-HOFFMAN: No, we are licensed as an ambulatory surgery center in the state of Nebraska. [LB609]

SENATOR ALBRECHT: Okay, so you... [LB609]

TRACY HOEFT-HOFFMAN: So that means we cannot have a patient in our building at 12:59...11:59 p.m. I want that to change. We may be back with that bill next year. [LB609]

SENATOR ALBRECHT: Yeah, okay. That's... [LB609]

TRACY HOEFT-HOFFMAN: So no, they have to go home yet that evening. [LB609]

SENATOR ALBRECHT: Very good. Thank you very much. [LB609]

TRACY HOEFT-HOFFMAN: That's why I need 50 staff every day. [LB609]

SENATOR ALBRECHT: Yeah, I'd say so. Okay, thank you for your testimony. [LB609]

TRACY HOEFT-HOFFMAN: Thank you. [LB609]

SENATOR ALBRECHT: Any other opponents? Hi there. [LB609]

BROOKE DAY: Hi, Madam Chairman and members of the committee. My name is Brooke Day and I represent the Nebraska Association of Independent Ambulatory Surgical Centers as well as Hastings Surgical Center in Adams County. I'm going to cover some of the things that Tracy has previously covered, but again, Medicare does not cover certain procedures in surgical centers which can force those cases to a higher cost setting. So we are paid differently than a hospital outpatient surgical center. So I hope you could understand that from Tracy's input. Medicare also does not allow reimbursement for implants in an ambulatory surgical center. Common procedures requiring implants would be rotator cuff repairs, ACLs, hernias requiring mesh, joint fractures, etcetera. So implants for these procedures are typically several thousand dollars more than Medicare reimbursement. A reimbursement based on Medicare fee schedule would discourage physicians and centers from treating these patients. Physicians have greater flexibility to schedule in an ASC. Work comp cases are often treated immediately, increasing the employee's return-to-work date. In closing, decreasing compensation will also force centers and physicians to ultimately make decisions based on finances rather than the best treatment or implant for a worker. Medicare is not the best reference for payment in an ASC. Implementing a payment system based on Medicare payments would decrease the quality of the implants and potentially the care the workers receive. Medicare based payments could realistically increase the overall cost to employers in the state of Nebraska due to forcing workers into a higher cost setting. Thank you. [LB609]

SENATOR ALBRECHT: Thank you. Any questions? Senator Crawford. [LB609]

SENATOR CRAWFORD: Thank you, Chairwoman Albrecht, and thank you for your testimony. Is there any other national standard or alternative that would provide a better set of base standards for procedures that aren't very well covered by Medicare which it sounds like implants

is a major example of a type of care that we need to be careful about? I mean is there some other basis that...? [LB609]

BROOKE DAY: For the reimbursement? [LB609]

SENATOR CRAWFORD: Right. [LB609]

BROOKE DAY: In the state of Nebraska, there are managed care organizations that contract with healthcare organizations already for reimbursement. So CorVel has approached Hastings Surgical Center to manage their employers. So I think the means are...the method is already here. It may not be being utilized as well as it could be by employers. But you know, as an ASC, Medicare is not the best reference for these people. It will not work. So I think you have to go maybe more the managed care route versus Medicare. [LB609]

SENATOR CRAWFORD: Thank you. [LB609]

SENATOR ALBRECHT: Thank you, Senator Crawford. Any other questions? Seeing none, thank you for your testimony. [LB609]

BROOKE DAY: Thank you. [LB609]

SENATOR ALBRECHT: Do we have any other opponents? Hi there. [LB609]

KEVIN CONWAY: (Exhibit 5) Hi. Good afternoon, Chairman Albrecht and members of Business, Labor Committee. My name is Kevin Conway, K-e-v-i-n C-o-n-w-a-y. I'm here to testify in opposition to LB609. In my full-time job I'm the vice president of health information for the Nebraska Hospital Association. In that role I have been involved with the APC system for a decade and a half. When Medicare implemented APC system, or the Ambulatory Payment Classification system in 2000, I served on a nationwide Medicare technical advisory group, or M-TAG group to advise Medicare about changes that need to be made in the system as they were implementing it. I also chaired the state uniform billing committee, or SUBC committee at that same time. Nebraska hospitals employs 41,000 people in Nebraska. And healthcare is one of the highest class codes for workers' compensation insurance. So we as employers have a marked interest in decreasing worker compensation cost. We feel that LB609 is not a viable solution though. It actually adds more complexity to the entire system. Nebraska shows, according to a recent Oregon study, Nebraska shows 19th in the country as far as work compensation premium rate. Senator Linehan talked that 19th is not necessarily the best position to be in. We'd like to be closer to number one. But around our surrounding states the only states that are a little bit better

than us are Kansas and Colorado. The other contiguous states actually have higher premium rates than we do in Nebraska. So, yeah, and actually 19th ranking improved by two points during the last study cycle. We've talked about workers' compensation not being health insurance. It appears to try to model (inaudible) after health insurance though under LB609. The Medicare system is complex as Hallstrom talked about. It is complex, so much that other large payers in Nebraska, the commercial payers, Blue Cross Blue Shield, Nebraska Medicaid have not attempted to implement an ambulatory payment classification system or anything similar to that for their hospital reimbursement. The APCs, talk about very complex, they have a comprehensive package APCs. They use the current procedural terminology, or CPT codes. They also use another coding system called HCPCS, Healthcare Cost Procedure Coding System, two difference coding system that work in concert with the system that makes that wrong assumptions that we can base our reimbursement fee schedules on the Medicare process. When Medicare developed the APC, they're not setting a rate per procedure. What they're doing is they're stacking up all the procedures done in the country and they assign a relative weight compared to other procedures. So a weight of one is neutral. It's not...it should take one unit, it's one. So a procedure that has a weight of 1.5 usually takes 50 percent more resources to do than a weight of 1. That is all defined in what Medicare calls Addendum A. If you look at LB609, there's no mention of Addendum A. They use Addendum B which takes the policies set forth in Addendum A and applies it against the coding identified in Addendum B. So what they're doing is they're picking the pieces they like and the pieces they don't like because addendum A is very complex, very burdensome to implement. So we're just going to skip Addendum A or pretend the alphabet is not in order. We're just going to go to Addendum B and use what we like out of the system and based upon Medicare rates. So Medicare we already heard cares for aged population or disabled individuals. So their consumption of resources is different from the working population that may need workers compensation. You heard about implant examples, surgery time examples, and other such examples. And I think some of the earlier proponents also highlighted that point just by the difference in charges. Those are all based on different resources that patient was using while at the hospital or the ambulatory surgery center. CMS also updates the APC system quarterly. The bill calls for an annual update but they actually update Addendum B on a quarterly basis. There are 15,000 codes on Addendum B. The inpatient DRG system which was implemented in 2007--and I was there with Korby as we implemented that, also a complex system--has a rate per hospital because CMS does or Medicare does reimburse hospitals differently across the state. With a quarterly update, that would be a fee schedule that has 1.6 million lines of fee schedule every year published. Again, and that is the attempted simplification of the system. That still is very complex. It looks alluring because it's a nationwide model. And I can tell you because other companies like Blue Cross and Medicaid, there is no such simple nationwide model to implement. We talked about managed care. There is a vehicle right now for fixed rate, known rates. It's called managed care. It's been around. It was in place before 2007 when inpatient schedules was introduced. At that time we had 1,689 employers covered by managed care. At...this year...2006 in the last report from the workers' compensation

court, there were 286 employers covered by managed care. Of those employers, they went from 66,000 employees down to 34,000 employees--so about half the population, about one-fifth of the number of employers actually in a managed care contract. Managed care contract addresses predictable fee schedules, but also it addresses care of the patient. One of the components always in a managed care contract is getting to make sure the patient is in the most appropriate setting for the most appropriate care to return that individual back to work as soon as possible. [LB609]

SENATOR ALBRECHT: Thank you. [LB609]

KEVIN CONWAY: So with that, any questions of the committee members and Chairman Albrecht. [LB609]

SENATOR ALBRECHT: Thank you very much. Do we have any questions? Senator Halloran. [LB609]

SENATOR HALLORAN: Thank you, Madam Chair. Thank you for your testimony. Managed care, why the reduction, such a harsh reduction? That's a naive question and everybody probably knows, but I... [LB609]

KEVIN CONWAY: You know, I do not know why there is a marked reduction. I can only assume it is because the payers, the carriers no longer have to do the work of negotiating rates. They can just go with the inpatient fee schedule. That's the hallmark of managed care. There are managed care companies out there. I call them brokers but they're networks. So as an employer or a carrier you can join that network. There's a fee to join a network but then when you join that network you get all the benefits of the managed care contract. The managed care contract addresses fee schedule, care guidelines, care coordination. It also addresses administrative simplification components like how you bill, how you process that bill, what type of documentation you have to send with the bill so it's predictable on both the hospital side and the carrier side. [LB609]

SENATOR HALLORAN: It's got a fee involved with it you say, an up-front fee? [LB609]

KEVIN CONWAY: They could be. You know, the managed care contract networks themselves negotiate with individual hospitals. And from what my member hospitals are telling me, yeah, there are fee structures associated with that. I just don't have a copy those fee structures. [LB609]

SENATOR HALLORAN: Usually business, volume of business declines when there's some level of dissatisfaction with what's being provided. Is that part of the equation there? [LB609]

KEVIN CONWAY: You know, part of a managed care contract has to do with volume of business. I don't know if that drives the discount that's giving a managed care company. A lot of it is by the overhead burden of a hospital to process those things. As they pointed out to me at one of the good discussions, an MRI is an MRI. Taking a little bit of a discount on MRI is not the solution to decreasing costs. It's not doing the MRI to begin with. [LB609]

SENATOR HALLORAN: Thanks. [LB609]

SENATOR ALBRECHT: Very good. Any other questions? Senator Crawford. [LB609]

SENATOR CRAWFORD: Thank you, Chairwoman Albrecht, and thank you for being here. So can I assume that you are then also familiar with how the current structure for inpatient care works as well? [LB609]

KEVIN CONWAY: Regrettably, yes. (Laughter) I've also been aged. [LB609]

SENATOR CRAWFORD: So I wonder if you could speak to a comparison of the complexity of the inpatient Medicare plan on which we've added something for workers' compensation to those cases compared to the complexity of this set of this outpatient care that's being discussed or brought into...that's being discussed as a possible basis for our workers' comp policy for this set of patients. [LB609]

KEVIN CONWAY: How many hours do I have? (Laugh) [LB609]

SENATOR CRAWFORD: Just a comparison. Are they similar? [LB609]

KEVIN CONWAY: Okay. In patient DRGs, Medicare is used in patient DRG since 1984. I was actually around when they were implemented. But it's a well-vetted system that a lot of payers use. Other payers--commercial, Nebraska Medicaid--use some sort of inpatient diagnostic related grouping system so it's not foreign to everybody. So it's well-vetted. It's known. Medicare made some significant changes in 2007 that actually helped us use that as a model for the workers' compensation. As we talked about, the ambulatory payment classification system, or APC, there is no such simplification. I think if you look at your bill and count the lines of text, even an attempt to simplify it, it's about another 50 percent longer than the line of text just for the inpatient DRG system. So I talked about the weights. It's all built upon the weights on these APCs. They're basically a four digit code and they say these procedures belong to this APC, so they're all going to be grouped in the same weight. Medicare defines that grouping to have a certain relative weight compared to other procedures done. And it could be a shoulder surgery. It

could be a blood test. It could be physical therapy. There's a lot of different CPT codes out there that they address that. So they attempt to address that. Like I said, the list of codes alone just in the published report is 15,000 lines. They have all these complicated status indicators. And if you read through the bill you see we're doing the Status Indicator, J1, but only if it's not an S and only if it's this type of status indicator. And I've tried to track it and I get lost in the where's the indent belong in reading that type of legislation? I readily admit that reading a legislation like that is not my forte. [LB609]

SENATOR CRAWFORD: So am I correct in reading...in hearing from your response that the outpatient structure for Medicaid is much more complex and has been in place and...for less time and is used by fewer other providers? [LB609]

KEVIN CONWAY: Correct. In fact, I will add a few, if I may, that Medicare realizes fee schedules are not the end-all to controlling healthcare expense. And nationwide they are implementing value-based purchasing programs, to use an internal lexicon, but basically looking at the...at capturing a cared-for patient and Lincoln is one of 50 demonstration areas where they have a comprehensive joint replacement. So a Medicare beneficiary that goes to Lincoln hospital, all that care associated with that patient whether it be in the hospital, be the pre-op work, or whether it be the 30 days of rehab afterwards is encompassed into one payment. And Medicare sees great advancements in that and that's the direction they're going. [LB609]

SENATOR CRAWFORD: So could you imagine or envision us in Nebraska trying to...thinking about value-based reimbursement for our workers' comp patients and moving in a direction of predictability but with attention to the value of the outcome? [LB609]

KEVIN CONWAY: Yeah, I want to go back to our vehicles that we already have: managed care contracts, that's the intent of managed care contracts. And again, Medicare value-based purchasing, go back to my earlier statements, that's really a health insurance. Medicare is not insurance per se. Workers' compensation is not insurance. It is the right to care for a workplace injury. [LB609]

SENATOR CRAWFORD: Thank you. [LB609]

SENATOR ALBRECHT: Very good. Any other questions? Thank you for your testimony. [LB609]

KEVIN CONWAY: All right. Thank you very much. [LB609]

JOHN McCARTHY: (Exhibit 6) Senators, my name is John or Jack McCarthy, M-c-C-a-r-t-h-y. We are here today to discuss if changes designed to strip resources from the medical system focused on care for productive workers who are injured should occur. Workers' compensation patients merit our current individualized care paths from diagnosis to surgery to recovery. Currently engaged workers, businesses, insurers, and physicians have the motivation and available resources to focus care for our injured workers from obtaining medical care to opportunities to early return to work and reaching settlement. The proposed legislation, LB609, will significantly change the dynamics for workers. The current system allows physicians access to unique and evolving products and state-of-the-art technology. This contrasts to non-workmen's comp cases where employers will not allow workers to return to work until they're 100 percent. Workers' compensation and Medicare are divergent programs in many ways. Medicare focuses on completion of government paperwork and cutting costs for government. The focus on patient satisfaction and not on results such as in work comp of disability, impairment, and return to work. Medicare and commercial insurers do not engage employers to help workers return to work. If disability or permanent occurs, the Workmen's Compensation Court facilitates a final resolution. Thus to try and compare and compensate care for Medicare and workmen's compensation patients similarly is creating a false alignment. In fact, with the Workmen's Compensation Court, the Nebraska Medical Association agreed Medicare basis is not appropriate and physician fees are thus not based on Medicare for workmen's comp. Insurers understand the uniqueness and challenge of the workmen's compensation healthcare and have added significant resources for these patients. These extra dollars are invested in case managers, claims adjusters who manage each case separately, early in intensive rehab programs, retraining, and thus all aspects of care. Understanding the individual care and decisions for workmen's compensation can be seen in the distal bicep avulsion at the elbow. The best end result is obtained with early access MRI imaging, early surgery, subspecialty surgical experience, utilizing more expensive fixations devices, early and frequent office visits, safe return to work, case manager utilization, stepwise advance from...to light to regular duty, and final assignment of disability impairment and future medical treatment. The current system works. LB609 does not facilitate our transition to better ambulatory patient care. As physicians and care teams, we are developing better care paths and engaging technologies that allow safe outpatient care. Our current goal in orthopedics is to move 80 percent of our surgical cases to outpatient surgery. LB609 encourages physicians and medical care team to provide care to injured workers in the inpatient facility. Senators, I'm here as a member of the Nebraska Medical Association and as an employer to ask your consideration of not letting this bill move forward. The bill fails to acknowledge our care for workers under Nebraska's workmen's compensation system is unique to healthcare as contrasted to Medicare and commercial programs. The Workers' Compensation Program need to retain the individualized care and added resources to help our employees return to work a normal life with the best care we can facilitate. A more thorough presentation is in the handout. [LB609]

SENATOR ALBRECHT: Thank you very much. Appreciate your testimony. Do we have any questions? Seeing none, thank you for your testimony, sir. Do we have any other opponents wishing to speak? Opponent? [LB609]

DANIEL LaROSE: Daniel LaRose, CEO of Advanced Surgery Center in Omaha, Nebraska. Thank you for...I don't want to repeat what was said, but I did want... [LB609]

SENATOR ALBRECHT: I just need you to spell your name for the record. [LB609]

DANIEL LaROSE: I'm sorry. [LB609]

SENATOR ALBRECHT: That's okay. [LB609]

DANIEL LaROSE: Daniel, D-a-n-i-e-l, LaRose, L-a-R-o-s-e. I listened to the presentation. You all good. One thing that we didn't talk about is the future. Medicare doesn't look at the future. Medicare, I see it in my practice all the time, is solving...they're seven, eight, nine years behind. We're not talking about the worker. The worker deserve...somebody that takes the risk to go on scaffold and falls down deserves today to be fixed as well as possible. He'll never be the same in most cases. But he deserves that we give him the technology that's available today. I'll give you an example: platelet injections. I started to do platelet injections for knee problem, tennis elbows. I did that two, three years ago. Work comp right now is approving it. I don't see in my career--I'm 57 years old--in my career platelet injection will not be approved by Medicare. So if we rely on a code system that piggybacks on Medicare, it's the wrong thing, it's just not going to work and it's not looking for the future of the worker. And we didn't talk enough about the worker--the guy that puts his life on the line. He's in the mine. I did three weeks ago, a gal almost amputated her arm at Tyson Foods. All that was attached was a nerve, a little bit of muscle. Well, first of all, she got fired because she didn't unplug the machine so she got fired. She lost her job. She almost lost her arm. And here are the people from the insurance industry haggling about the cost. That makes no sense. They're haggling about the cost. We're discussing how much we're going to pay and there's...first of all, most of their evidence are anecdotal. We can all bring anecdotes. We need some facts. But thank you for the members. I didn't want to take too much of your time, but let's look at the future and the worker, please. [LB609]

SENATOR ALBRECHT: I appreciate your testimony. Thank you. And no questions. Do we have any other opponents wishing to speak, any other opponents? Seeing none, is there anyone in neutral position? [LB609]

SCOTT BRENER: Madam Chair, members, my name is Scott Brener; that's S-c-o-t-t B-r-e-n-e-r and thanks for having me today. I'm coming at this from a point of kind of technical expertise in neutrality. A little background on myself, I am currently the senior vice president and general counsel of a company called SFM Mutual. We're a monoline work comp company. We write...we've been the largest, the dominant writer in Minnesota since our inception a little over 30 years ago. We write in five states including Nebraska. However, prior to that I served in three gubernatorial administrations in Minnesota and more recently served as, we call them commissioners, the commissioner of labor for the state of Minnesota. And amongst other things, our Labor Department does take jurisdiction over workers' compensation. So I've been around workers' compensation and workers' compensation design since 1993, 1994. I've served on a variety of national and international boards, primarily within the regulator community which I'm still quite active with, including your state of Nebraska. So I come...I've heard a lot of concerns. Frankly every proponent and opponent argument I have heard in many, many other places so it's not surprising. To give you a little macro perspective, this issue really became forefront in our industry about 15, 20 years ago. Traditionally workers' compensation from benefit perspective was indemnity based--it paid for lost time, right? In approximately 2000 the dynamo shifted to where the medical expense within the system outweighed the indemnity expense. Now nationwide the medical expense comprises approximately anywhere between 60-70 percent of the spend. So as that spend has increased and work comp in many jurisdictions remains unchecked from a medical perspective, it's become more of an issue and you're hearing...you're seeing these kind of conversations take place all over the country. Approximately in today's environment, about between 25 and 30 American jurisdictions have adopted a fee schedule governing inpatient, outpatient, and ASC. Most of those, I'd say about 75 percent, 80 percent of those fee schedules are indeed Medicare based because Medicare provides the primary coding expertise coupled with a percent payment that everyone argues over, some percent over Medicare and that ranges anywhere...tends to range from anywhere over Medicare which is not that predominant but you see it in a few jurisdictions, all the way up to the usually about 225 percent of Medicare. So that's the range you tend to see it in. Often on the ASC side you see it a little bit higher because the system is trying to encourage folks to utilize ASC facilities for a variety of reasons. So that's really where the debate is. I could address a lot of other things, you know, implants, a lot of other issues that rose to the surface today. But I'm really here just kind of at your service to see if I can help with any technical questions. [LB609]

SENATOR ALBRECHT: Very good. Thank you. Questions? Senator Crawford. [LB609]

SENATOR CRAWFORD: Thank you, Chairwoman Albrecht, and thank you for being here. So you have experience with this kind of a structure in Minnesota, is that right? [LB609]

SCOTT BRENER: In Minnesota we also at this point in time only have...but we have a provider fee schedule like Nebraska and an inpatient DRG premised fee schedule. We're actually as we

speak in negotiations on the outpatient and the ASC language we have agreed on. It hasn't passed out of our...we have an advisory council process. It's a... [LB609]

SENATOR CRAWFORD: So you have or have not agreed on the ASC? [LB609]

SCOTT BRENER: We have agreed on the ASC component. It has not been enacted yet. The two parties have agreed to that. We're still negotiating the outpatient fees. [LB609]

SENATOR CRAWFORD: Okay. And what you're negotiating or discussing about for ASC there, is it based on Medicaid or something else? [LB609]

SCOTT BRENER: It's Medicare based. [LB609]

SENATOR CRAWFORD: Medicare I mean, excuse me, Medicare or something. But it's still being negotiated. When you mentioned that the 225 (percent) plus is what you've seen when you've looked at other states, that's for the... [LB609]

SCOTT BRENER: Anywhere from Medicare up to 225 (percent) is what you see in the vast, vast majority. [LB609]

SENATOR CRAWFORD: And that was for the inpatient though, right? [LB609]

SCOTT BRENER: That's inpatient, yes. [LB609]

SENATOR CRAWFORD: And then you said... [LB609]

SCOTT BRENER: No, excuse me, that's outpatient. [LB609]

SENATOR CRAWFORD: That's out... [LB609]

SCOTT BRENER: Yeah, inpatient rose just slightly below that. [LB609]

SENATOR CRAWFORD: But then I think you said something about ASC is higher than that. [LB609]

SCOTT BRENER: ASCs tend to run little higher, they tend to be a little bit higher. [LB609]

SENATOR CRAWFORD: Higher than the 225 (percent). [LB609]

SCOTT BRENER: You're trying to encourage ASC usage. [LB609]

SENATOR CRAWFORD: Right, right. So higher than 225 (percent). And I think...are there other...? [LB609]

SCOTT BRENER: Remember that number, it depends on geography and political issues, right. But that's the range. [LB609]

SENATOR CRAWFORD: Right. And you're encouraging the ASC because overall that you expect costs to be better and the worker to be returned... [LB609]

SCOTT BRENER: Costs tend to be better and patient satisfaction tends to be higher. [LB609]

SENATOR CRAWFORD: Right, using those facilities. [LB609]

SCOTT BRENER: Yes. [LB609]

SENATOR CRAWFORD: Have you seen any other practices to try to encourage utilization of those centers that we should consider? [LB609]

SCOTT BRENER: The ASC centers? [LB609]

SENATOR CRAWFORD: Right, in thinking about this policy, yes. [LB609]

SCOTT BRENER: Not in particular. [LB609]

SENATOR CRAWFORD: And is...states that don't have a Medicare basis, do you tend to see a...? [LB609]

SCOTT BRENER: The problem when you don't have a Medicare basis, and some don't...matter of fact, our provider fee schedule in Minnesota is proprietary. [LB609]

SENATOR CRAWFORD: Okay. [LB609]

SCOTT BRENER: The problem with the proprietary system, and some states do utilize it, it becomes very burdensome for your state administrators to keep coding in price points current. I mean you heard the concerns and maybe Medicare is not perfect but they're the best out there I would argue. Having your state agencies go through the expense of, whether it's through a rule-making or through administrative action, keeping that type of procedural expertise current has been very, very difficult and commands hiring medical resources that I don't think your state agencies currently... [LB609]

SENATOR CRAWFORD: So the Medicare is one option. The proprietary list is another option. And other option would be negotiation for that with... [LB609]

SCOTT BRENER: Well, I think what they were getting to--and I don't want to speak for my predecessors today--I think when they are speaking to managed care they're talking about group health-based managed care contracts, right, where the Blues, for examples, and goes in and negotiates a pricing arrangement with a particular hospital system, right. It doesn't work in comp because in comp, in work comp the insurance market is much, much more disparate. It's not as concentrated and it's not an oligopoly or a monopoly in some situations as most state jurisdictions are on the group side. On the comp side, there are literally, in most cases, usually about 200 comp providers in a given state. On top of that you have the self-insurance. So there's not enough market leverage to generate really any pricing relief on the provider side of things. [LB609]

SENATOR CRAWFORD: And I guess the other difference that we'd want to be careful about is sometimes we use managed care and a health insurance market would look different because, again, this is a workers' comp so we're supposed to be providing the care for the worker who needs that care, not utilize...sometimes managed care is used more to utilize...to help manage utilization. And we have a different mindset of what that looks like in a workers' comp, right, so the workers' comp needs to have a different... [LB609]

SCOTT BRENER: Yeah, to some degree. I mean with a lot of state...that's a whole different...we've been focusing...I don't want to move off this topic but this whole hearing has been concentrated on the supply side of workers' compensation, right, price point, right, fee scheduling. The whole other side we haven't talked about is the whole demand side of the economic equation, right, which is utilization control like you're speaking to. This doesn't speak to that. So on the behavioral side of the medical utilization piece, yeah, it's a little different in the comp than it is on the standard Medicare patient population base which you recognize, but that's why jurisdictions pay more for it. [LB609]

SENATOR CRAWFORD: Thank you. [LB609]

SCOTT BRENER: Does that answer your question, Senator? [LB609]

SENATOR CRAWFORD: Yes, yes. [LB609]

SENATOR ALBRECHT: Very good. Other questions? Seeing none, thank you. Did you have one? Thank you for being here. Do we have any other neutral testimony? Any other neutral testimony? Seeing none, will Senator Linehan be back? She'll be waiving her close. We have no other letters. So we will be moving on to our next bill with Senator Lowe introducing LB408. Do you need some time? Can you just take two minutes? We've got to make sure that this is recording. We will be just a few minutes. We're having some technical difficulties so if everybody wants to take a five-minute break we could do that. [LB609]

BREAK

SENATOR ALBRECHT: Okay, if we can take our seats and we're going to go ahead and get started. We're ready to get started with Senator Lowe. He will be introducing LB408. And I have a...I probably...let's see, I have one, two, three of us. Is that enough? [LB408]

MEGHAN CHAFFEE: Yeah, that's fine. [LB408]

SENATOR ALBRECHT: We're good to go. Okay, go ahead, Senator Lowe. [LB408]

SENATOR LOWE: Thank you, Chairman Albrecht and the fellow members of the Business and Labor Committee and technology for breaking down and giving us a break. I'd like to thank Senator Linehan for warming up the committee and the testifiers today. I'm here today to introduce LB408, which is intended to implement an evidence-based drug formulary for prescription drugs. LB408 is a continuation of LB1005 which Senator Harr brought before last year. The formulary would apply to those Schedule II, III, IV, and V drugs prescribed and dispensed for workers' compensation claims with a date of injury after January 1, 2018. A prescription drug listed and recommended in the formulary is presumed to be reasonable and may be prescribed without obtaining prior authorization from the insurer. A prescription drug that is not included in the formulary or one that is included within the formulary but not recommended requires prior authorization from the insurer before it is presumed to be reasonable. Drug formularies for workers' compensation are currently used in California, Ohio, Texas, Washington, Oklahoma, Tennessee, and Arizona. The workers' compensation formulary process has had significant success. Texas has seen a decrease in cost, a decrease in the number of prescriptions being written, and a decrease in the number of workers' compensation claims for drugs that need preauthorization. This has led to more individuals using prescription drugs that

are deemed safer and more effective which leads to a better clinical experience for these individuals by minimizing the potential for these individuals to become addicted or dependent upon prescription drugs and allows them to return to work in a more timely manner. A study by the Workers' Compensation Research Institute looked at what would happen in 23 states if they took similar formulary as Texas. The study found that total prescription costs could go down as much as 29 percent. The study did not look at Nebraska but did look at a few surrounding states. It estimated the potential cost reduction as high as 14 percent in Missouri, 15 percent in Iowa, and 16 percent in Kansas. However, cost reduction is not my primary objective in introducing LB408. We have all seen the stories in the news recently that illustrate the horrific nature of the opioid overdose problem facing many states in this country. My hope is that implementing a drug formulary for workers' compensation claims will be one tool to help Nebraska minimize this risk. This will be done because the formulary will improve the way the opioids are prescribed which will help lead to a safer, more effective chronic pain treatment. While reducing the number of people who misuse, abuse, or overdose from these powerful drugs. LB408 is designed to help individuals on workers' compensation stay safe and get back to work as quickly as possible, help doctors, save money, and help society as a whole. I urge you to support LB408 and thank you for this time. And I await your questions. [LB408]

SENATOR ALBRECHT: Thank you, Senator Lowe. Any questions? Senator Howard. [LB408]

SENATOR HOWARD: Thank you, Senator Albrecht, and thank you, Senator Lowe, for bringing this bill. We spoke earlier on the floor about some of the questions I was going to ask you to sort of build a record around this bill. And so I thought I would start off by asking you who would create this formulary. [LB408]

SENATOR LOWE: The formulary will be looked at by the Workers' Compensation Court. And they will look at it and they will probably use other formularies from around the country as an example. [LB408]

SENATOR HOWARD: Will they be utilizing the assistance of medical professionals, is that your expectation? [LB408]

SENATOR LOWE: I would think that that would be very good that if they would use medical expertise in this too. [LB408]

SENATOR HOWARD: Is that something you would consider adding to the bill, is the expectation that they would use them? [LB408]

SENATOR LOWE: I will take a look at it. [LB408]

SENATOR HOWARD: Yeah. And tell me a little bit about how an individual might appeal if their medications were not included in the formulary. [LB408]

SENATOR LOWE: They would appeal to the Workers' Compensation and then they would negotiate with the medical doctors, between them. [LB408]

SENATOR HOWARD: And so if somebody needed a specific type of medication that was not included and it was an emergency situation so they paid for it out of pocket, would there be a way for them to rectify that type of situation? [LB408]

SENATOR LOWE: That would be a question I think you'd have to ask somebody behind me. [LB408]

SENATOR HOWARD: Okay. And then tell me a little bit about their reasonableness presumption or sort of why that's there and maybe a little bit of background about that. [LB408]

SENATOR LOWE: Reasonableness is that if it pertains to the workers' compensation claim, that...you know, and there should be no obstacles in getting it paid for. [LB408]

SENATOR HOWARD: Okay. And that's based on 48-120, is that...? [LB408]

SENATOR LOWE: I believe so, yes. [LB408]

SENATOR HOWARD: Okay. Great, thank you. [LB408]

SENATOR ALBRECHT: Thank you very much. Do we have any other questions? Anybody? Nope. Seeing none, will you sit in the audience and wait or you can come back and wait but you can't ask any questions. So what would you prefer? [LB408]

SENATOR LOWE: Where is it cooler at? (Laughter) [LB408]

SENATOR ALBRECHT: All right. Okay, we'll start with proponents of LB408. Do we have any proponents wishing to speak? [LB408]

BRIAN ALLEN: Thank you, Senator Albrecht, members committee. My name is Brian Allen, B-r-i-a-n A-l-l-e-n. I am the vice president of government affairs for Optum Workers' Comp and Auto No Fault program. We provide managed pharmacy care and managed care to injured workers and also to people who are injured and covered under a personal injury protection of an auto policy, so a very unique niche that we fill. I'm here to speak for this bill. We were involved in the Texas formulary starting in 2005 when the concept of a formulary was first introduced into legislation. I'm also here for a very personal reason. I have a sister who was actually lost to opioid overdose about eight years ago, and then six years after that her husband died from complications from a medical condition that was problematic due to his opioid use and I inherited two children. And so I've seen firsthand the devastation that this does to individuals and to families. It's a very, very tragic circumstance that we face in our country with these medications. So we support the concept of a formulary. A formulary, working with other tools that are out there in the system, is seen to be very effective in reducing the instance of opioids for workers' comp patients. PDMPs are a tool. You'll hear probably a little bit about those. Nebraska I think last year made your PDMP mandatory for prescribers to check. Several states have done that. The PDMP Center of Excellence at Brandeis University has done a study. And for those states who have actually implemented mandatory checking of a PDMP, they have reduced opioid use by about 8 percent. So, a bit of a drop, not as significant as we would hope for. New York was the highest with 9.5 percent. When it's not mandatory, it's problematic. And you'll probably hear that this is a problem that may take care of itself. And I've heard this in a number of states that I've testified in. The reality of it is prior to your PDMP being made mandatory, only...and according to this, according to a Pew study that was done in December, only 14.4 percent of your prescribers had actually checked the database in 2014. So it was a pretty small number. So when you make it mandatory, it helps a ton. But the formulary is just another tool in that toolbox, so it works actually hand in hand with the PDMP and it gets significant results. When Texas implemented their formulary, it was not specific to opioids like yours would be but it does...they had what they called N drugs, or not recommended medications, and they had Y drugs which were recommended. The N drugs reduced by 77 percent and that was according to latest study that they did. So their formulary went into effect in September of 2011. This study was released in July of '16. They have persistently seen a 77 percent reduction in the use of...in the use of N drugs which is fairly significant. In Ohio when they implemented their formulary, they saw 40 percent reduction in the use of opioids. So when you couple the PDMP and opioid restrictions together, it really makes a huge difference. There are states back east that are going to limits on how many days you can prescribe an opioid for acute pain. This is not quite that dramatic, but it certainly is a help. And the thing you need to understand about a formulary is it is not a barrier across the roadway. It's a speed bump. So you can still get the medications. There's a process you go through. In Texas, in Oklahoma, in Tennessee who's implemented theirs, they use a preauthorization process where the physician can contact the carrier or the employer, whoever is managing the claim, work with their medical staff and figure out, is this medication appropriate for the injured worker? So the injured worker can still get it. The important focus on all of this is

getting the right medication to the injured worker at the right time and for the right reasons. In 48-120, you talk about providing care that is necessary to cure or relieve the workplace injury and that's what the formulary attempts to do. Opioids, when they are used in work comp claim, add a number of complications for injured workers. There was a Journal of Occupational and Environmental Medicine study that was released that was done in Michigan in 2012 and when short-acting opioids were used on a claim there was a 1.7 percent greater likelihood that the claim would cost over $100,000. And if a long-acting opioid was used it was 3.94 times more likely to exceed $100,000. It's not about the money though. If $100,000 is being spent on an injured worker that's a catastrophic injury. And what typically happens and what I saw in my own personal experience with my family is when someone gets on an opioid, they never get...once they become addicted, they rarely ever get back to productivity. It's just...it just inhibits them from doing the things they need to do to get back. There was also another study done in Illinois in 2014 also released by the Journal of Occupational and Environmental Medicine. And the physician...if a physician dispensed an opioid, medical costs were 78 percent higher, indemnity costs were 57 percent higher. And there was an 85 percent higher frequency of lost days. So those are significant numbers and that's a significant impact on the life of an injured worker. And there are times when opioids are appropriate. I'm not here to say that opioids should never be used. But they need to be used sparingly. We have a crisis in this country. We have had a culture of prescribing opioids because I think a long time back a lot wasn't known about them, or if it wasn't known, it wasn't shared appropriately. And so we have this opioid crisis in our country that we're dealing with right now. This is a very good way, at least for the workers' comp system, to check that and to provide at least a speed bump, not a barrier but at least a speed bump. If you're going to prescribe an opioid, think about why you're prescribing it and is it really necessary? Thank you. [LB408]

SENATOR ALBRECHT: Thank you, Mr. Allen. Do we have any questions? Senator Howard. [LB408]

SENATOR HOWARD: Sure. Thank you, Senator Albrecht. Thank you for visiting with us today, Mr. Allen. Can you remind me how opioids are scheduled, which schedules they are? [LB408]

BRIAN ALLEN: Well, I'm not a clinician, but most of them are Schedule II. There are some I think that are Schedule III and there may be some that are less than that. But I think the majority of them are Schedule II or III. [LB408]

SENATOR HOWARD: So in reference to this legislation, if we're really trying to reach into the opioid epidemic, why are we including all of the schedules? [LB408]

BRIAN ALLEN: Well, I don't know that you are trying to just limit to opioids. I don't really know what the intent of the sponsor is certainly don't want to speak to that. I think he could speak to that as well. But I think...so in many states the formulary encompasses all drugs, not just scheduled medication. So yours would actually be one of the narrowest in the country. And I think any scheduled medication is scheduled for a reason. There's some inherent risk involved in it. And I think it always makes sense...and again, once you evaluate what gets through the gate easily or what gets over the speed bump easily and what doesn't, that's really the discussion that's had. And there are a couple of really good, already evidence-based standardized sort of formularies being used out there. They've taken all of that into consideration. And so some of the scheduled medications, they may not be right for an injured worker or for a particular injury and that's why it may be...it may make sense to have them go over that speed bump rather than just get a pass to go through. And I think, you know, depending on the injury and the injured worker and whatever their medical condition is what their physiology is, I mean it's...I mean at least you have the opportunity to have the discussion and it's not just a carte blanche we're just going to allow this to go through. And I think that's an important discussion to have. I mean I think that...I don't think we have enough of those discussions in our country. [LB408]

SENATOR HOWARD: Just for narcotics or for every medication? [LB408]

BRIAN ALLEN: I think for a lot of medications. I mean anything that has an inherent risk to it, there should be a discussion about why is this being used, and is it really the right medication for this injured worker at that time? And there is a host of scientific evidence out there about when medications are appropriate for injuries and when they're not. And that ought to be the basis for how you come to your formulary--what does medical evidence tell you? And if there's a drug that seems to be more problematic than another, that ought to be on your formulary as a speed bump drug that's got to go over the speed bump. If there are other drugs that seem to work well and not have a lot of side effects and other problems, then they probably don't need to go over the speed bump. They should be on the approved list. That's the way I would look at it. [LB408]

SENATOR HOWARD: And I just wanted to clarify a few things if I may. [LB408]

SENATOR ALBRECHT: Go right ahead. [LB408]

SENATOR HOWARD: In reference to your statement about our prescription drug monitoring program, in full disclosure, that was my bill last year. [LB408]

BRIAN ALLEN: Oh, congratulations. [LB408]

SENATOR HOWARD: And my sister passed away from an opioid overdose as well. [LB408]

BRIAN ALLEN: Oh. I'm sorry to hear that. [LB408]

SENATOR HOWARD: And so just to clarify, we do not have a mandate for checking. We've never mandated that our providers or dispensers check. It is free for all prescribers and dispensers in the state. And it's embedded into our health information exchange. So when you indicate that only 14 percent of providers were checking the PDMP, previously they were only checking the med history in our EHR in our electronic health information exchange. It means that anybody else who was a subscriber already had all of the information at their fingertips. The other piece that I would like to point out, since we're having the discussion, is that our PDMP is different not only because it's embedded in our health information exchange but also because it captures all prescriptions, not just narcotics. And so every provider and every dispenser in the state has access to that information. And I won't ask you to comment on that, but we do have one of the best prescription drug monitoring programs in the country. [LB408]

BRIAN ALLEN: I like it. I like it. I'd like to see more of that. [LB408]

SENATOR HOWARD: I'll brag about Nebraska as much as I can. [LB408]

BRIAN ALLEN: Yeah. Nothing wrong with that. [LB408]

SENATOR HOWARD: Thank you. [LB408]

SENATOR ALBRECHT: Thank you, Senator Howard. Any other questions? Senator Crawford. [LB408]

SENATOR CRAWFORD: Thank you, Chairman Albrecht, and thank you for being here today. [LB408]

BRIAN ALLEN: You bet. Thank you. [LB408]

SENATOR CRAWFORD: So I just want to go back on a couple of issues. I think you said that you...did you say you were instrumental in helping to create a formulary for some states, is that correct? [LB408]

BRIAN ALLEN: Right. So we worked heavily with Texas and we worked heavily with Tennessee this last year on their rule-making and helping them figure out kind of the nuances of how to make that work for their particular state. [LB408]

SENATOR CRAWFORD: And when you say we you mean? [LB408]

BRIAN ALLEN: It would be...well, I was significantly involved and my team that I work with was involved and other people and similarly placed...you know, similarly placed positions in other competitive industries were involved. But I was very heavily involved in both those case. [LB408]

SENATOR CRAWFORD: So were you working with the state to help them create a formulary on contract with the state? [LB408]

BRIAN ALLEN: No, we were brought in as outside experts and advisers, not as a...we weren't paid to do it. We just volunteered our time to do it. [LB408]

SENATOR CRAWFORD: You were not paid to help put the formulary together. [LB408]

BRIAN ALLEN: Yeah, no. [LB408]

SENATOR CRAWFORD: Okay. [LB408]

BRIAN ALLEN: You can't get paid for everything unfortunately. [LB408]

SENATOR CRAWFORD: And in that work that you were working on in terms of the formulary, was there attention and consideration to the fact that this is for a workers' comp situation where, again, the philosophy and the idea is that the worker is supposed to be...is deserving to get the health care that they would want, which is a different environment than a health insurance environment where there might be manage and utilization of care? [LB408]

BRIAN ALLEN: No question that an injured worker is entitled to all necessary care to relieve their workplace injury. What we try to keep them from getting is unnecessary care. And that happens sadly. I mean it does happen and sometimes the overuse of opioids is unnecessary care. And so creating a speed bump where there's discussion about is this really necessary just creates that sort of check and balance that needs to occur sometimes when we're dealing with care that could be potentially harmful in the long term to an injured worker. [LB408]

SENATOR CRAWFORD: Could you give an example of maybe a particular kind of drug that a formulary has been particularly helpful for in other states? [LB408]

BRIAN ALLEN: Well, I know in Texas they have...if a drug is considered a Y drug or it's on the approved list, if it's prescribed, it goes through the process. It's subject to retrospective review, but the injured worker can get their hands on the medication. The other thing I think that's important to point out is that Texas and Tennessee and other states that have done this, in an emergency situation where there's a dispute between the physician and the insurance carriers about whether or not it's an appropriate care, they can get a limited supply of the medication that's paid for by the carrier while they're working through that dispute process so the injured worker isn't left standing at a pharmacy, you know, with nothing to relieve their situation. But it does at least buy some time to have that discussion and to allow that discussion to take place. And sometimes they come back and say the drug is appropriate, and sometimes they work it out with the doctor and says, you know, I'm going to prescribe something else. But what we've really found in Texas and other places is when it's not on the approved list, a lot of the times the doctors just go to the medications that they know will work on the approved list and start with those. And most of the time those are working out. And when they don't work out, then they have a discussion with the carrier saying it's not really working out on the approved list. Can we try one of these that's not of the approved list and see if it will help the patient better? And that happens and a lot of those do get approved. [LB408]

SENATOR CRAWFORD: Meanwhile the emergency supply, those kind of policies, were policies sort of built around the formulary. [LB408]

BRIAN ALLEN: Yeah, they typically allow for like a seven-day supply of medication. And it's not just opioids, any medication, that they would allow the injured worker to get while they work through a dispute if there's a disagreement on whether or not the care should be provided. [LB408]

SENATOR CRAWFORD: Thank you. [LB408]

BRIAN ALLEN: Fortunately there haven't been that many of those, strangely enough. [LB408]

SENATOR ALBRECHT: Well, I appreciate your testimony and thank you for coming. [LB408]

BRIAN ALLEN: Thank you very much. Good luck. [LB408]

SENATOR ALBRECHT: Any other proponents? [LB408]

ROBERT HALLSTROM: (Exhibit 1) Chairman Albrecht, members the committee, my name is Robert J. Hallstrom, H-a-l-l-s-t-r-o-m. I appear before you today as registered lobbyist for the Nebraskans for Workers' Compensation Equity and Fairness and the National Federation of Independent Business. I have also been authorized to sign in on behalf of the Nebraska Trucking Association and the Greater Omaha Chamber of Commerce in support of LB408. Mr. Allen has done a nice job of talking about his experience in some of the other states. Senator Lowe had also touched on what's happened in the other states. Many of those pieces of information are contained within my testimony, so I won't belabor that point. But I do want to make clear when this legislation was first brought forward by our members in terms of wanting to look at this issue, as Senator Lowe suggested in his opening, it was not driven by a cost savings type of approach, although the cost savings at the back end were more, I think, what our employer members were looking at which is the return to work. As those before me have testified, when you have a situation with opioids, the dependency and the addiction issues that accompany that really do have an adverse impact in either delaying the ability to return to work or perhaps that individual unfortunately never does return to work. So what we would like to see with the formulary, I think what we've seen in other states, is that it has had a positive impact primarily on return-to-work outcomes and as well as some cost savings along the way. And I have provided a number of facts I think everybody has read. You see all kinds of articles day to day on what the opioid crisis and epidemic is, the issues related to addictions and dependency. I would note two more recent issues. The one is that the Nebraska Medicaid program has now recently implemented a 150 tablet or capsule per month limitation because of the problems in this area. The CDC, the Centers for Disease Control has also issued guidelines for prescribing opioids for chronic pain. Perhaps a little more significantly adverse back in the east we've seen states that are putting statutory limitations, as little as a seven day supply on opioids. That's much more significant than what we're looking at here. But we think we can get some positive outcomes and would encourage the committee to act favorably on this. I do want to note that in the legislation that was introduced last year we had some suggestions that we're trying to tell the medical providers how to how to practice medicine. We certainly don't want to do that but we want to provide a guideline or a road map that says for purposes of education, if you can see through evidence-based guidelines what other professional experts are looking at. This type of issue has not always been a part of medical education, for example, easy, at your fingertips to look at and say should I try that particular option? If I do, it's a Y drug, a Yes recommended drug. There should be no obstacles to payment and approval in that particular issue. If it's an No drug similar to what happens in many cases under the current system, you pick up the phone, you call and you ask the insurer or the medical review expert can I get authorization for taking something that's a No recommendation? So I think we look at that. I've had my own personal experience with hip replacement surgery. I routinely automatically without even knowing it got a 30 day supply of both OxyContin and hydrocodone when I was released from the hospital. I didn't want it. I didn't know I was going to get it. But I got it nonetheless and they've been disposed of. With regard, Senator Howard, to your questions with regard to a medical panel, we certainly have no

objections to working towards looking at that medical involvement, if you will. I will indicate--and we've got a new sheriff in town in terms of the Nebraska Work Compensation Court Administrator--but former Administrator Morton, when we looked at this very issue through the amendment process a couple of years ago, had suggested his preference that when the Workers' Compensation Court approves the formulary, if you will, they are going to and have routinely independently and informally looked for the experts to come in to help them in formulating what the final decision is. And then they have a second public hearing where they also get formal comment. And when we were going down this path last time when those discussions took place, at least at that moment in time the people said that was satisfactory. If we are assured, as we always have, to have involvement we'll feel comfortable with that, have the public hearing, the regulation, and that's where you'll get your input from the panels. If we have to do something statutorily that doesn't disrupt the ability to move quickly and get things done we have no objections to that. Second issue, Senator Howard, obviously the primary emphasis not only from this bill but publicly is on opioids. We certainly would entertain narrowing the scope. I think there are some reasons why you have Schedule II through V. But, yes, that's the primary issue, that's where most of our problems are seen as occurring and causing problems for employees. So with that, I'd be happy to address any questions you might have. [LB408]

SENATOR ALBRECHT: Thank you very much. Senator Howard. [LB408]

SENATOR HOWARD: Thank you. Thank you, Mr. Hallstrom, for bringing this bill to us today. I wanted to ask, does Workmen's Comp Court have the expertise to build a formulary? [LB408]

ROBERT HALLSTROM: Senator, what we've done in similar situations, the last hearing talked about the medical fee schedule, for example, that's been adopted for inpatient and inpatient trauma. What the court was able to do there is to go out and they were directed to go to a specific format but yet they have to do the conversions and the switchovers to make that system work and to publish the schedule. I would suggest that there are similar types of ready-made, evidence-based formularies that are out there that the Workers' Compensation Court can review and determine which one or which combination of issues might be best for our state. So I don't know that it's going to be based necessarily on someone in the Workers' Compensation Court making a decision that this is the way we go. But there's already been...the legwork has already been done. For example, we've talked on this issue. We've talked with other states that have gone out and when they did utilization and treatment guidelines or drug formularies, some states have looked into at making it from whole cloth and most of them routinely say, and this was before that the evidence-based guidelines were out there by third parties, they said if we had to do it again we wouldn't have done it on our own. If there's something out there that somebody else has done the legwork, let's take advantage of that. It's evidence based, professionals have had input on it. So I would imagine that's one of the options that would be at the disposal of the Workers' Compensation Court coupled with the issue that I talked about earlier that they certainly have

historically reached out to the pharmacists and leave medical providers in this particular instance to get information that would help make their decision. [LB408]

SENATOR HOWARD: So I guess maybe I used the wrong language when I asked you if they had the expertise to create one. Do you know...do you think that they have the expertise to even choose one because they don't have medical backgrounds? [LB408]

ROBERT HALLSTROM: I think, Senator, that what we've looked at in other states is that...and I can't speak to whether or not there was a level of expertise in the other states, but they have routinely looked to these third-party created evidence-based formularies and they have grasped on to them and used them on that same basis. [LB408]

SENATOR HOWARD: But our workers' compensation, do you think that they have the expertise to make this decision? [LB408]

ROBERT HALLSTROM: I probably won't respond to that, but I think the Workers' Compensation Court Administrator is here today and if she's inclined to come up she can probably provide you with some background on how they would go about this and what their comfort level is. [LB408]

SENATOR HOWARD: Great. Thank you. [LB408]

ROBERT HALLSTROM: Thank you, Senator. [LB408]

SENATOR ALBRECHT: Any other questions? Senator Crawford. [LB408]

SENATOR CRAWFORD: Thank you, Chairwoman Albrecht, and thank you, Mr. Hallstrom, for being here. I wonder if you would speak to the discussion that was had about the schedules that are included in the bill. So the schedules, it says Schedule II, III, IV, and V. Would you just speak to what was behind that choice of including all of those schedules. [LB408]

ROBERT HALLSTROM: Well, I think I would probably just reiterate what Mr. Allen said in terms of they are scheduled for a reason and a purpose, because there are some issues involved with the utilization of a particular drug with a particular patient for a particular malady. And so I think anything in those scheduled drugs has that element about it that. Admittedly, the Schedule IIs are probably those that are the most relevant and potentially harmful and addictive. But again, that's probably the general thought on that. [LB408]

SENATOR CRAWFORD: Do you know if the other formularies in states that you have looked at and considered, were they formularies that included all of the schedules? [LB408]

ROBERT HALLSTROM: My understanding, Senator, they not only include all of the scheduled drugs, but all drugs. [LB408]

SENATOR CRAWFORD: Right. [LB408]

ROBERT HALLSTROM: So they're broader. This...LB408 would be, to my knowledge, the most narrow drug formulary and if we were to look at only opioids we'd even be more narrow. And certainly we're open to that issue. I think we want to make sure that the opioid issue is addressed properly. And as Senator Howard well knows with her PDMP, and we're proud of PDMP, but I think every little bit every tool that we can add to that is going to enhance our ability to address the problem. I might add, too, and somewhat surprisingly to me, we've even had some candid discussions with MDs. And I had one MD who happened to tell me when looking at this that one of the real issues, and I can imagine it's somewhat gut-wrenching, is if you're in a small community and you're sitting next to the person that you've been treating and they're in constant pain and they're asking you for another prescription. I was told at time that one benefit of the guideline is it might be somewhat of a crutch to say, you know, those guidelines are out there and they're telling me I'm not supposed to do this. And then you can use that. I would hope that wasn't always the case, but any port in a storm. If it helps to not get those people addicted and those types of things that run with it, the guidelines can have a beneficial impact in that regard as well. [LB408]

SENATOR CRAWFORD: Thank you. [LB408]

SENATOR ALBRECHT: Other questions? Seeing none, thank you for your testimony. [LB408]

ROBERT HALLSTROM: Thank you, Senator. [LB408]

SENATOR ALBRECHT: Any other proponents wishing to speak? [LB408]

PHIL ESSAY: Good afternoon, Senators. Thank you for giving me a few minutes here. My name is Phil Essay. I'm board certified by the American Board of Anaesthesiology. [LB408]

SENATOR ALBRECHT: Can you spell your name. [LB408]

PHIL ESSAY: (Exhibit 2) I'm sorry. P-h-i-l E-s-s-a-y. I'm also board certified by the American Board of Pain Medicine. I'm testifying as a proponent for LB408. I see patients on a one-by-one daily basis and I know at the end of the day I'm only scratching the surface of this problem, and I'm hoping that this testimony can help more people. It may seem odd to you that a pain management physician is testifying as a proponent for a bill that makes some physicians feel as if they're handcuffed or feel as if they're under constraints in regards to how they can practice, but we are in fact in an opioid epidemic. In this state of Nebraska we have a tendency to underreact I think in part because the numbers that we see are maybe not as eye-catching as they are in some other states but the fact of the matter is that death rates in this state in 1999 were 36 from drug overdoses and 150 in the year 2015. They've quadrupled. And 70 percent of these people are employed citizens. They're not necessarily the homeless and the unemployed. These are people in suit and ties and high school football uniforms. And the fact of the matter is that chronic pain nationwide has not changed in the last 15 years, the incidence of chronic pain, and yet the number of prescription sales has quadrupled. Now if you believe in coincidences then this is a big one for you that the death rate from opioid overdoses has also quadrupled. In other words, there's a direct correlation between the number of opioid medications that are released from the pharmacy and the number of unintended opioid deaths. That was to the tune of 16,700 in this in this country. It's not the medication that's evil. I'm not here to breathe fire and make everyone afraid of these medications. These medications do not cause addiction. But we know which types of pain are responsive to opioids. We also know which types of pain are not responsive to opioids and yet those facts are either not known or they're ignored. We also know which populations are at very low risk for misuse and addiction--those with cancer, those with severe traumatic injury, those with recent surgery, those with significant illness. Their risk of misuse and addiction is well less than 1 percent. However, we also know those populations that have an extremely higher risk of misuse and addiction--benign chronic back pain, muscle strains of the low back in workers' comp cases, headaches, fibromyalgia. Those patient populations have a much higher risk of misuse and addiction. If we agree that the more opioid medications out of the pharmacy results in more unintended deaths then we have to do something to try and reduce those numbers of opioids that are unnecessary and, quite frankly, unhelpful to most of the patients that receive them. These are controlled substances that we're talking about. And I guess I greatly applaud Senator Howard. The PDMP is a huge thing for these...for our local physicians. It's not the entire puzzle however. We have to reduce those unnecessary prescriptions. Mr. Hallstrom provided an excellent example of the fact that he was given something like 120 pain pills when he had surgery. I ran into a young lady that had shoulder surgery. She had 120 pills. She used four of them after her surgery. Now she's a responsible individual and those ended up being disposed of appropriately. But this happens a hundred times a day or more in this state in our surgery centers and our hospitals. People are let go with these prescriptions, they're utilized, and we don't know for sure what happens with those. LB408 is one step in the right direction. [LB408]

SENATOR ALBRECHT: Thank you very much. Do we have any questions? Senator Howard. [LB408]

SENATOR HOWARD: Thank you. I know the physicians groups are working on prescribing guidelines. Can you tell me a little bit about how that's going. [LB408]

PHIL ESSAY: Well, I can't really. I just know that I sat in...it's hard to cross party lines over here. Got the NMA over here and all going to...you're going to hear their testimony in just a little bit. And so I don't know what's happening at the level of the Nebraska Medical Association. But I will say this about my physician colleagues who I love dearly and they're very compassionate, but most of the questionnaires that those physicians get, 70 percent of doctors will report that they are significantly undertrained in pain management. There was a study by the...I don't remember who it was by, the National Safety Council. The average physician at the end of their training through medical school and residency receives less than nine hours worth of training in pain management; veterinarians, 87 hours. That's a problem and until that's addressed by our medical schools and our medical institutions then we have a responsibility to protect our constituents. Yes, I'm concerned about those individuals with opioid prescriptions that were given to them. I'm more concerned about the societal implications and what happens to individuals who happen to be...who happen to come across that bottle of pain pills. And not to speak in anecdotes, but a 12-year-old young lady in northeast Lincoln here just two years ago by the name of Serena Garrett got into a bottle of pills at a house that she was babysitting. Those pills should never have been prescribed in the first place because that individual was taking them for a disease process that will not respond to opioids. And that child took two of those pills and didn't wake up from her babysitting job. That happens every day across this country and we need to stop worrying about physicians' ability to have independence and this and that. We need to protect our society and it goes beyond just those individuals receiving those prescriptions. [LB408]

SENATOR HOWARD: If I may, a follow-up. [LB408]

SENATOR ALBRECHT: Go right ahead. [LB408]

SENATOR HOWARD: Thank you. Who's allowed to prescribe narcotic pain medications in the state of Nebraska? [LB408]

PHIL ESSAY: Licensed providers, that includes MDs, physician assistants, and nurse practitioners under the direction of a physician. [LB408]

SENATOR HOWARD: And so when we're talking about the flow of unnecessary opioid prescriptions out of the pharmacy, the real gatekeepers are the prescribers? [LB408]

PHIL ESSAY: Absolutely. However, it's not happening. [LB408]

SENATOR HOWARD: So this is the first time I've ever heard testimony, and I serve on Health and Human Services, from a physician saying that their training is inadequate. We hear a lot about scope of practice issues and comparisons between training. And so it is very concerning to me if the medical profession doesn't feel as though their training is adequate enough to manage pain or prescribe opioids. [LB408]

PHIL ESSAY: This is not a secret. You can look in any of the pain literature and there have been a number of questionnaires about the adequacy of training in pain management. And greater than 70 percent of physicians will report that they're not adequately trained. [LB408]

SENATOR HOWARD: So would a formulary help them to be better trained? [LB408]

PHIL ESSAY: No, of course not. But it does make them pause and think twice about what they're doing. And it slows that bleeding, if you will, of opioids out of the door the pharmacy. What was great about the PDMP was it closed a couple of windows and a door. But there's still a lot of medications that come out of the pharmacy that really should not be there. They're unnecessary for treating the problem that providers are trying to treat and they're unhelpful to those patients that are receiving those medications. And once they're out of the pharmacy, they're no longer controlled. They sit in grandma's medicine cabinet and the kids come over and those medications are gone. I receive reports twice a day in my office from people that, well, my medications were taken out of the bathroom. Well, you didn't have them locked up like we had agreed in our opioid agreement, did you? [LB408]

SENATOR HOWARD: Would you advocate for a prescribing cap like a lot of other states have done? [LB408]

PHIL ESSAY: Again, it depends on what problem we're treating. I am not an advocate for deprivation of controlling pain in the people who opioids will be effective for. That includes cancer patients, trauma patients, the groups that I've already mentioned, and some chronic pain patients, selectively chosen. But I am an advocate for reducing and capping the use of those medications in pain diagnoses that we know they will not be effective for. [LB408]

SENATOR HOWARD: Thank you, Dr. Essay. [LB408]

SENATOR ALBRECHT: Senator Crawford. [LB408]

SENATOR CRAWFORD: Thank you, Chairwoman Albrecht, and thank you, Dr. Essay, for being here and I appreciate your experience in helping us to understand what this looks like in terms of your work with patients. One question I would have is whether or not there is a professional peer review that would help us ensure that if we were going with a formulary that we could make sure that those evidence-based decisions are truly grounded in pain management evidence-based decisions. I get nervous about some formularies because I get worried that they're about cost management as opposed to what I think I hear you saying you're concerned about which is making sure we're really looking at evidence in terms of the patient characteristics and expectations and make sure we're directing medications where we expect them to have the most medically appropriate use. Have you seen involvement of your profession or have you seen ways that any states or...have been able to make sure that medical evidence is key or checks to make sure we have that medical evidence being the key driver? [LB408]

PHIL ESSAY: Well, believe me, Senator Crawford, I still practice medicine here and I don't want to throw out the baby with the bathwater for myself either. And so, yes, I think a critical element of a bill like this would be some educated medical involvement with the Work Comp board or whoever it is because I have some trepidation about who it is that's making those decisions too. [LB408]

SENATOR CRAWFORD: Thank you. [LB408]

SENATOR ALBRECHT: Very good. Other questions? Senator Halloran. [LB408]

SENATOR HALLORAN: Thank you, Madam Albrecht. Thank you, Dr. Essay, for your expertise and your testimony. You've already likely stated it, but just for the record I'd like to ask the question. Do you see anything in this proposal that would interfere with the doctor-patient relationship? And by interfere, I mean negatively interfere with that relationship. [LB408]

PHIL ESSAY: I think some of that will be dependent upon how this bill is executed. And Senator Crawford's comments about having some medical direction in that regard is going to be a critical element of it. But, no, I do not see there being impediment to the people that need these types of medications being adequately treated. [LB408]

SENATOR HALLORAN: Okay. Thank you. [LB408]

SENATOR ALBRECHT: Thank you. Any other questions? I have a couple. [LB408]

PHIL ESSAY: Yes, ma'am. [LB408]

SENATOR ALBRECHT: Do you feel like...obviously there are a lot of people here for the same reasons that you are and I appreciate your testimony. But we have interim studies on different things. And when I look at the bill before, Senator Linehan's and this one as well, you know, to ask a legislative body to go forward with something as important as this to save a life, do you feel that the medical society or advisory committees would prefer it to be obviously maybe what they would like, but everybody has different situations, whether you're orthopedic or hospital emergency rooms or wherever the people go to get their pain managed with whatever they have? Can you see an advisory council like that we should decide to put together in an interim study? You know, if I were to select 12 people from all walks of life in the medical field and some folks here on our committee as well as the Workmen's Comp Court to sit down and really take a look at this, because I mean we can go out and pull from the better states what do they already have. But we're talking about Nebraska and we're talking about our problems and how do we solve them together. Is that something that you feel would be beneficial? [LB408]

PHIL ESSAY: In regards to the first bill that was presented, yes, I agree with that. In regards to this bill, there's some urgency to this. And the idea of forming commissions and so on to sort of work through the details of this I have an issue with because of the rate at which we're losing human life unnecessarily. [LB408]

SENATOR ALBRECHT: Okay. So you feel that everything in this bill is ready to go to the floor? [LB408]

PHIL ESSAY: No, it likely isn't. And I think... [LB408]

SENATOR ALBRECHT: So that's what we need to hear. [LB408]

PHIL ESSAY: ...Senator Crawford has pointed out some of that... [LB408]

SENATOR ALBRECHT: Yeah, some amendments. [LB408]

PHIL ESSAY: But I guess I would urge you in whatever way that you can to find out as expeditious of a process that you could come up with because this problem is not going away. As recent as last week the governor of Maryland stated an emergency crisis in the state of Maryland. In this, he's not the first one. There's a long list of this. [LB408]

SENATOR ALBRECHT: Okay. [LB408]

PHIL ESSAY: Nebraska with the PDMP was the 49th state, which makes me a little sad. I'm very happy that it happened, but makes me sad that we were that far behind. [LB408]

SENATOR ALBRECHT: And did you feel like the medical profession had their arms wrapped around the problem? [LB408]

PHIL ESSAY: I'm not so sure that the medical profession nationally has wrapped their arms around the problem. There can be a conflict of wanting to practice freely and not be told how to practice and yet this is a societal crisis and a societal emergency that needs to be addressed. [LB408]

SENATOR ALBRECHT: Okay. Well, thanks... [LB408]

SENATOR HOWARD: May I ask a question? [LB408]

SENATOR ALBRECHT: Yes, go ahead. [LB408]

SENATOR HOWARD: Dr. Essay, just for my reference, you have death rate from 36 in '99 to 149 in '15. Where did you get those numbers? [LB408]

PHIL ESSAY: Hmm... [LB408]

SENATOR HOWARD: It's just we had a hard time because on your death certificate we don't have a checkbox for overdoses or opioid overdoses. So we were only able to get information from the coroner's office in Douglas and Sarpy County. And that was 99 deaths in '15. [LB408]

PHIL ESSAY: As a matter of fact, I believe it was from the NMA journal that came out after the PDMP was released. There were six or seven different articles and I don't remember what the reference was. Now that 149 that is quoted is not all opioid overdoses. [LB408]

SENATOR HOWARD: Right. [LB408]

PHIL ESSAY: They're drug overdoses. Forty percent of those were directly opioid overdoses. [LB408]

SENATOR HOWARD: Thank you. [LB408]

PHIL ESSAY: Yes, ma'am. [LB408]

SENATOR ALBRECHT: Thank you so much for your testimony. Any other proponents? [LB408]

KORBY GILBERTSON: Chairman Albrecht, members of the committee, for the record, my name is Korby Gilbertson; it's spelled K-o-r-b-y G-i-l-b-e-r-t-s-o-n, appearing today as a registered lobbyist on behalf of the Property Casualty Insurers Association of America as well as Tyson Foods in support of LB408. I'm going to try to skip over a little bit of the conversation that's already been talked about as far as the different scheduled drugs that are included in the bill and try to focus a little more on one issue that goes past just the formulary and that is the issue of challenges that are facing employers and employees because of prescription drugs abuse in Nebraska and that how this bill, I think as Dr. Essay said, is one more tool in trying to address issues that are getting worse for both employers and employees. And once you have employees that are impacted by these medications, obviously their problems can compound and it impacts their ability to work and the ability for that employer to provide for them. I also wanted to...I looked at a number of different articles last year and this year that talked about all over the country issues with employees who are suffering with drug abuse and trying to get off opioids and other drugs that obviously either stimulate or depress their central nervous system and the way that they impact their ability then to function in the world that they need to. And in Nebraska, the Governor back in February in cooperation with the Broadcasters Association and the Press Association, the U.S. Attorney and our Attorney General started a campaign called Dose of Reality and some of you have probably heard the advertisements. But it was a program by the Broadcasters Association committed to spend over $300,000 for this year promoting just different ads that will be placed on radio and on television to try to highlight the issues that we have in the state. And in our opinion, LB408 is just another way to try to deal with those issues. With that, I'd be happy to take any questions. [LB408]

SENATOR ALBRECHT: Thank you for your testimony. Do we have any other questions at this time? Thank you. [LB408]

KORBY GILBERTSON: Thank you. [LB408]

SENATOR ALBRECHT: Other proponents. [LB408]

CARLOS LUNA: I want to thank you all so much for allowing me the opportunity to come and testify before you. My name is Carlos Luna, spelled C-a-r-l-o-s, last name is L-u-n-a. I am the director of government affairs for Reed Group, owners of the ACOEM-based drug formulary and practice guidelines which are researched and developed independently by the American College

of Occupational and Environmental Medicine. As I mentioned earlier, also known as ACOEM. In addition I serve on the research and standards committee, the disability management and return to work committee, and medical issues committee for the International Association of Industrial Accident Boards and Commissions, also known as the IAIABC, and the claims Administration Committee and Medical and Rehabilitation Committee for the Southern Association of Workers' Compensation Administrators, also known as SAWCA. I'm here today to share, from my perspective at least, how drug formularies can be used to improve the quality of medical care provided to injured workers to restore function post injury or illness and avoid dangerous health effects like prescription drug addiction due to inappropriately prescribed drugs. I'd like to focus my comments this afternoon on the following: number one, what is a drug formulary? I think that there's an opportunity for all of us in the room to really get a better grasp of what a drug formulary actually is, and secondly, the benefits that it provides to injured workers. The formulary concept as you may or may not know is not a new concept. In fact the earliest version that I was able to track down was from the 1700s. The purpose of the early versions of a formulary was to define a standard for compounding and dispensing of medications to U.S. military hospitals. And by the late 1950s and early '60s, formularies had been adopted by nearly every hospital in the country. According to the American Academy of Managed Care Pharmacy, formularies promote best therapeutic outcomes. The inclusion or exclusion of drug agents into a formulary is based primarily on sound clinical evidence. Cost consideration should only influence decisions after safety, efficacy, and therapeutic needs have been assessed. The concept of a formulary has evolved well beyond the simplistic drug list of its origins. Today's options include formularies that consider the patient's medical condition, whether their condition is in the acute or chronic phase, and provides visibility to the strength of scientific evidence. The modern application allows prescribers to take into consideration each patient's unique medical needs. Modern formulary versions also have clear links to the scientific evidence helping all stakeholders like providers, payers, employers, and even employees have access to view the science that supports the drug's recommendation, or lack thereof in the modern formularies. These modern traits ensure that the right pharmacological therapy is provided to the right people at the right time. Health benefits to injured workers are achieved by a formulary's separation of drugs into two categories using scientific and evidence-based information. Firstly, formulary or what you would consider recommended drugs, and secondary, nonformulary or what you would consider nonrecommended drugs. Formulary drugs as you can imagine are preselected, are preferred, and their delivery can be simplified and expedited to injured workers. The primary goal of drug formularies in workers' compensation is to keep injured workers safe from negative effects of drugs that are not medically necessary, are overly prescribed, or are not proven to be effective. Nonformulary drugs are not part of the expedited streamlined approach, as some mentioned earlier today, and will require preauthorization. I want to emphasize, this doesn't mean that nonformulary options are definitively unavailable to injured workers. It does mean that based on the preponderance of evidence and expert medical consensus, these options may not be the most effective, medically necessary, or serious risks and adverse effects outweigh the benefit

to the patient, thus requiring prospective utilization review prior to dispensing. Some jurisdictions, like California, have created special fill or first fill policies that allow certain formulary or nonformulary drugs to be made available to patients for short periods of time, as explained earlier. Based on the information that I've provided respective to what a formulary is and is intended to do, I hope you're now able to reach a conclusion on what a formulary is not. A formulary is not a license to say no to patients. A formulary is not a cost containment tool. A formulary is not a blunt instrument. A formulary essentially is a help and a guide to provide practitioners a pathway, if you will, to the most effective treatment for injured workers. Now the question, who benefits most from a drug formulary? I'd venture to say that it would be the injured workers who are being spared inappropriate prescriptions for these drugs. [LB408]

SENATOR ALBRECHT: Thank you for your testimony. I have to stop you just to be fair with everyone else. But I'm sure you'll have questions. [LB408]

CARLOS LUNA: Thank you. [LB408]

SENATOR ALBRECHT: Do we have any questions at this time? Well, seeing none...oh. [LB408]

SENATOR HALLORAN: Excuse me. Less a question than a compliment. [LB408]

CARLOS LUNA: Senator Halloran, yes. [LB408]

SENATOR HALLORAN: Thank you, Madam Chair. A lot of us probably thought we knew what a formulary was or is, but I think we all know better now. Thank you. [LB408]

CARLOS LUNA: Thank you, Senator. [LB408]

SENATOR ALBRECHT: Very much appreciated. Thank you. Okay. Any other proponents? [LB408]

RON SEDLACEK: Good afternoon, Chairman Albrecht and members of the Business and Labor Committee. For the record, my name is Ron Sedlacek, R-o-n S-e-d-l-a-c-e-k, here on behalf of the Nebraska Chamber of Commerce and Industry. We support in concept the legislation before us as we supported previous iterations of this bill--in the previous session, Senator Harr's bill. And we also believe that and would agree with Dr. Essay, this is a subject matter that should be taken seriously this session. I believe there could be time to work out any details to satisfy those concerns expressed by the committee or for those who may weigh in otherwise. And we'd be

happy to help in that regard. With that, so much of the case has been made on behalf of why the State Chamber supports the legislation I don't need to repeat it. But if you have any questions I'd be happy to answer them. [LB408]

SENATOR ALBRECHT: Thank you very much. Any questions? Seeing none, thank you for your testimony. [LB408]

RON SEDLACEK: Thank you. [LB408]

TAD FRAIZER: Good afternoon, Senator Albrecht and members of the committee. Again, my name is Tad Fraizer, T-a-d F-r-a-i-z-e-r, representing the American Insurance Association, a national trade association of property casualty firms and worker comp underwriters. Again, to save time I would echo the statements of the previous testifiers. I think at least the concept of this bill provides a method of moving forward with safe harbors for a variety of drugs that can be prescribed without questioning by the insurer. There's a provision for other drugs to go through an approval process if they're not on the safe harbor provision of the bill. And in the event of further dispute, there's always the resort to the independent medical examiner. So I think it provides both the guidance and options to the prescriber while trying to channel the appropriate drugs to get the best result for the injured worker. And I would try to answer any questions you might have. [LB408]

SENATOR ALBRECHT: Thank you very much. Do we have any questions? Seeing none, thank you for your testimony. Do we have any other proponents wishing to speak? Any other proponents? Seeing none, we'll move on to opponents. [LB408]

DAVID DURAND: (Exhibit 3) Good afternoon. My name is David Durand, D-a-v-i-d, Durand, D-u-r-a-n-d. I am a Nebraska physician specializing in work injuries. Thank you for the opportunity to address the Business and Labor Committee. I am speaking on behalf of the Nebraska Medical Association. I have 20 years of experience in the field and have worked in Nebraska for over 12 years. I am on the front line of caring for Nebraska's sick and injured workers. While I am sure of the honorable intent of LB408, I would like this committee to carefully consider its unintended consequences. A workers' comp drug formulary will limit choice in important ways, delaying care and harming Nebraska's injured workers. Drug treatment is constantly changing. New drugs arrive daily. New and old drugs frequently are discarded because of harmful side effects or ineffectiveness. A governmental formulary will have trouble staying current and up to date, delaying and degrading medical care. Nebraska has an aging workforce, just like the rest of the United State. That means our workers have more medical problems and take more medicines than in the past. I frequently have trouble finding a medicine that will treat their work injury but won't interfere with their other medicines. That's

when choice and flexibility are so important. The limitations imposed by this bill would make it harder to find the best medicine in those situations. This is particularly true in some special situations. For example, it's not unusual for workers to have multiple medicine allergies which limits choice. A similar situation arises in pregnancy when I must simultaneously treat two individuals: the mother and fetus. The limits imposed by this bill would create a hardship. Speed is important when it comes to pain management. I need to have patients who can sleep, can concentrate on their treatment and recovery. Each day a worker is off work, or working at a reduced schedule costs the patient and their employer a lot of money. In my opinion, an independent medical evaluation, which can take weeks or months, is not a satisfactory option for overriding the formulary restrictions. A better alternative to LB408 is the Nebraska Health Information Initiative, NeHII, prescription drug monitoring program. Please let that program do its job. I am pleading for the flexibility to treat my patients, Nebraska's workers, and your constituents the best that I can. Thank you. [LB408]

SENATOR ALBRECHT: Thank you for your time. Do we have any questions? Senator Crawford. [LB408]

SENATOR CRAWFORD: Thank you, Chairwoman Albrecht, and thank you for being here, Doctor. I wonder if you'd just speak to how you currently get approval if someone comes into your office and needs one of these scheduled drugs. [LB408]

DAVID DURAND: For the vast majority of the time, Senator Crawford, I don't need to have approval for drug prescriptions. I need to get drug approval for certain kinds of expensive procedures. But for the vast majority, I do not need to get approval for drug prescriptions. [LB408]

SENATOR CRAWFORD: At all. [LB408]

DAVID DURAND: I would assume that if I was prescribing something that was quite out of the ordinary and experimental I might need do that. But I very rarely do that. [LB408]

SENATOR CRAWFORD: Thank you. [LB408]

SENATOR ALBRECHT: Any other questions? Seeing none, thank you for your testimony, Doctor. [LB408]

DAVID DURAND: You're welcome. [LB408]

DENNIS BOZARTH: Good afternoon again. Dennis Bozarth, D-e-n-n-i-s B-o-z-a-r-t-h, orthopedic surgeon here in Lincoln. Thank you for allowing me to testify in front of your committee. I would agree with everything Dr. Essay said. We do have a problem and we have not really addressed it as much as we should. And it is a national problem as well as in Nebraska. The problem is multifactorial and it is not just a workmen's compensation issue. I am a member of the Nebraska Medical Association. I am part of a committee currently working on a pain treatment guideline. We have meetings and we are trying to maybe have something by this summer brought out so that we at least can get it to our physicians to help them deal with and give them guidelines on treating people and prescribing medications. These are similar to other guidelines in other states so we didn't really create them all ourselves. These would be applicable to all patient-physician relationships, not just workmen's compensation and they are to be compatible with the chronic pain guidelines of the CDC. One of my personal concerns is always about commercially available guidelines. They are readily assessable but they do cost us. And so, I'm just looking up on-line, one prescription...or subscription for one of the guidelines is $600 a year per license and there are 4,000 licensed physicians in the state of Nebraska. So that's about $2.5 million it would cost us to get these guidelines. Then we have to be trained in how to use them and use them appropriately. So we would have to carry that burden. My biggest, again, concern is we are trying to work on it as a group to try to help control this problem and I'd ask you to maybe delay passage of this so we can work on a solution. [LB408]

SENATOR ALBRECHT: Thank you very much. Do we have any questions? Senator Crawford. [LB408]

SENATOR CRAWFORD: So just to clarify, you're talking together about a plan, an approach for more peer review of professional standards on... [LB408]

DENNIS BOZARTH: Prescriptions, yes. [LB408]

SENATOR CRAWFORD: ...the prescriptions, is that what you're saying? [LB408]

DENNIS BOZARTH: So that we can go to all of our colleagues and say this is appropriate. This is inappropriate. You don't do that for these conditions, similar to the guidelines but it'd be simple, like a person comes in for back pain, nontraumatic just, oh, kind of hurt. Well, you don't give those people narcotics. That's not appropriate in that setting. If you come in and you have a broken arm, that is. And so you want you want to get consistency with what we do. We also know that certain combinations of drugs are very bad for you, especially narcotics and benzodiazepines. The common one is Vicodin and Valium or something like that. Trying to get our colleagues to say, no, don't do that and get this information out educate them. We think we can do a better job of controlling this, or at least help to control it. [LB408]

SENATOR CRAWFORD: Would you imagine there would be some kind of peer identification so someone could know if a provider is accepting those standards and adopting or abiding by those standards? [LB408]

DENNIS BOZARTH: Well, I think with some of the prescription formulary...the monitoring program we could probably get some information of that. We should look for bad characters in our business. [LB408]

SENATOR CRAWFORD: That's what I was trying to figure out, is how... [LB408]

DENNIS BOZARTH: Have we addressed that? No. [LB408]

SENATOR CRAWFORD: ...how would you know or how would we make sure that there's knowledge of and encouragement and incentives to make sure that the providers who are adopting professional standards would be used? [LB408]

DENNIS BOZARTH: Well, I think the monitoring program that Dr. Howard...Senator Howard (laughter) introduced would be helpful. At least we have some data now. We can look and see. Where are these prescriptions going? Are they in a certain area, certain county, certain areas that we can go try to find the source? [LB408]

SENATOR CRAWFORD: So you're saying we have certain professional standards. The drug monitoring system will let us see where those standards aren't being met. [LB408]

DENNIS BOZARTH: I think that would be one of the things we could do, yes. [LB408]

SENATOR CRAWFORD: Thank you. [LB408]

SENATOR ALBRECHT: Any other questions? Senator Howard. [LB408]

SENATOR HOWARD: Thank you, Senator Albrecht. Can you give me your feedback around medical education around prescribing guidelines or pain management. [LB408]

DENNIS BOZARTH: Well, there really aren't very good...there's not very good education just on it. You know, we get educated on how they work and those type of things. Then you just...you do basically what your colleagues do or your mentors did. Over this past two years I do a lot of workmen's compensation. I go to national meetings and one of the things is brought up is the

narcotic use. My prescribing habits have changed over these years, but this is education I sought out on my own. We do, as Dr. Essay said, we do lack education in a lot of the appropriateness of medications. We do overuse them. Some of that is because of regulations. For instance, he was saying a person went home with 120 pain medicines. Well, if you did a surgery that you thought was painful and you thought, well, they're probably going to go through maybe 40 or 80, you write the 80, why? Because you can't refill them. They have to come and get another prescription. So there's unintended consequences of regulations that have been done to us. And that's also a dumb way to practice medicine. [LB408]

SENATOR HOWARD: Thank you. [LB408]

SENATOR ALBRECHT: Any other questions? Seeing none, thank you for your testimony, Doctor. Opponents. And you can certainly take some chairs up front so I know how many others want to come testify. [LB408]

JOHN McCARTHY: (Exhibit 4) Thank you. My name is Jack or John McCarthy, M-c-C-a-r-t-h-y. Senators, thank you for asking us to participate in the discussion of which medication should be available to workmen needing our care in Nebraska. Three concerns are part of our consideration of LB408. First, physicians in their medical practices need to be knowledgeable about medications risks, benefits, cost, and interactions. Today, the vast scope of medications can be daunting. The efficacy and cost of medications has been compiled for our decision process, yet cost alone should not be the sole determinate of workmen's compensation prescriptions. Second, the challenge is implementing changes into our practices which, I believe, should be done in a step-wise approach. Implementing the prescription drug monitoring program is important. This bill, which most physicians favor, is designed to increase our awareness and limit the prescription of opioid medications. This is important in any workmen's compensation program as opioids are often necessary following injuries or surgery. Most likely this group is also at an additional risk of abuse or addiction because of the multiple psychological pressures that occur in a work-related injury. It would be hard to assess whether adding a new, full formulary in contrast to further opioid limitations would improve the acceptance or enactment of the PDMP program. Just a word of caution, if we don't accept a formulary already used in Nebraska such as the Blue Cross Blue Shield program, I can tell you medical education on medications is changing. What I learned compared to what my daughter is currently learning in medical school is very different. Third, the population covered under workmen's compensation should have access to the conveniences and therapeutic benefits of convenient, newer medications and combination drugs, even if these are associated with an added cost as it may improve compliance. Areas where challenges arise in trying to follow a cost-focused formulary are as follows. For instance, two medications may have the same therapeutic benefits, yet one is once a day and the other is three times a day. If you are balancing work and home, the three times per day medication is unlikely to happen. Second, the combination medications that have

and are increasingly entering the market provide additional ease in prescribing and taking medications. For instance, many patients have gastrointestinal intolerance to non-steroidal medications which we often use for inflammation, pain, and arthritis. We can either give two medications which may or may not be taken simultaneously or one combination drug that are available, but are often more expensive. In reality, many of these patients don't even want a pill. Finally, the workmen's compensation population is young. This population merits access to medications that may have fewer side effects and potential long-term benefits for obvious reasons. In addition, younger patients don't take medication routinely. It's not that they don't want to be compliant, but rather a new twist in life. As you can see, our major concern is not the medications under Schedule II; it's all the other ones in this bill. I hope the questions raised will encourage the delay for the passage of LB408 until we are successful with the PDMP. Enactments of an unknown state formula for work comp may have negative effect on physician practices and our ability to care for patients under the Nebraska workmen's compensation program. Thank you. [LB408]

SENATOR ALBRECHT: Thank you, Doctor. Do we have any questions? Seeing none, thank you for your testimony. [LB408]

JOHN McCARTHY: Thank you. [LB408]

JON REHM: Good afternoon. My name is Jon Rehm. Good morning...good afternoon, Senators and Chairwoman. Jon Rehm testifying on behalf of the Nebraska Association of Trial Attorneys in opposition to... [LB408]

SENATOR ALBRECHT: Can you spell your name, please? [LB408]

JON REHM: Rehm, R-e-h-m. And here in opposition to LB408. And our objective in opposing LB408 is not to hinder efforts to solve the opioid or reduce harms from opioids. These are my clients as well. I've represented injured workers here in the state of Nebraska for 12 years. John Corrigan is going to testify I think in front of the AFL-CIO has represented workers longer than I have. These are our clients. These are people we see every day and I am very sensitive to the addiction issues. I also like the fact that Dr. McCarthy brought up the gastrointestinal issues which are also a huge problem. We have kind of an under known...lesser known problem than addiction issues. I represented a client who had a $60,000 emergency room bill from narcotic bowel blockage, for example. So I mean we want to be part of the solution. States like Massachusetts, for example, have developed like something akin to a workers' comp drug court within their...a drug court within their own workers' compensation court to help deal with these issues. And we'd fully support also any efforts to help our clients, especially those with lower back and orthopedic injuries reduce...look for ways to reduce pain without drugs, whether that's

exercise programs, whether that's nutrition, things that don't rely on drugs. Again, these are our clients and the more money that's spent on drugs is less money that they can get in benefits. And that's what the program...that's what workers' comp is supposed to do is benefit the employee. I have some concern...NATA has some concerns specifically about the use of drugs formularies in workers' compensation. And I think Senator Howard has touched on this a little bit wondering like who puts together the formulary? And nobody has really answered that. And from my research, who puts together the formulary...who administers the formulary is going to be a pharmacy benefit management corporation. So, the way the pharmacy benefit managers work is that they're paid a percentage of the discount that they can attain from a drug company, which presents two problems. One, the pharmacy benefit manager is the drug...is going to put the drugs on the formulary that they have a relationship with the drug company rather than maybe what's medically the best. Secondly, because they're paid off of a discount that they can obtain on the cost, there's incentive for drug companies to push up prices of these drugs. And this is a real thing. According to NCCI, which is a research...sort of a nonpartisan research organization for workers' comp, in 2015--and again, these are generic drugs--generic OxyContin with acetaminophen, which is a really old drug, went up 35 percent. Oxycodone went up 60 percent. Backlafin, which is a muscle relaxer, went up 86 percent. And again, these are generic drugs that have been around for as long as I've been in practice, as long as Jenny Panko has been in practice, John Corrigan has been in practice. And these, you know, the drug formularies push up costs in the system. And again, they say drug formularies aren't just about cost and that's fine. But in fact, I think drug formularies may in fact drive up costs. The other thing is with the IME if a drug is not on that list, if you want to go out and find a drug that's not on that list, that adds more litigation costs into...that adds more litigation cost, that adds more time in resolution of claims. And workers' compensation is supposed to be something like Dr. Bozarth said at the beginning, it's something that you substituted a tort, you substitute the right to sue your employer for negligence, you have a simplified procedure, and now we're adding procedures in because a drug that we'll say Dr. McCarthy wants to prescribe to his client isn't the one that he thinks is the best. Well, that's not on the list because, well, whoever is running the drug formulary didn't put it on the list. And so then again maybe I have to go to court or John Corrigan has to go to court and take up court time that...and do that. So it adds delay into the system. So we're...and I add again, we're willing to work on any proposal to deal with opioids. I've got personal...I know plenty of people with experience with addiction. We're not downplaying that, but we want to be part of it. But we have concerns, especially about the use of pharmacy benefit managers as it relates to drug formularies. [LB408]

SENATOR ALBRECHT: Very good. Thank you. Any questions? Can I just ask one. [LB408]

JON REHM: Sure. [LB408]

SENATOR ALBRECHT: So most of your testimony is that you don't think a pharmacy, those companies should be part of the formulary. But if that be said and then the medical field decides to get together and they know where they maybe want to be but yet the workmen's comp have seen some...I mean I feel like there would have to be quite a few different players here to find out what the best practice would be. [LB408]

JON REHM: And I agree, Senator. And the reason that...which is why I like the idea maybe of studying things. And I think the more information, the better because if we just ram the bill through what would probably happen is the Workers' Compensation Court would go out and get, you know...have a drug formulary and have a pharmacy benefit manager without the input from our doctors here in Nebraska. So I mean eventually somebody is going to have to administer the plan. I agree. But we need to go into that with eyes wide open and I think there needs to be some supervision from the Legislature and not just, you know, punt this off to the administrative state and let the...give the Legislature a role in overseeing that. [LB408]

SENATOR ALBRECHT: I appreciate that. Thank you for your comment. Thank you for your testimony. Another opponent? [LB408]

JOHN CORRIGAN: Good afternoon, Madam Chairman. It's John Corrigan, C-o-r-r-i-g-a-n. I'm here testifying on behalf of Nebraska AFL-CIO and in opposition to LB408. And I know it's late. I just want to reiterate a couple of issues. First, the question is whether the court will establish or be required to establish an evidence-based formulary. Our question is, whose evidence? And that's a question that is very important, because some of you may remember, maybe you don't, a few years ago we were here on another bill where the idea was we're going to have an evidence-based medical protocol for all workers' compensation injuries or treatment. And I think this is a way to open the door into that perspective. And the reason I think I'm probably right about that is because you have Schedules III, IV, and V on this list rather than what has taken up most of our time today and is the discussion of opioids. Workers' compensation is designed to benefit the injured worker and having a system that creates an impediment to the doctor's treatment is not in the interest of working people in our concept and that's why we have opposed this bill. I think another issue though is simply the question of how do you...what if there's a dispute? You have something in the bill that says you can have a request to receive an independent medical examination. And as that system exists now, there has to be a dispute between physicians before an independent medical examiner can be appointed. And right now under this proposal, you could have the formulary saying one thing, a physician saying another, and the court really can't do anything at that point because there is no other physician. There's just one physician saying, yeah, I think this is a reasonable and necessary medical treatment. And the bill doesn't go beyond that process in stating what do you do and in the event that there is a dispute between two physicians or if you request an independent medical opinion and that medical opinion is in favor of one side or the other, then who gets...what do you do after that? So that needs to be cleaned

up. But be that as it may, there's a lot of things that are in the hands of the employer in the workers' compensation context and not really at the whim of the employee and this is one more roadblock that is being pushed by the insurance carriers and it is not, in our opinion, necessary to do that when the medical community is standing up and saying we don't need this, we're going to police ourselves, because they're the ones that are for prescribing this medication. And so with that, I'd invite any questions and thank you for your consideration. [LB408]

SENATOR ALBRECHT: Thank you for your testimony. Senator Halloran. [LB408]

SENATOR HALLORAN: Yeah, thank you, Madam Chair. So, don't misunderstand me but just quizzically, do you think self-policing works well for any entity in life? [LB408]

JOHN CORRIGAN: Well, if the Legislature said we want to have these drugs, Schedule II drugs can't be given out to everybody because we have to have, as a matter of law, a formulary, okay, that may make more sense than saying to the injured workers, you are subject to different treatment because you're getting treated under work comp. Now, that's exactly what's happening here. They're suggesting work comp because these workers' compensation carriers and the people that...the Trucking Association and the truckers for equity or whatever they're called, they had the power to get together and decide let's try to influence policy. And is that necessary at the detriment to the relationship of the physicians to their patients to treat them as they deem appropriate? Now, if the Legislature's position is it is, then why would it be necessary for everybody that got medical treatment in the state of Nebraska regardless of whether it was because of a work injury or any other medically necessary treatment? [LB408]

SENATOR HALLORAN: I understand, but don't misunderstand my question. You mentioned self-policing you thought was the best way for the medical industry to... [LB408]

JOHN CORRIGAN: Well,... [LB408]

SENATOR HALLORAN: So you...I guess my question in general, I'm not a firm believer in self-policing of many things in life, but I'm just trying to qualify why you think that's the better approach. [LB408]

JOHN CORRIGAN: Well, under...as I understand it every physician has a license and that license is issued by the state of Nebraska. If they're going to practice medicine here and if they're a bad physician and they're giving out medications to people that are hurting them and not helping them, they can have their license pulled by the state of Nebraska by the Medical Director. And so... [LB408]

SENATOR HALLORAN: Does that happen often? [LB408]

JOHN CORRIGAN: It happens once in a while. And it happens to the people that we represent, too, that have to have professional licenses. But that is not...I guess what I'm saying is that's not the only aspect of self-policing. But what they're doing is trying to treat it in a holistic way, all parts of the medical community. And what the proponents of this bill are doing is saying, no, let's just do it to the people that are injured in work accidents without looking at how it affects all aspects of the medical community. And we think that is a power grab and nothing more in this sense. Now, if we're just talking about opioids and we're just talking...and we're talking about a system that is based on actual medical evidence as opposed to insurance industry prerogatives then maybe that's a conversation that we could have. [LB408]

SENATOR HALLORAN: Can you think of a better alternative than what this bill proposes, I mean in terms of misprescribing the opioids, for example. I mean it does appear as though from some testimony and just from some evidence of articles I've read that part of the big problem is it's just...it is overprescribed in the wrong...for the wrong purpose. [LB408]

JOHN CORRIGAN: I guess I do understand the statements from both sides of this issue, that there is a problem with opioids. I don't know that it's particularly a workers' compensation problem, but there is a problem with opioid use in our population. But the best alternative to that process is probably the PDMP program that has been advocated both in the floor of the Legislature and by the medical community. But to say we're going to fix the problem by eliminating or altering access to medical care for injured workers as opposed to the rest of the society is really not fair in my mind. [LB408]

SENATOR HALLORAN: So you don't think this is a speed bump? You think this is really going to minimize access for certain painkillers? [LB408]

JOHN CORRIGAN: Well, if...no, right now it says Class II, III, IV, and V. And that's certainly going to eliminate access and, as the doctors pointed out, this formulary is not going to keep up with medical science. So I as an injured worker I'm not going to have the same access to medication that I might have if I wasn't injured at work, if I ran through my general or group health insurance because that doctor isn't going to have that impediment or I'm not going to have that impediment of paying out of pocket as opposed to having the responsible party pay for it at the point that I buy the drugs. So that's the problem and that is part of the objection. [LB408]

SENATOR HALLORAN: Okay. Thank you. [LB408]

SENATOR ALBRECHT: Any other questions? I have just one. Your example you were talking about, who...it would be the patient, the doctor. And the patient is wanting more drugs because he's in more pain. Do you feel that the Workmen's Comp Court could step in and get a second opinion since there's only one doctor? [LB408]

JOHN CORRIGAN: I suppose the judge could...a Workers' Compensation Court judge could ask for a medical evaluation if they wanted to. But right now, the way that system works is if I want the court to appoint an independent medical evaluator I have to show that there are two competing medical opinions that exist at that time. And then they will appoint an independent medical evaluator to decide the question. And not even necessarily to decide the question but to opine on the question. Then the judge is free to do whatever they want. But under this current...the language here, you have an insurance...an evidence-based formulary--I'm not sure again who's evidence it is--that makes a decision to exclude a particular type of medication and a treating physician who says, yes, this is necessary and needed. And then there's going to be this application for the appointment of a medical...independent medical evaluation that may take three or four weeks to process. Then the doctor is going to get appointed. And then three months or 90 days, 30 days down the line that doctor has time to see that person, formulate an opinion, send it in writing back to the court. And then you're going to go in front of a judge for a hearing. And all the while, one, this individual is not getting the medication that their physician says they need. Now, whether they need it or not is obviously maybe an issue. [LB408]

SENATOR ALBRECHT: I mean that would be a long time to wait, but would you at that point already be working with that person possibly to help them? [LB408]

JOHN CORRIGAN: People come to lawyers when something bad happens to them. They don't come say hi to us because everything's going very well. But... [LB408]

SENATOR ALBRECHT: But would you be able to step in on their behalf... [LB408]

JOHN CORRIGAN: I couldn't do anything until a judge says, yes, you get this medical benefit. And this happens under the current system regularly. But we don't have fights about medication. I mean hardly ever does it come up that we're going to fight about whether a particular medication is covered or not. We may have fights about whether it's duty related or if it's related to the condition caused by the work accident, but not whether the medication is appropriate. These fights really don't exist in the workers' compensation context to the point that they would if we implemented this program. [LB408]

SENATOR ALBRECHT: Okay, but would you agree with the conversations that we've had today that there is a problem out there with the drugs? [LB408]

JOHN CORRIGAN: Well, there's certainly a problem with opioid drugs. I mean if you look at the percentage of medication consumed in this country versus the rest of the world, we have a real problem. Now, does that mean the injured workers are the problem? I don't think so. [LB408]

SENATOR ALBRECHT: And I can agree with you that it shouldn't just be the workmen's comp people. It should be anybody that has to go on a pain medication that some facility or doctor might not know whether it's a good one or bad one. But if we're recognizing that we do have problems with III, IV, and V then maybe we need to be addressing it for everyone. But thank you for your testimony. [LB408]

JOHN CORRIGAN: Okay. Thank you. [LB408]

SENATOR ALBRECHT: Do we have any other opponents wishing to speak? Any other opponents? Seeing none, we'll go on to a neutral position. Anyone in a neutral position? [LB408]

TAMRA WALZ: Good afternoon, Senators. My name is Tamra Walz, T-a-m-r-a W-a-l-z. I'm the current Administrator of the Workers' Compensation Court and I'm here testifying in a neutral capacity, much as I did last week before you. Just to let you know that in terms of our court and how this bill, if it were to be passed would be implemented, we would look to an outside source to assist us in terms of finding a drug formulary to use. We do not have the expertise, as Senator Howard asked about earlier, to make those kind of determinations in terms of pharmaceuticals. That's not within our purview. So we would be looking outside for that. Additionally as a court, we generally try to remain the adjudicatory wing or the part of the judicial branch of government, not the legislative. So we feel like this is a policy decision for you to make as a Legislature to let us know is this something that you want us to implement? If you do then we will. We bow to your expertise as the policymakers. But as far as the judiciary goes, we would listen to what you say and we would go out there and look for a formulary that we feel would best suit the injured employees with our state and that's how we'd administer it. So I just wanted to clarify that given the questions that Senator Howard had previously. [LB408]

SENATOR ALBRECHT: Thank you. Questions? Yes, Senator Howard. [LB408]

SENATOR HOWARD: So when you're saying that you would go to an outside source for the formulary, does it look like a third party contractor or do you think you would just find a formulary and apply it? [LB408]

TAMRA WALZ: Well, I've talked with our manager in regulatory programs and he's the one that would actually be in...that I would put in charge of that facet in terms of developing the formulary. And he's not certain if we would go to a third party company that would look at Nebraska and formulate something specific or if we would look at something that already exists perhaps in another state. We haven't gotten that far into the process yet because we're waiting to see as a policy...as policymakers what you're going to kind of decide and tell us to do. And then we'll implement whatever it is that you decide. [LB408]

SENATOR HOWARD: So should we be more prescriptive that we want you to use, say, for example, a Nebraska formulary? One of the physicians mentioned it would be better if we were using a formulary that already exists in the state rather than going to another state. [LB408]

TAMRA WALZ: I understand the concerns that people want it to be applicable to injured workers here in our state because certainly...I know there's been some talk about Texas this afternoon. That's certainly a different state than Nebraska in many ways. So I guess I would prefer to have something that's tailored to our state. Now, without talking to our regulatory manager about his knowledge about all the various formularies, I can't intelligently answer that. But I can certainly talk with him and get back to you about that if that would be helpful. [LB408]

SENATOR HOWARD: Yes, that would be really helpful. And then can you tell me the medical background of your regulatory manager. [LB408]

TAMRA WALZ: We don't have any medical expertise within our office. I say that with all due respect to my employees because I have an excellent team. But we do not have, for example, a medical director. When the bill came forward a number of years ago, there was some talk about us getting a medical director. And I believe the fiscal note for a part-time medical director was $250,000. And so at that point I think whoever had drafted the bill that point--I apologize; that was before me--took a step back and decided that maybe that fiscal impact was a little bit too much for us to absorb at that point. [LB408]

SENATOR HOWARD: Okay. Thank you so much. [LB408]

TAMRA WALZ: You're welcome. [LB408]

SENATOR ALBRECHT: Very good. Any other questions? Seeing none, thank you for coming. [LB408]

TAMRA WALZ: Thank you. [LB408]

SENATOR ALBRECHT: Do we have anyone else in a neutral capacity that would like to speak? (Exhibit 5) Seeing none, we do have one letter from Joni Cover, CEO of Nebraska Pharmacists Association. She's a proponent. And Senator Lowe to close. [LB408]

SENATOR LOWE: (Exhibit 6) First of all, I'd like to thank everybody who came out today to testify, both pro and against. It's been eyeopening and a very good discussion today. LB408 is a bill designed to help individuals, doctors, and the state of Nebraska. This bill is modeled after drug formularies that have been implemented in Democrat- and Republican-run states, large states and smaller states. It is an idea that could bring about cost reduction for the state and better care for individuals that need medication. These two benefits in and of themselves make this a worthy discussion, but there are potentially an even more important reason to support this bill: A drug formulary could play a role in helping to address opioid addiction issues. Recently the Governor and Attorney General took steps to help curb this issue and I believe this bill could be one more tool to accomplish that important goal. Now we have heard some concerns about this bill today. One of those concerns was that this bill was too broad. I would ask those individuals to present language so that we can work together to address those concerns. Others have mentioned that the prescription drug monitoring bill brought by Senator Howard has...excuse me, Dr. Howard (laughter) has addressed this issue. To that I respectfully disagree. Senator Howard's efforts have gone a long way in helping our state address the prescription drug overdose but I believe there is still more that can be done and should be done. The nice thing is we don't have to reinvent the drug formulary. We are not the first state to look at this. We can look at other states and tweak them to Nebraska and our people and our laws. This is narrower than most states have in their formularies. And I believe no worker should be without pain care and that this will look at proper and safe drugs that may be less addictive. And the last thing I want to do is tell a doctor how to doctor or a PA how to doctor or a nurse practitioner how to care for their patients, but we need to look at new drugs and have that opportunity too. These are not restrictions. This is a guideline to help the doctor do what the doctor does best. I now await any additional questions. [LB408]

SENATOR ALBRECHT: Senator Halloran. [LB408]

SENATOR HALLORAN: No, I'm just waving. (Laughter) [LB408]

SENATOR HOWARD: He's just waving. [LB408]

SENATOR ALBRECHT: No other questions? I appreciate you wanting to work with everyone. So hopefully they'll get a hold of you and we can see what we can do with this. Thank you for your bill. Moving on to LB319. Senator Halloran, you're up. Thank you all for being here and putting up with the heat. We get to do this every day. (Laugh). [LB408]

SENATOR HALLORAN: Do we have a telephone book? [LB319]

SENATOR ALBRECHT: You're fine. I can see. [LB319]

SENATOR HALLORAN: Are we ready? Okay. Good afternoon, Chairperson Senator Joni Albrecht and members of the Business and Labor Committee. For the record, my name is Senator Steve Halloran--now look closely at the spelling--S-t-e-v-e H-a-l-l-o-r-a-n, and I represent the 33rd Legislative District. I'm here today to introduce LB319 to the committee for your consideration. I intend to keep my remarks brief this afternoon allowing for more time and for individuals that will follow me. LB319 would make first injury reports related to workplace injuries confidential unless the employee waives confidentiality to allow the report to be made available for public inspection, except as necessary for the Compensation Court to administer and enforce other provisions of the Nebraska Workers' Compensation Act or unless--and there's eight unlesses--number one, and employee elects to waive confidentiality; two, the requester is the employee who is the subject of the report or an attorney or authorized agent of the employee; three the requester is the employer, workers' compensation insurer, risk management pool, or a third-party administrator that is a party to the report or an attorney or authorized agent of such party. This is exciting stuff, I know. The requester is an authorized agent, authorized representative attorney, investigator, consultant or adjuster of an insurance carrier, or a third-party administrator who is involved in administrating any claim for insurance benefits relating to any injury of the employee whose report is filed with the Compensation Court. Number five, the report is used for the purpose of state or federal investigation or examinations or for the state or federal government to compile statistical information; six, the report requested is sought for the purpose of identifying the number and nature of any injuries to any employee of an employer identified in the request without revealing the identity of the employee; seven, the report requesting is...the report requested is a pleading or an exhibit submitted with a pleading filed with the Compensation Court; and eight, release of the report is ordered by a court of competent jurisdiction. Please note...please make note of the following amendments, AM475, which is on...for page 5, line 3 which simply adds "or conduct research" after the word "information". Place also note, HIPAA laws do not cover workmen's compensation first injury reports. Other states that have similar protective laws in place are North Dakota, South Dakota, Kansas, Missouri, and Montana. And with that, I would be glad to answer questions, but I will certainly relinquish any questions I can't answer to those that will follow me. [LB319]

SENATOR ALBRECHT: Very good. Questions? [LB319]

SENATOR HALLORAN: Dr. Howard. [LB319]

SENATOR ALBRECHT: Senator Howard. [LB319]

SENATOR HOWARD: Can you tell me who brought this bill to you? [LB319]

SENATOR HALLORAN: I can. It was the Nebraskans for Workers' Compensation Equity and Fairness. [LB319]

SENATOR HOWARD: Okay. Thank you. [LB319]

SENATOR ALBRECHT: Any other questions? Seeing none, would you like to sit in the audience or...? [LB319]

SENATOR HALLORAN: I would be glad to join the audience. [LB319]

SENATOR ALBRECHT: Okay we're opening up for proponents. [LB319]

ROBERT HALLSTROM: Chairman Albrecht, members of the committee, for the record, my name is still Robert J. Hallstrom, H-a-l-l-s-t-r-o-m. I appear before you today as registered lobbyist for the Nebraskans for Workers' Compensation Equity and Fairness as well as the National Federation Independent Business. I've also been authorized to sign in in support of LB319 on behalf of the Nebraska Trucking Association and the Greater Omaha Chamber of Commerce. Senator Halloran has touched on most of the materials that are in my written testimony. I think just a couple things--I think with regard to the solicitations that come from the publication of the first injury reports is the fact that we probably don't have an inability of individuals to find lawyers today, whether it's through the old fashioned Yellow Pages or a click on the Internet. I Googled Nebraska compensation trial lawyer and I had at least 50 workers compensation lawyers, and from what I know, many of them very good ones, probably all of them very good ones. But there is not a dearth of ability of folks to find an attorney. And so we don't think the solicitation letters that go out by being able to comb the first injury reports that are public should be continued. Senator Halloran noted that a majority of the states, not just those that are around us that he has mentioned, a majority of the states have these types of provisions. My testimony also notes that interestingly in 48-612 and 48-612.01 relating to unemployment insurance, we do have confidentiality protections for unemployment insurance records regarding individuals who have been laid off through no fault of their own. Similarly workers' compensation is a program designed to help people who have been injured through no fault of their own. A couple things I'd like to end up with, the first one is with regard to the solicitation letters. With my comments earlier about the ease with which individuals can find attorneys coupled with the fact that the Workers' Compensation Court and in many cases the individual employers provide information to the employees regarding their rights, I found it interesting, and I'll try to quote exactly Mr. Corrigan on the last bill said, people come to us when something bad has happened; they don't come to us when things are going well. So I question

why we need to have solicitations at the inception when we don't know yet whether something is going bad or things are going well to encourage people to get representation under those circumstances. Another issue and, Senator Howard, I want to publicly thank you for what you did with regard to the redacted information. I think that's very significant and appreciate that on the earlier hearing. But it also I think highlights the sensitivity of the issue. Workers' compensation records are exempt under HIPAA, not sure why but that's what the federal law provides. But that's not the expectation that our employees have. Our employees expect for information regarding their sensitive medical information to remain private and if it's sensitive enough that I can see that the information that you redacted on the paper isn't quite good enough, our employees have the same concerns because that same information--name, address, and diagnosis of injury--are on the first injury report. And that's the information they would prefer, unless they opt out under this bill as drafted, not to have shared with the public. So with that, I'd be happy to address any questions the committee may have. Thank you. [LB319]

SENATOR ALBRECHT: Thank you for your testimony. Any questions? Seeing none, thank you. [LB319]

ROBERT HALLSTROM: Thank you. [LB319]

RON SEDLACEK: Chairman Albrecht, members of the Business and Labor Committee, for the record, my name is Ron Sedlacek, R-o-n S-e-d-l-a-c-e-k, on behalf of the Nebraska Chamber of Commerce and Industry. I'm not sure if this is the twelfth time I've testified on this bill, perhaps more. I'm not sure. It's been a long time since Judge Novicoff in the early '80s brought...he was Presiding Judge of the Work Comp Court at this time presented a similar concept all the way up to Senator Kolowski's bill a couple years...two or three sessions ago dealing with this and allowed for the patient to do the opt out as far as confidentiality is concerned. I know there was legislation after that. Again, we support the concepts contained in this legislation. The very reasons that Mr. Hallstrom spoke of, quite often the solicitation letters come in, employees wonder why this health information is being released, and some find it intrusive. Even if it takes another...we have a number of notices to employees injured employees as to how...what their rights are even if we have to have another notice to say here are your rights again immediately, that would be fine. But it would satisfy a common complaint. And with that, I'll end my testimony. [LB319]

SENATOR ALBRECHT: Very good. Questions? Seeing none, thank you. [LB319]

RON SEDLACEK: Thank you. [LB319]

ROBERT BALL: Senator Albrecht, members of the committee, my name is Robert Ball, R-o-b-e-r-t B-a-l-l. I'm here representing Hormel Foods in support of LB319. I'm going to keep my comments brief in the essence of time and temperature today. If I was to do this every day I think I probably would wear less clothes. Our concern on the employer side is I have employees that when they return to me in the clinic, their first words to me are, why did you give my information to all those attorneys because they have received numerous letters when that first report of injury gets filed to the state and the attorneys solicit by giving...sending out letters to those employees. So they ask the question why did you give my information? We explain that we have to provide a first report of injury to the state of Nebraska and that's public record. The next question is, do I need an attorney? I don't think I put the company in a very good position because we're not going to answer that either way yes or no. It's not up to us to make that determination. So that being said, we certainly support LB319. That's all I have. [LB319]

SENATOR ALBRECHT: Thank you for your testimony. Do we have any questions? Seeing none, thank you very much. [LB319]

ROBERT BALL: Thank you. [LB319]

SENATOR ALBRECHT: Hi. [LB319]

JIM STEELE: Do I wait for the green light? [LB319]

SENATOR ALBRECHT: She'll put the light on as soon as you say your name. [LB319]

JIM STEELE: (Exhibit 1) Okay. Hello, my name is Jim Steele; that's spelled J-i-m S-t-e-e-l-e. I am the Environmental, Health, and Safety Manager with Airlite Plastics Company, a manufacturing company in Omaha, Nebraska. I am speaking in support of LB319 which gives our employees the right to protect their personal information when first reports of alleged occupational injuries or illness forms are submitted to the Workers Compensation Court. I support this bill for the following reasons: one, the right to privacy of medical information. Most people have come to appreciate their right to privacy of medical records. They are surprised and sometimes incredulous when they learn their rights don't apply when it's work related, when their injuries are work related, or their medical conditions are work related. One maintenance worker recently told me that he was never reporting another injury as soon as he realized that his medical records were not going to be confidential. Early reporting is the second reason and this is something that we do well at my particular company. Employees who learn their injuries are...I'm sorry, employees who learn their injury illness reports will be public records are reluctant to report minor conditions. Many of these minor conditions can worsen over time if not treated properly in the early stages. Strained shoulders and back injuries are an example at my

company. What starts with a minor discomfort can quickly become a serious condition that is painful, debilitating, and difficult and expensive to treat. My own experience and all of the research I've read shows the sooner a condition is reported, the better the outcome for the injured worker. However, the lack of privacy employees can expect makes it difficult to encourage employees to report these early symptoms. The third reason is litigious letters to employees. Many times employees tell me they received numerous letters from attorneys encouraging them to litigate. When they start getting these letters, some complain angrily that we reported their early symptoms which is required by the workers' compensation rules. At my company because employees complained about the attorney letters and lack of privacy, we started giving the employees information sheets telling them about these letters explaining their rights as outlined in the Workers' Compensation Court Web site and giving them contact information if they have any questions. Of course, no one wants attorneys sending letters encouraging litigation against them. But the lack of privacy a person can expect for their medical information and the dampening of employees' willingness to report early conditions can cost employees and employers considerably. [LB319]

SENATOR ALBRECHT: Thank you. Questions? Seeing none, thank you for your testimony. [LB319]

JIM STEELE: Okay. [LB319]

SENATOR ALBRECHT: Do we have any other proponents wishing to speak? Any other proponents? We'll move on to opponents. I do have one letter in support...nope...okay, sorry. Opponents. [LB319]

JOHN CORRIGAN: Good afternoon, Madam Chair. John Corrigan, J-o-h-n C-o-r-r-i-g-a-n. I'm an attorney in Omaha and I represent the Nebraska AFL-CIO and we're here to advocate our opposition to LB319. I was in front of this committee I think two years ago. I think this is an identical bill. A little bit has changed but essentially it's the bill to make the first report of injury forms private except by some release or under certain terms. And the reason that the AFL-CIO executive board over time has been opposed to this bill is, one, the fact that a first report of injury report is a public record doesn't mean that your medical records are public record. The only thing that shows up on that form is the name of the worker, the name of the employer, there might be some addresses on there, there might be the insurance carrier, and the nature of the injury describes maybe...the area of the body that was alleged to have been injured, and some other information. If you haven't seen it, we can certainly get a copy the first report to you. But that doesn't mean that then all of your medical records are going to the court or to anybody. The reality is though that once an injured worker says I injured my body as a result of a work accident, that person's entire medical history is open to discovery by the employer. That's what

people don't know and should know. And yes, people get letters from lawyers and our clients, our members get letters from lawyers. Maybe they like them, maybe they don't. But at the end of the day you have to ask yourself who is asking you to get rid of this? Is it the workers? Is the AFL-CIO coming and saying stop these lawyers who are giving all this free information to us to help our injured workers? No, it's the truck...Nebraskans for Workers' Compensation Equity, which I don't even know what that means, but in any event it's the people that have to pay for workers' compensation benefits that don't want this information going to their people that have suffered work injuries. And the reason it's really important is workers' compensation, they don't teach it to you in high school, they don't teach it to you in college, it's really complicated. I want you to ask yourself, do you know whether or not the employer can have you sign a Form 50 when you get hired and if they do, is that effective for the rest of your employment? If you don't know that, you're probably in the 99th percentile of people in the state of Nebraska. But why that's important is because that form and when you sign it, it's the selection of a physician form, is only effective after an injury has occurred. But if you didn't get a letter from an attorney telling you that, maybe you'll get bulldozed by the employer who says, here, no, remember when you started and I had you sign all those forms and one of them was that you'd agree to treat with my doctor in case you got injured? Well, you have to treat with my doctor now. And six months down the road when it didn't go well and they show up at our office and they say hey something bad happened and now I need help, they didn't know that. But these letters are a public service in some ways because the lawyers spend the money to send it out. And if the employers don't like that I can understand that. But it is not necessary to protect the privacy of workers injured in accidents to close off this access to advice that is very valuable in a very dangerous point in people's lives that is when their income and their ability to take care of their families has been placed in jeopardy. And so with that, I'd entertain any questions and I thank you for your time. [LB319]

SENATOR ALBRECHT: Thank you. Are there any questions? Seeing none, thank you. [LB319]

JOHN CORRIGAN: Thank you. [LB319]

SHAWN RENNER: Good afternoon, Chairman Albrecht, members of the committee. My name is Shawn, S-h-a-w-n, Renner, R-e-n-n-e-r. I'm a lawyer with the Cline Williams Law Firm here Lincoln. I appeared today on behalf of a client, Media of Nebraska, Inc. Media of Nebraska, for those of you new to the legislative process, is a nonprofit corporation comprised of the print and broadcast news media in the state. Its constituent members are the Nebraska Broadcasters Association, the Nebraska Press Association, the Nebraska Daily Publishers Association, the Omaha World-Herald, and the Lincoln Journal Star. I'm here today to oppose LB319. I want to mention as I do this and I'll wrap it up with the same comment to you, I've been in touch with Mr. Hallstrom. There is an amendment that he is aware of that would except or provide

additional exception to the list in the bill right now for news media. My clients have agreed to be neutral on the bill if that amendment is adopted. That is actually a change in position for my organization. As Mr. Sedlacek indicated, this bill has been around forever in one form or another. I don't know if 12 is a correct count or not, but I'm sure I've testified at least 10 times on it over the years. And to be clear why the news media oppose the bill, this is a filing that's made with a court. The diet that my clients have in order to provide information to the public consists largely of gathering, reviewing, analyzing, and reporting on public records. First reports of injury are among those public records. Court filings generally are among those public records. I agree with the previous testifier, the issue here is not medical records. A first report of injury is a single page form. It does not contain detailed medical information. It commences the workers' compensation process. This bill is driven by the fact that employers don't want lawyers soliciting people by getting workers' compensation first reports of injury and writing them letters. I understand that and my clients have no dog in that fight whatsoever. I represent the regular news media, the folks you see on TV and newspaper. And I'll tell you also that they're not using these records often. It comes up every once in a while though when there is a prominent Workers' Compensation Court case, for example, and the employer and the employee disagree on what happened, why it happened, what the consequences are, and there's a court decision on it. That's something the news media does report on, on occasion. And my clients believe that when you avail yourself--in this instance that's how an employee has to operate, they have no choice, this is the system we provided to them--when you avail yourselves of the public court system, the public has an interest in knowing what's going on in their court system. And our objection is no more significant than that, nor no more complicated than that I should say. And that applies across the board. I'll close with the comments I made three or four years ago the last time this bill was up, I can't remember for sure when it was. I had been in a car accident the week before the hearing on the bill at the time. And as happens with car accidents, there was an accident report that was filed. The police officer wrote it out. It got filed in the court file. And that's available for public inspection too. That's a public record. Within a week I had a dozen letters from lawyers in Lincoln here offering to represent me in connection with the accident that I had. So this is not a workers' compensation issue as such. I mean there are...the nature of our public society is that there is much public information about everybody out there. And when the court system is involved my clients, the news media, believe that's entirely appropriate. This is the means that we have used to resolve disputes in our society so we don't all get clubs and hit each other. And when that's true the media needs access to court records in order to do what it believes its job is and that is to find out what's happening and report on it. Again, you won't see a story in the Omaha World-Herald saying John Jones...there was a first report of injury that said John Jones was hurt last week. That's not what's going on from my clients' standpoint here. Again, I'll close by saying there is an amendment. I don't know if it will be accepted by the proponents of the bill or Senator Halloran, but to the extent that it would except the news media, add an exception to the long list that's already in the bill about people that can get access to these reports, my clients will live with it. We'll be neutral. However, if the answer is, no, only the

employee, the employer, and the insurers get to have access to information, I think that's not in society's best interest. Thank you. [LB319]

SENATOR ALBRECHT: Very good. Questions? Seeing none, thank you for being here. [LB319]

SHAWN RENNER: Thank you. [LB319]

JON REHM: Good afternoon. Jon Rehm again and for this bill I'm testifying on behalf of both Nebraska Association of Trial Attorneys and the Nebraska State Bar Association. I just got tagged. [LB319]

SENATOR ALBRECHT: And just spell your name for us again. [LB319]

JON REHM: Jon, J-o-n, last name Rehm, R-e-h-m. And to make the NSBA's argument first, other...public...there's records that are used...public records that are used as bases of solicit...for public solicitation: birth records, death records, marriage records, real estate records. Why should lawyers be any different? You know, why should that be any different, especially since the communications that we send of lawyers are regulated by what the Supreme Court says we can say. So our communications with our prospective clients are already more regulated than other potential businesses. My concern about the...a couple things. You know, John Corrigan talked about Rule 50 which is the right to pick your own doctor, now...which the Workers' Comp Court makes rules. And if an employee chooses to see their own doctor, not the doctor that the employer might want them to see, the employer right now has the right to look at their medical records, not just for the fact that, you know, maybe look for preexisting knee or ankle problems. But they can look at everything including sexually transmitted diseases, mental illness, stuff that may or may not have anything to do with their employment. If the employee decides that they want to pick their own doctor, the employer right now has the right to, by rule, to look at those. A couple of the concerns that I have or that NATA has about the first reports of injury not being confidential, I see this is a worker safety issue. OSHA right now has a new reporting rule that requires the OSHA logs to be posted in a public break room. Part of the advantage of having the first reports of injury, having the first reports of injuries being public is that an employee can look at those anonymously and see, okay, well, it looks like I hurt my hand here. How many other people have carpal tunnel at my work site? And that's something that they could look up right now. And I understand there's an exception in the bill. But if you're an employee and you're asking for a first report of injury, I think there's going to be some legitimate fear on behalf of an employee that they're...that they might be retaliated against. In fact, that situation might invite retaliation if somebody is looking, doing investigation for a work injury. The other thing is there is a lack of information about workers' compensation laws in Nebraska. I mean for example, we

don't have a poster about workers' compensation rights that's objective like some other states do. Like Illinois has a pretty good poster. We don't have that similar to what we have for minimum wage laws, Family Medical Leave Act, Fair Labor Standards Act, even unemployment. And getting to unemployment, going back to Bob Hallstrom's argument, I think the difference between a workers' compensation and unemployment is workers' compensation is a workplace safety law, you know. Unemployment is about economic security. Workers' compensation addresses both workplace safety and economic security because of a work injury. I think finally in conclusion, the bottom line is if there's problems in a workers' compensation case from the from the prospective of the employer--something is not getting paid or if there's a dispute--those employees are not going to be calling...they're not going to call lawyers. And you know, I looked at the workers' compensation statistics I believe for 2014 or 2015 and only 3 percent of these cases that are...that merit a report end up even litigated. So this is the cases where there's a problem, where there is a dispute is very...is fairly small. So we're looking at a very small subset of cases and the more information people can get, the better. And you know, maybe the letters are a little bit old school but not everybody has Internet access, has readily accessible Internet access, especially in rural areas. People with lesser educations, people who don't speak...you know, maybe don't speak English, maybe it's harder for them to access it. Sometimes for...the letters can be phrased in Spanish. So I mean it's just the more information, the better, so. And I realize that there's probably more information now than when this bill came out available on-line. But not all...there's that old meme on the Internet where Abraham Lincoln is quoting don't believe everything you read on the Internet. So it's good to get people in contact with people who know what's going on. So I think that's the...one of the other purposes of these solicitation letters. So I entertain any questions. [LB319]

SENATOR ALBRECHT: Do we have any questions? I guess I do. [LB319]

JON REHM: Sure. [LB319]

SENATOR ALBRECHT: You talked about that 3 percent. Only 3 percent really even talk to you all about their situation, or do you find that it really starts to escalate if there's problems with their care or the employer is wanting them to come back sooner than later. I mean when is it that they solicit... [LB319]

JON REHM: When they're calling us? [LB319]

SENATOR ALBRECHT: Yes. [LB319]

JON REHM: One, if they're not...if they've been off work and the not being paid. If they're at risk of maybe...they've been off work and for whatever reason they're maybe being...some people feel

like they're being pressed to go back to work too soon. Other times if somebody has, you know, maybe exhausted what FMLA leave can get 12 week...most bigger employers have FMLA leave. You're out of your 12 weeks of FMLA and they're asking when can you come back, what can you do? People contact us. So it's problems with medical care. I mean they're contacting us when there's problems. And again, the 3 percent figure is...I think there's roughly about 40,000 cases first report of injuries filed with the Nebraska Workers' Compensation Court. And I think there's about 1,200 petitions filed in the Nebraska...petitions. There's a separate court, so a lot of cases happen where they get hurt. People are off work. They pay them their permanent disability and they move on. We don't see cases like that. [LB319]

SENATOR ALBRECHT: Do you think some employees, you know, they might be told what to do once something has happened? But do you feel a lot of them probably wouldn't want to sue their employer or take anything like that up if they...? [LB319]

JON REHM: Yeah, there's some reticence to do it. But I think in particular it's people who grew up in Nebraska I think that are tend to be...that, you know, people say, oh, I'm not somebody to sue somebody. But by the time they're talking to a lawyer they've kind of...they're at their wit's end. So, yeah, I mean that's a common situation that people don't want to cause trouble but they're not...they're in a situation where, for whatever reason, either they're not getting their medical care paid or they're getting their medical care paid and they're off work and not being paid. [LB319]

SENATOR ALBRECHT: Have you testified on this bill often in these ten years that they're talking about it has been around? [LB319]

JON REHM: Personally? No, this is the first time I've come down for this one. [LB319]

SENATOR ALBRECHT: Okay. Very good. First time for us, too, me anyway. So, appreciate your testimony. Thank you. [LB319]

JON REHM: Yeah, thanks. Thank you, Senator. [LB319]

SENATOR ALBRECHT: Okay, any other opponents? Hi there. [LB319]

MIKE DYER: (Exhibit 2) Hi, my name is Mike Dyer, M-i-k-e D-y-e-r. In 1983 I was a police officer in New York City and I was injured in the line of duty. I was forced out on a medical disability in 1985 and I've been receiving workers' compensation benefits including medical treatment ever since. I've been a licensed practicing attorney in Nebraska since 1991 and help

people who are injured. The pamphlet that's being handed out, I mail that out to people who are injured. The ethics rules say I can't call somebody who's injured and I can't directly contact a person who's injured. And if I do send anything out, it's going to say in the bottom that this is an advertisement. This pamphlet provides workers employee-driven information about their rights under the workers' compensation laws. These rights are really not something that laborers, truck drivers, or a nurse would have any reason to really know about in their normal course of employment until they have a work-related injury or a reason to know about it: for example, choice of physicians, to be able to choose their own physicians, to be paid for mileage to go to the doctors, to be reimbursed for that, compensation for temporary disability benefits or permanent impairment or possible loss of earning ability, vocational rehab, and all the other benefits that this legislative body have given to injured workers in Nebraska. There's no obligation for the workers' compensation carriers to advise an injured worker of their rights. It doesn't exist. In fact, if a workers' compensation carrier fails to communicate pertinent information to the claimant or doesn't act in good faith by not telling the truth or in a number of other reasons, the Supreme Court of Nebraska says...prohibits the claimant from bringing an action of bad faith against the workers' compensation carrier. So there's no recourse. If the claimant looks to Workers' Compensation Court for advice, they can look at the court's Web site and they can make a phone call to the court, but the court is specifically prohibited from giving legal advice. The Workers' Compensation Court can tell an injured employee where to find the law, but they can't tell them how that law applies to their specific circumstance. So when the injured worker asks, okay, I read the law, I know what it is, how does my fact scenario plug into that, the person at the Workers' Compensation Court they may be speaking to can't answer that or they would be practicing law. And these people are injured employees. By definition, an employee is subordinate to the employer. The employee wants to do what they're told. They want to be an asset. They don't want to be a liability. They want to be helpful and they don't want to be a burden to the employer. They're there to make a profit not to cost them. When an injured employee goes through an injury there's a lot of thoughts. From personal experience I can tell you you're embarrassed. You're thought of maybe...you're being perceived as a whiner or a complainer, or even worse, a faker or a fraud. No matter what the circumstance, people have those things in the back of their mind. And they'll be compliant and do what they're told by their employer or the workers' compensation carrier because of their subordinate role in being compliant not only to preserve their integrity of, no, I'm really hurt, I'll do whatever you want me to do, but to preserve their employment. In LB319, Paragraph (3)(b) of the bill states in part: An employee may waive confidentiality for reports involving such employee. How does a subordinate answer the question that the employer asks, you don't want your injury report being made public, do you? Now rule...form 50 which is the choice of physician form that the employee has to look at and check a box gives the employee, the injured worker, an opportunity to choose who the doctor is instead of the doctor being appointed by the company. And they've got to affirmatively check one of those boxes. This is a reverse. This LB319 language puts the burden on the employee to say I waive my confidentiality. The passage of this bill would mean

that injured workers would not receive employee-driven information but receive information from the employer, from the insurance carrier, from locker room, from gossip, from sources that may not have their best interests in mind. For many years, I along with a lot of other attorneys in this state have used the workers' compensation injury reports to mail detailed information to injured workers on the list about their rights. And I routinely get positive feedback from these injured workers. Information I send them has provided them with helpful information they were unaware of. And a lot of these injured workers are not very sophisticated. Some of them are. Some of them are computer programmers who hurt their back lifting a PC. Other ones who are finishing cement or swinging a hammer all day, some of them don't even have an e-mail address and they don't really look at the computer and know where to go on Google to find things that we may find second nature. We have a variety of different residents and people in Nebraska and we should be able to help everybody by giving them as much information as possible. If they get something in the mail that they don't like, the garbage is right...I know in my house when I go through the mail, my wife does too, the garbage can is right there. About half of it goes away. If you don't look at it that's fine. But the information I send out is made to even the playing field so that the injured workers have that information to at least go to, to question if their rights are being preserved. Thank you. [LB319]

SENATOR ALBRECHT: Thank you for your testimony. Do we have any questions from the committee? Seeing none, thank you for coming. [LB319]

MIKE DYER: Thank you. [LB319]

SENATOR ALBRECHT: Okay, any other opponents? [LB319]

JOHN LINGO: Good afternoon, Senators. My name is John Lingo, J-o-h-n L-i-n-g-o. I'm a solo lawyer in Omaha. Mike Dyer is a law school classmate of mine. I do about 95 percent of my work as personal injury work for injured workers. I don't represent any insurance companies, never have in 26 years. I send out these letters. I've been doing it for longer than ten years. I probably send out over 2,500 letters a year. I'm very confident to testify that I've sent more than 25,000 of these letters with an insert, not quite as detailed as Mike's which I've seen for years and years and years. I received one complaint phone call from a gentleman who wasn't happy and wondered how I got his information. I was happy to talk to him on the phone and explain it to him and he understood at that point. I asked him if he'd ever been in a motor vehicle accident before. He said no. And the more we talked about it he says, gosh, I guess I have public information out there all over the place. And I said, yeah, you do and you probably don't really actually realize it at the time. It really is information and education. I take issue with some of the testifiers before me to talk about the employer or the insurance carrier providing information and education to workers and frankly I find that laughable. Clients constantly come to me and tell me

how much they've been lied to: been lied to by the supervisor, been lied to by HR, been lied to by the nurse case manager, been lied to by the insurance claim adjuster, sometimes lied to by the company doctor. They finally get to me. And I say, no, it goes like this and lay it out under the law. Well, I got on the work comp Web site and I tried to read that but I couldn't understand it. My typical client is a guy named Joe Schmuckatelli (phonetically). Joe Schmuckatelli really doesn't stand a chance out there in the world until somebody is able to stand up for him when he's getting worked over by the system. So we're really well-regulated by the Counsel for Discipline about this with this is an advertisement on the outside of the envelope. We receive very minimal information about these people. We know the situs, the body part of the injury, and that's it. I get to screen through an e-mail every week done very efficiently by the Comp Court and I get to decide who I want to send a letter to on what body part, what employer, etcetera, etcetera, etcetera. I do it as carefully as I possibly can. About half the calls that I receive from people are the result of these letters being sent out. Why does the insurance industry want us to stop this? Because it's effective. Think about a garden hose with me for a quick second. If I'm standing at the end of the garden hose waiting for water to come out, what's the quickest way to get rid of me? Run to the house and turn off the faucet. Keep that worker away from somebody like me that knows what they're doing and knows how to get them through the system. As far as I can tell, the sole purpose about all this bill anyway is to end direct mail communication early in the process as possible, to have those employees listening only to the employer's side of the story, and to have them further isolated. One of the things that you folks wouldn't know because you're not a work comp expert and frankly I am, the beneficent purpose of the workers' compensation law is something that goes way back to the beginning, long before Judge Novicoff whose name was mentioned earlier, somebody who you folks probably don't have any idea who that was, but he's one of our old godfathers long since gone. The beneficent purpose of the Comp Court says you've got to take care of these people; you've got to protect them. That's what we're asking you to do. Thank you. I'm happy to answer any questions. [LB319]

SENATOR ALBRECHT: Thank you. Any questions? [LB319]

JOHN LINGO: Go ahead. [LB319]

SENATOR ALBRECHT: Go ahead, Senator Crawford. [LB319]

SENATOR CRAWFORD: Thank you, Chairwoman Albrecht, and thank you for being here to testify. I wondered if in any conversations with colleagues from other states if you could comment on how Nebraska compares to other states on this front in terms of the ability to... [LB319]

JOHN LINGO: I don't know. [LB319]

SENATOR CRAWFORD: ...see these records and communicate. [LB319]

JOHN LINGO: I don't know. I'm a Nebraska lawyer. I'm licensed in Nebraska only. I don't have communication with others. I know enough to be dangerous in Iowa. I don't know how other states handle it. I really don't. [LB319]

SENATOR CRAWFORD: Thank you. [LB319]

SENATOR ALBRECHT: Other questions? I'm just going to just... [LB319]

JOHN LINGO: Please. [LB319]

SENATOR ALBRECHT: ...a little question for you. Twenty-six years, obviously you enjoy what you do. [LB319]

JOHN LINGO: I do. [LB319]

SENATOR ALBRECHT: Twenty-five thousand letters, I mean would you have a percentage of how many people actually call you and say, hey, I need help? [LB319]

JOHN LINGO: Sure. Twenty-five thousand letters in ten years. [LB319]

SENATOR ALBRECHT: Ten years, okay. [LB319]

JOHN LINGO: Not even half of my time. Break it down a little bit less--2,500 in a year. In my experience, I probably talk to 150 or 200 potential clients in a year. Jon Rehm was talking about a 3 percent figure and how many lawsuits get what we call a petition, how many lawsuits get filed--infinitesimally small number compared to 40,000 claims annually in the state of Nebraska. [LB319]

SENATOR ALBRECHT: And do you just find that you're just kind of helping them through it, or are you full bore into a employee-employer situation. [LB319]

JOHN LINGO: It's a case-by-case basis. Of those people I talk to, way less than half of them become clients. Usually it's a conversation that starts out, no, they're doing everything right. They're paying you what they owe you. No, there's no real need to come into my office right now. Hang on to my letter. Something happens down the road I may or may not hear from them

again. Chances are they're mostly being handled correctly. I give the insurance company credit for that. Most claim adjusters are honest. Most claim adjusters are pretty good. Those that don't are my best friend because they piss the client off and the client comes to me. [LB319]

SENATOR ALBRECHT: Thank you. Okay. Yeah, Senator Lowe. [LB319]

SENATOR LOWE: Thank you for coming today and testifying. [LB319]

JOHN LINGO: Sure. [LB319]

SENATOR LOWE: You said you give out 2,500 a year. [LB319]

JOHN LINGO: Twenty-five...correct, sorry. [LB319]

SENATOR LOWE: Yeah, yeah. And you get the list from the Workers' Compensation Court. [LB319]

JOHN LINGO: Yes, sir. [LB319]

SENATOR LOWE: Is that same list mailed to other attorneys then? [LB319]

JOHN LINGO: We get it by e-mail. [LB319]

SENATOR LOWE: Well, e-mailed to... [LB319]

JOHN LINGO: Yes. In Omaha, Nebraska, there's about 20 lawyers that send out these letters. We receive an e-mail from the Comp Court every week in an Excel spreadsheet that we sort through of what we want...who do we want to send that letter to and then we make that decision who to send. [LB319]

SENATOR LOWE: So one employee might get 10 to 15... [LB319]

JOHN LINGO: Or 20 letters. [LB319]

SENATOR LOWE: Or 20 of these letters. [LB319]

JOHN LINGO: Correct. In about a two- to three-week period after they filed this document called first report of injury. [LB319]

SENATOR LOWE: Okay. [LB319]

JOHN LINGO: Correct. Consistently. Used to be six or eight. When this bill started, there was about...there was less than a dozen of us. It's effective. There's over 20 of us now. My competition has raised dramatically. [LB319]

SENATOR LOWE: It may go to a hundred then. [LB319]

JOHN LINGO: It wouldn't surprise me. And there's Internet and there's advertising and there's billboards and there's bus benches and and and and and. It's one of the methods of advertisement that we use. [LB319]

SENATOR LOWE: Okay. Thank you. [LB319]

SENATOR ALBRECHT: I guess I have one more question. So you send this letter but it has to be in advertisement form. It cannot be...you can't call them and you can't physically go to their home, can't go to their work. [LB319]

JOHN LINGO: Correct. I lose my license the day that happens. I can only mail it to them. Counsel of Discipline does...controls everything that lawyers do in the state of Nebraska. Very specific rule that says when we send a letter, in whatever form, in a font that's equivalent to any other size font on the front of that envelope, it has to have these specific words this is an advertisement prominently displayed at some place on the outside of the envelope. Don't have to open that letter to find it. You get 20 items in the mail and you say, lawyer, lawyer, lawyer, lawyer, lawyer. Oh, I want to open up this one. Have to say it on every single one. Can't e-mail them. Can't call them. Can't visit them. Mail only. [LB319]

SENATOR ALBRECHT: Very good. Seeing no other questions, thank you for coming up and testifying. [LB319]

JOHN LINGO: Thank you. [LB319]

SENATOR ALBRECHT: Okay, any other opponents? Anyone in a neutral position? Seeing none, we have no letters. Senator Halloran, would you like to close? [LB319]

SENATOR HALLORAN: Thank you, Chairman Albrecht and Committee. I would just like to compliment everyone who has testified on either side of the issue. The discussion I think it has been helpful for all us. I would like to say...I would like to add just what I learned from the last few testifiers--3 percent is a success story. It really is. Out of 3 percent out of 40,000; that's not to belittle the fact that 3 percent is 1,200 individuals that sought help and got help. And that's another success story. But the other side of that equation is 97 percent of those that didn't seek an attorney, their information...and didn't...I guess didn't need litigation or litigation wasn't necessary in their case, 97 percent of those that submitted workmen's comp...filed a workmen's comp, their information was out there for everybody. And I think we've all grown a little bit...we've grown comfortable knowing that our own personal health history is protected with HIPAA. And this is kind of an exception to that and I would just encourage the committee to look at supporting LB319 and advance the bill to General File for those 97 percent whose information is out there and it's not helping. Thank you. [LB319]

SENATOR ALBRECHT: Thank you. Any questions? [LB319]

SENATOR HALLORAN: Any questions? [LB319]

SENATOR ALBRECHT: Seeing none, we'll close this bill. And up next we have Senator Hansen on LB147. Welcome. Go right ahead. [LB319]

SENATOR HANSEN: Thank you. Good afternoon, Senator Albrecht and members of the Business and Labor Committee. My name is Matt Hansen; for the record, M-a-t-t H-a-n-s-e-n, and I represent the 26th Legislative District in northeast Lincoln and I'm here today to introduce LB147. There are two main components of LB147 spread throughout the bill. The first is the new subsection (1)(c) starting at the bottom of page 2 which deals with the determination of disability payments. In workers' compensation cases, when an insured determines that a worker has been injured on the job and cannot work, the insurer starts making disability payments as required by law. On most occasions the disability payments will continue until the employee returns to work or a court makes a determination of permanent disability, but in many cases an insurer will stop payments with no warning to the worker. Remember, by definition the worker is injured and cannot work, so he has no other income. Termination of the benefits results in utilities going unpaid or being turned off, rent or house payments being missed threatening foreclosure or eviction, as well as, you know, the risk of families going without food and other missing payments. All of this happens without an opportunity for a judge to decide if the termination of benefit is legal. LB147 will require that once an employee's disability payments have been commenced such payments cannot be terminated or suspended without giving the employee at least 30 days' notice. This will allow a worker to get before a judge and let the judge determine whether or not the insurer was justified. The second component of this bill deals with

warning time payments. This is language that's been added to the existing Sections (1)(b) and (2)(a). The language would clarify that payment of attorneys fees would not be allowed if the employer performs a reasonable investigation as to whether benefits were owed; the employer actually relied on the investigation to terminate, deny, or delay the payment of benefits; and the employer conveyed the results that investigation to the employee at the time of termination, denial, or delay. It was my intent for these sections and waiting time to be a restatement of current case law, but it's my understanding is that interpretation is up for debate. I will note that there are worker compensation practitioners who are following me who will be sharing their personal experience and technical expertise. I'd be happy to answer questions about what the state's public policy should be in this area. I have also been in contact with people all...from all perspectives on this bill and continue to work with stakeholders on how to get the best legislation moving forward. With that, I'll close on LB147. [LB147]

SENATOR ALBRECHT: Thank you. Do you want to wait or you going to close? Do you want to sit back? [LB147]

SENATOR HANSEN: Oh, I'll wait (inaudible). [LB147]

SENATOR ALBRECHT: Okay. Any questions at this time? Seeing none, thank you. Okay, we'll start with the proponents. [LB147]

ADAM TABOR: Chairperson, members of the committee, thank you for the opportunity to appear before you today. My name is Adam Tabor, T-a-b-o-r, and I'm a workers' compensation attorney out of Omaha, Nebraska. I'm appearing today in support of LB147. As Senator Hansen explained, LB147 addresses two issues. First and foremost, the most important issue it addresses is in Section (1)(c) which is...which would require that once benefits have been started they cannot be shut off unless 30 days' notice has been given or the employee has returned to work. What's important to realize here is that injured workers are in a precarious financial situation. They're receiving a weekly benefit that is substantially less than if they were working. And they're dependent on that benefit just as if they were dependent on their weekly paycheck or their biweekly paychecks. They use it to pay for rent, food, utilities, car payments, things like that. Under the current law, there's no requirement to provide them notice ahead of a denial. In my practice what often happens is a claim may be accepted. The claim progresses for a while. They get weekly payments. They get medical benefits. Then the insurance carrier decides to get a defense medical exam. There is something in the defense medical exam that the insurance company relies on to deny the claim. Payments are...weekly benefits are stopped without any notice being provided to the injured worker. LB147 tries to give them 30 days' notice. I mean with the intent of hopefully that will help them give them some heads up, maybe get in front of a judge if they need to. The second portion of LB147 addresses waiting time and waiting time

benefits or penalties and attorney fees. Under the current law, the Nebraska Supreme Court has read into this statute a reasonable controversy standard. And essentially what the problem is, is that the employer or the insurance carrier is able to bring the evidence that creates the reasonable controversy to trial. What I mean is they don't have to have it...it doesn't have to exist at the time of the denial. I feel, you know, that that's unfair. I feel that they should be required to do some investigation and rely on that investigation to deny the claim and to convey that to the injured worker at the time of the denial. With that, I'd be happy to answer any questions. [LB147]

SENATOR ALBRECHT: Thank you. Do we have any questions? Seeing none, thank you. [LB147]

ADAM TABOR: Thank you very much. [LB147]

SENATOR ALBRECHT: Any other proponents? Any other proponents? We'll move on to opponents. Do we have any opponents wishing to speak? [LB147]

JOHN CORRIGAN: Good evening, Madam Chair, members of the committee. John Corrigan on behalf of the AFL-CIO, J-o-h-n C-o-r-r-i-g-a-n. And we do...I testify in opposition to this bill. We do agree with the notice provisions. I'll give you an example of a case just happened two weeks ago in my office. A gentlemen is injured. They sent him to an urgent care facility. The doctor there says clearly work related. Sends him on to a specialist. The specialist does an evaluation, orders two weeks of physical therapy. The specialist then dictates his office note, client goes to two weeks of physical therapy. The office note gets typed up. About ten days later, the insurance adjuster gets the office note and the office notes says I believe this is a degenerative condition not related to the work accident. My client got stuck with the two weeks of physical therapy that his employer didn't have to pay for anymore because they said it wasn't work related. No one told him that. And so this notice provision has real effect on people's lives. Now the reason I'm testifying in opposition to the bill is with respect to the provision about this attempt to clarify the existing law, that you have penalties provisions in the law that say the employer has to pay penalties or attorney's fees if there was no reasonable controversy and they failed to pay workers compensation benefits in a timely manner. And we know what the term reasonable controversy has come to mean through years of case law. My concern with this bill or our concern that this bill is that now that the status is that the employer...the insurer conducted a reasonable investigation into whether benefits were owed. I don't know how we're going to prove whether that was done or it wasn't done. I assume that's going to take expert testimony from somebody in the insurance industry to say, oh yeah, I looked at those facts and those seem reasonable to me. I'm not sure, but in any event we are certainly willing to go on record in support of this bill if that provision can be rectified to ensure that the...you know, the purposes of those penalties is to create an incentive on the part of the employer to make a decision about

whether the claim is compensable or not. And we don't want to make it more complicated for the trial court then to have to decide these issues of whether a reasonable investigation was done. The current language of reasonable controversy takes...there's going to be some medical opinion about whether this condition is or is not work related and we do know what that means. And so with that trepidation, that's the reason for our opposition to LB147. Thank you. [LB147]

SENATOR ALBRECHT: Thank you. Have we...do we have any questions? Have you seen this bill come up before in the past? [LB147]

JOHN CORRIGAN: No, we have not. Well, there's always been a desire for the 30-day notice. The other language has not been an issue before, although the purpose or the concern is two days before trial after they've denied benefits for nine months they get a doctor's report and their doctor comes in and says I don't think it's work related. I'm saying they, the insurance carrier. So then the worker and the...they go to trial and the judge says, well, there is a reasonable controversy here because Dr. X said it wasn't work related; Dr. B said it was. I'm going to credit Dr B. But because Dr X. said it was nine months ago, now there's no reasonable controversy and there's no penalty for employer's conduct. The problem for the employer comes in when Dr. X says, yeah, I do agree with Dr. B. And this is work related. Now there's a penalty and it's much more expensive because they didn't...there wasn't controversy and they didn't pay in a timely manner. [LB147]

SENATOR ALBRECHT: Appreciate that. Thank you. [LB147]

JOHN CORRIGAN: Okay. Thank you. I'll fill out the form. [LB147]

SENATOR ALBRECHT: Do we have any other opponents? [LB147]

PAUL BARTA: (Exhibit 1) Members of the committee, my name is Paul Barta, P-a-u-l B-a-r-t-a. I am here on behalf of Nebraskans for Workers' Compensation Equity and Fairness, a group alluded to earlier by one of my colleagues as he had no idea who we were. I'm one of them. I am here to speak in opposition to LB147 and I'll be relatively brief. I think there's a couple points that Mr. Corrigan raised which I think are pretty essential to why this bill is unnecessary. The first proposed amendment discussing the waiting time penalties and the reasonable investigation I think it's pretty clear and we heard from the members of the plaintiff's bar earlier that litigation, increased litigation is something they want to avoid also. I think anything that's codifying the idea of a reasonable investigation, all that's doing is going to create further litigation. He raises a good point. I think you're going to have significant legal expenses involved and frankly you're going to have sideline fights that really aren't necessary in the context of workers' compensation just over this. Why isn't it necessary? It's not necessary by virtue of the fact that there already are

penalty provisions. If the employer...there was a discussion of how sometimes employers or insurers will sit on a case. They'll deny it and they'll try and swoop in at the last minute and get a report to save their bacon. I will tell you that doesn't happen as much as plaintiff's bar would like to suggest it would by virtue of the fact that if the employers are unable to come up with a basis of denial at the time that they're doing it, it's going to be very hard for them to do it later on and swoop in. So there is already significant penalty exposure for employers who don't have a reasonable basis. So my concern on this is all you're doing if this gets passed as it is as to the waiting time penalties is you're inviting further litigation and you're just adding more stress on the court which is really unnecessary. As to the second part which is the 30 days' notice, I will note that both of these provisions and I understand, of course, that imitation is the best form of flattery and when legislation comes before the Unicameral obviously a lot of times that's coming from different places. So to say, well, this is from Iowa, therefore, we shouldn't use it, I get that. I get that we borrow from a lot of different pieces. But I would note that both of these provisions are substantially borrowed from Chapter 85 of the Iowa Workers' Compensation Code. I practice over there. I'd also note that if you strain to listen across the river right now, there are some major, major reforms taking place in workers' compensation over there because this system from where this is drawn has been overly onerous on the state. Obviously this body is going to do what it needs to do for Nebraskans, but I'd note that these provisions are taken from Iowa law and there's currently a pretty significant reform movement that may get passed soon over in Iowa to take some of the stuff out. Now on the 30-day notice provision, by no means as an opponent of this am I blind to the idea that at times having someone's benefits shut off can work some kinds of hardship. But you also have to look at the other end of this. The employer typically has to have a basis or they will already be subject to penalties to cease benefits when they do. What this is doing is requiring the employee either return to work or benefits continue for 30 additional days. Now that sounds great but there is an inverse. What if that employee...what if that employee was terminated for a legitimate cause? And now you're telling the employer even though this employee doesn't have work restrictions, this employee did something at work which anybody, regardless of whether you filed a claim or not would have been terminated for, you have to pay that individual 30 days worth of benefits. There was the discussion of, well, if you give them 30 days maybe you'll be able to get him into court. I wish, as a practitioner, I wish that somehow people could just wave a wand and get an issue hammered out on something like that because it goes to compensability and that's going to be a trial issue and that's going to be months down the road depending where you are. There's a chilling effect--this is the final part I'll tell the body--is we've been here, we've heard the plaintiff's bar talk about how, well, these employers, these insurance carriers they do this, they do that, and it's all against the worker. Well, here's a question. As an employer, why would I voluntarily step up and pay benefits on a claim that's questionable but I'm investigating it if I knew as soon as I did that I was going to lock myself into some kind of additional provision where I either had to return this person to work or pay them additional 30 benefits...30 days worth of benefits. So my concern on this is it actually is going to have the opposite effect. If we're worried about workers, what's going to happen is

employers are going to say, well, wait a second. We need to pump the brakes on this in terms of picking up medical care or directing medical care down the road because we're going to be on the hook for further benefits. So that would be my testimony. I'm obviously open to any questions if you have any. [LB147]

SENATOR ALBRECHT: Thank you very much. Do we have any questions from the committee? Seeing none, thank you so much for coming. [LB147]

PAUL BARTA: Thank you. [LB147]

ROBERT J. HALLSTROM: (Exhibit 2) Chairman Albrecht, members of the committee, my name is Robert J. Hallstrom, H-a-l-l-s-t-r-o-m. I appear before you today as registered lobbyist for the National Federation of Independent Business, the Nebraskans for Workers' Compensation Equity and Fairness, and I'm also signing in in support on behalf of the Nebraska Trucking Association and the Greater Omaha Chamber of Commerce, and if Mr. Sedlacek has left, I think the Nebraska Chamber of Commerce and Industry as well. I'm not going to repeat anything here other than I would agree with Mr. Corrigan, and for future reference, perhaps if you put Mr. Corrigan and I in a hot room for 4.5 to 5 hours maybe we can come to agreement more frequently. But I think designating an undefined reasonable investigation in the statutes as proposed under LB147 just leads to increased litigation to determine exactly what that means going forward. I think the reasonable controversy standard that the court has established is well established, well known, and should be kept. With regard again to the additional 30 days' benefits. I think you have a situation again where if an employer voluntarily pays benefits and then subsequently determines that there was some type of fraud or improper conduct that may not even be work related and he wasn't even obligated, the employer wasn't even obligated to pay those benefits in the first place, this bill would say you still pay another 30 days, notwithstanding the fact that you never should have paid or were required to pay the benefits in the first place. So for those reasons we oppose LB147. [LB147]

SENATOR ALBRECHT: Thank you for being heard and for your testimony. Do we have any questions? Seeing none, thank you. [LB147]

ROBERT J. HALLSTROM: Thank you. [LB147]

KORBY GILBERTSON: Good evening, Chairwoman and members. For the record, my name is Korby Gilbertson; it's spelled K-o-r-b-y G-i-l-b-e-r-t-s-o-n, appearing today as a registered lobbyist on behalf of the Property Casualty Insurers Association of America in opposition to LB147. To make this quick I'll just say that we also have concerns about the definition of what a reasonable investigation is and as far as the 30-day period, time period goes, I think Mr. Corrigan

kind of said it best. If there is someone who was injured and then they went and had care and then it was later determined that that was not a workplace injury, then this is saying well even though it's not workplace injury and that employer really shouldn't have been on the hook for these damages or the services that that employee got, they should still be on the hook for an additional 30 days. That concerns us and the overall purpose of the Workers' Compensation Act. Be happy to answer any questions. [LB147]

SENATOR ALBRECHT: Thank you for being here. Do we have any questions? Seeing none, thank you. [LB147]

KORBY GILBERTSON: Thank you. [LB147]

TAD FRAIZER: I think I may be tail-end Charlie here tonight. Good afternoon, Chairman Albrecht, members of the committee. My name is Tad Fraizer, T-a-d F-r-a-i-z-e-r, representing the American Insurance Association, a national trade group that includes worker comp carriers. I'd echo the comments of the prior proponents. Obviously we've got fairly subtle case law on waiting time and attorneys' fees at the moment. And when you start tinkering with that by trying to write it into the code then the courts wonder are you meaning something different and you kind of open it up to further uncertainty. So we think it's fairly well established as is and doesn't need additional tweaking. And I'd again echo the questions about the 30-day period. If it's determined ultimately that compensation was not properly payable, then you paid out a month of compensation that was not due in the first place. And obviously that pushes up costs and there's some question about how you handle that payment or recover it or anything like that. I would try to answer any questions you might have. [LB147]

SENATOR ALBRECHT: Thank you. Any questions? Seeing none, thank you for being here. Do we have any other opponents wishing to speak? Any other opponents? Seeing none, anyone in neutral position? (Exhibit 3) Seeing none, I have one letter: an opponent, Christy Abraham from League of Nebraska Municipalities. That would be the only one. Would you like to close? Senator Hansen waives the closing. Thank you and that concludes our committee hearings today for Business and Labor. [LB147]